EMTALA

California Hospital
EMTALA Manual

A guide to patient anti-dumping laws

Written by M. Steven Lipton

CALIFORNIA HOSPITAL ASSOCIATION

EMTALA — A Guide to Patient Anti-Dumping Laws

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Written by
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Quick Reference

INTRODUCTION

AUTHOR ACKNOWLEDGMENTS

WHERE TO FIND LAWS REFERENCED IN THE MANUAL

LIST OF ACRONYMS

CHAPTERS

Chapter 1	Overview of Patient Anti-Dumping Laws
Chapter 2	When and Where Does EMTALA Begin and End?
Chapter 3	Medical Screening Examinations
Chapter 4	Financial Considerations — EMTALA and Managed Care
Chapter 5	Transferring or Discharging an Emergency Patient
Chapter 6	EMTALA and Psychiatric Emergency Patients
Chapter 7	Obligations of Receiving Hospitals
Chapter 8	Patient Refusal of Stabilizing Treatment or Transfer
Chapter 9	Maintenance pf the Central Log
Chapter 10	Required Signage
Chapter 11	Physician On-Call Responsibilities
Chapter 12	Reporting Patient-Dumping Violations
Chapter 13	Regulatory Enforcement of EMTALA
Chapter 14	Private Actions to Enforce EMTALA
Chapter 15	Quality Improvement and Risk Management
Chapter 16	Application of EMTALA to Disasters and Public Health Emergencies

INDEX

APPENDIXES

Appendix A	EMTALA Statute
Appendix B	EMTALA and Emergency-Related Federal Regulations
Appendix C	EMTALA *Interpretive Guidelines* (Part II: Responsibilites of Medicare Participating Hospitals in Emergency Cases)
Appendix D	California Hospital Licensing Laws on Emergency Services and Care
Appendix E	CoP for Emergency Services: Hospital *Interpretive Guidelines*

Appendix F	Knox-Keene Act Provisions
Appendix G	Medicare Advantage Regulations
Appendix H	Special Advisory Bulletin
Appendix I	EMTALA Enforcement Chart
Appendix J	Hospital Records Subject to EMTALA Enforcement Survey
Appendix K	Investigative Procedures for EMTALA Surveyors (Part I of EMTALA *Interpretive Guidelines*)
Appendix L	Sample Survey Tools for Patient Transfers and Medical Screening Examinations
Appendix M	An Explanation of the Scope of RN Practice Including Standardized Procedures
Appendix N	Policies Recommended for EMTALA Compliance
Appendix O	Model Hospital Policy on Compliance with EMTALA
Appendix P	CHA Transfer Forms and Model Signage
Appendix Q	CMS Survey and Certification Memorandum 08-08: Requirements for Off-Campus Emergency Departments (Jan. 11, 2008)
Appendix R	CMS Survey and Certification Memorandum 09-52: EMTALA Options in a Disaster (Aug. 14, 2009)
Appendix S	Sample Transfer Agreement
Appendix T	Sample Transfer Checklist and Script for Accepting Emergency Patients
Appendix U	CDPH All-Facility Letter 12-17 (May 17, 2012)
Appendix V	CMS Letter Regarding Transfer of Patients to Crisis Stabilization Units
Appendix W	EMTALA Physician Review Worksheet
Appendix X	CMS Survey and Certification Memorandum 14-06: EMTALA Requirements & Conflicting Payor Requirements or Collection Practices (Dec. 13, 2013)
Appendix Y	CMS Survey and Certification Memorandum 13-38: Critical Access Hospital Emergency Services and Telemedicine (June 7, 2013)
Appendix Z	CMS Survey and Certification Memoranda 06-21 and 07-20: Detaining EMS Personnel and Equipment (July 13, 2006 and April 27, 2007)
Appendix AA	CMS Survey and Certification Memoranda 15-10 and 15-24: EMTALA and Ebola (Nov. 21, 2014 and Feb. 13, 2015)

Introduction

EMTALA — A Guide to Patient Anti-Dumping Laws, 9th edition (2018), provides guidance to hospitals and physicians on compliance with the Emergency Medical Treatment and Labor Act (EMTALA). Where applicable, the EMTALA manual also addresses California hospital licensing, involuntary commitment and managed care laws regarding the provision of emergency services and post-stabilization care.

Since the adoption of the initial EMTALA regulations in 1994, the U.S. Department of Health and Human Services (HHS) has committed extensive resources to enforcing EMTALA. The Centers for Medicare & Medicaid Services (CMS) is charged with the administrative interpretation and enforcement of EMTALA. As discussed in a 2001 HHS Office of Inspector General (OIG) report, the number of EMTALA investigations and their outcomes vary widely by CMS region; however, administrative enforcement by CMS Region IX (California, Arizona, Hawaii and Nevada) has been among the more active in the nation. In addition, the OIG has the authority to enforce EMTALA against hospitals and physicians by imposing civil money penalties or exclusion from the Medicare and Medicaid programs. In 2017, the civil penalties for an EMTALA violation were updated for inflation which increased sanctions to over $100,000 for an EMTALA violation (more than $50,000 for a hospital under 100 beds).

Despite three decades of experience with EMTALA, there is still considerable confusion by hospitals, physicians, state survey agencies, and even some CMS officials, on the scope and application of the law. In 1994 and 2000, CMS expanded the scope of EMTALA; in 2003, CMS both limited and expanded the scope of EMTALA in an overhaul of the 1994 and 2000 regulations. Between 2004 and 2013, CMS periodically amended the EMTALA regulations in piecemeal fashion. The EMTALA *Interpretive Guidelines* issued by CMS were last updated in 2010, and have been supplemented by several Survey and Certification memoranda on various topics related to EMTALA compliance

Despite the efforts to clarify EMTALA, there are still several long-standing areas of confusion. These include the application of EMTALA to hospitals that do not operate a licensed or organized emergency department, and to hospital urgent care centers and other services that are held out for both scheduled and drop-in patients. As to emergency department operations, there are still questions about the scope of an appropriate medical screening examination, the meaning of “stabilized” and the relevance of “clinical stability” to a transfer, the obligations of receiving hospitals, and the standards for on-call coverage. There is the increasing struggle, if not crisis, in the overlay of EMTALA obligations to state involuntary commitment laws and regional treatment networks for psychiatric patients that include a mix of hospitals and ambulatory settings.

Hospitals are also subject to court decisions establishing interpretations of EMTALA, some of which vary from the EMTALA regulations or the CMS *Interpretive Guidelines*. As discussed in chapter 14, "Private Actions to Enforce EMTALA," courts have issued decisions on the standard of proof for an EMTALA violation, the application of EMTALA to inpatients and to individuals in nonhospital-owned ambulances en route to a hospital, the scope of an appropriate medical screening examination, the determination of a dedicated emergency department and the obligations of a receiving hospital to accept emergency patient transfers.

The EMTALA manual is designed to summarize the EMTALA obligations for hospitals and physicians, and answer the most frequently asked questions. Readers familiar with EMTALA know that the interpretation of EMTALA is fast-changing (and at times, mind-numbing and frustrating). The 9th edition includes updates to the EMTALA regulations, the *Interpretive Guidelines* and CMS program memoranda through October 2017.

The EMTALA manual is written for hospital staff and physicians; therefore, the text does not include footnotes identifying the sources for the content. To assist readers, the appendices to the manual include the EMTALA statute and regulations, the *Interpretive Guidelines* and California hospital and managed care laws on emergency and post-stabilization services. Additional appendices include a model hospital compliance policy, a receiving hospital transfer checklist and other materials. References to these materials are marked with a ☞ throughout the manual.

The EMTALA manual is generally limited to EMTALA and California laws governing the provision of emergency services. It does not address numerous other laws and legal obligations applying to hospitals, physicians and other health care personnel in providing emergency care. These include hospital licensing laws for emergency departments; professional practice acts; accreditation standards; consent and privacy laws; reimbursement issues; requirements of regional emergency medical service networks; the rights of persons subject to involuntary detention; trauma standards; and other laws that apply to emergency services and personnel.

The EMTALA manual is limited to the obligations to comply with EMTALA and other emergency service laws. Hospitals, physicians and other caregivers are encouraged to consider ethical, philosophical (e.g., mission and values) and industry standards in making decisions related to emergency services and care, whether or not implicated by EMTALA or other laws.

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Where to Find Laws Referenced in the Manual

All of the laws discussed in *EMTALA — A Guide to Patient Anti-Dumping Laws* can be found on the Internet.

FEDERAL LAW

A federal statute is written by a United States Senator or Representative. It is voted on by the United States Senate and the House of Representatives, and then signed by the President. A federal statute is referenced like this: 42 U.S.C. Section 1395. "U.S.C." stands for "United States Code." Federal statutes may be found at www.gpo.gov/fdsys or at www.law.cornell.edu.

A federal regulation is written by a federal agency such as the U.S. Department of Health and Human Services or the U.S. Food and Drug Administration. The proposed regulation is published in the Federal Register, along with an explanation (called the "preamble") of the regulation, so that the general public and lobbyists may comment on it. The federal agency must summarize and respond to each comment it receives on the proposed regulation. The agency may or may not make changes to the proposed regulation based on the comments. The final regulation is also published in the Federal Register. A federal regulation is referenced like this: 42 C.F.R. Section 482.1 or 42 C.F.R. Part 2. "C.F.R." stands for "Code of Federal Regulations." Federal regulations may be found at www.gpo.gov/fdsys or at www.ecfr.gov. The preamble, however, is only published in the Federal Register and not in the Code of Federal Regulations. The Federal Register may be found at www.gpo.gov/fdsys or at www.federalregister.gov.

The Centers for Medicare & Medicaid Services publishes its *Interpretive Guidelines* for surveyors on the internet. They may be found at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html (click on Publication 100-07, "State Operations Manual," then "Appendices Table of Contents"). There are several appendices that hospitals will find useful, for example, A (hospitals), AA (psychiatric hospitals), V (EMTALA), and W (critical access hospitals).

A federal law must be obeyed throughout the United States, including in California, unless the federal law expressly states otherwise. As a general rule, if a federal law conflicts with a state law, the federal law prevails, unless the federal law expressly states otherwise.

If there is no conflict, such as when one law is stricter but they don't actually conflict with each other, both laws generally must be followed. For example, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the federal law states that providers must conform to whichever provision of federal or state law provides patients with greater privacy protection or gives them greater access to their medical information.

STATE LAW

A state statute is written by a California Senator or Assembly Member. It is voted on by the California Senate and Assembly, and then signed by the Governor. A state statute is referenced like this: Civil Code Section 56 or Health and Safety Code Section 819. State statutes may be found at www.leginfo.legislature.ca.gov. Proposed laws (Assembly Bills and Senate Bills) may also be found at this website.

A state regulation is written by a state agency such as the California Department of Public Health or the California Department of Managed Health Care. A short description of the proposed regulation is published in the *California Regulatory Notice Register*, more commonly called the *Z Register*, so that the general public and lobbyists may request a copy of the exact text of the proposed regulation and comment on it. The state agency must summarize and respond to each comment it receives on the proposed regulation. The agency may or may not make changes to the proposed regulation based on the comments. A notice that the final regulation has been officially adopted is also published in the *Z Register*. The *Z Register* may be found at www.oal.ca.gov/notice_register.htm.

A state regulation is referenced like this: Title 22, C.C.R., Section 70707. "C.C.R." stands for "California Code of Regulations." State regulations may be found at www.calregs.com.

A state law must be obeyed in California only. As a general rule, if a California law conflicts with a federal law, the federal law prevails, unless the federal law expressly states otherwise. (If there is no conflict, such as when one law is stricter but they don't actually conflict with each other, both laws generally must be followed.)

List of Acronyms

ABN	Advance Beneficiary Notice of Noncoverage
AIDS	Acquired Immune Deficiency Syndrome
AFL	All Facility Letter (issued by CDPH)
AII	Airborne infection isolation
AirID	Airborne Infectious Disease
ALJ	Administrative Law Judge
AMA	Against medical advice
ATD	Aerosol transmissible disease
BRN	Board of Registered Nursing
CAH	Critical access hospital
CDC	Centers for Disease Control and Prevention
CCP	Community call plan
CDPH	California Department of Public Health
CHA	California Hospital ASsociation
CFR	Code of Federal REgulations
CMS	Centers for Medicare & Medicaid Services
CoP	Medicare Conditions of Participation
CSU	Crisis stabilization unit
DAB	Departmental Appeals Board
DED	Dedicated emergency department
DHCS	California Department of Health Care Services
DHMC	California Department of Managed Health Care
ED	Emergency department
EMC	Emergency medical condition
EMS	Emergency medical services
EMT	Emergency medical technician

EMTALA	Emergency Medical Treatment and Active Labor Act
Fed. Reg.	Federal Register
GAO	General Accountability Office
HCFA	Health Care Financing Administration (the former name of CMS)
HHS	U.S. Department of Health and Human Services
HMO	Health maintenance organization
HSAG	Health Services Advisory Group
ICU	Intensive care unit
IPA	Independent practice association
IRS	Internal Revenue Service
LPS	Lanterman-Petris-Short Act
LWBS	Left without being seen
MA	Medicare Advantage
MICRA	Medical Injury Compensation Reform Act
MRI	Magnetic resonance imaging
MSE	Medical screening examination
OB	Obstetrics
OBRA	Omnibus Budget Reconciliation Act
OCR	Office for Civil Rights (part of HHS)
OIG	Office of Inspector General (part of HHS)
OSHA	Occupational Safety and Health Administration
OSHPD	Office of Statewide Health Planning and Development
PHF	Psychiatric health facility
QAPI	Quality assurance/performance improvement
QIO	Quality improvement organization
S&C	Survey and Certification (Medicare)
TAG	EMTALA Technical Advisory Group

1 Overview of Patient Anti-Dumping Laws

I. EMTALA Overview And History 1.1

A. The EMTALA Statute 1.1

B. The EMTALA Regulations 1.1

C. The EMTALA ***Interpretive Guidelines*** 1.1

D. Special Advisory Bulletins and Other Guidance 1.2

E. Enforcement and Penalties 1.2

F. EMTALA Committees and Reports 1.3

Office of Inspector General 1.3

General Accountability Office 1.4

EMTALA Technical Advisory Group 1.4

II. EMTALA Compliance 1.5

III. State Laws 1.5

IV. Definitions 1.6

A. Campus of a Hospital 1.6

B. Capacity 1.6

C. Comes to the Emergency Department 1.6

D. Consultation 1.7

E. Dedicated Emergency Department 1.7

F. Emergency Medical Condition 1.7

G. Emergency Services and Care 1.8

H. Hospital Property (also referred to as the "Campus of a Hospital") 1.8

I. Labor 1.9

J. Psychiatric Emergency Medical Condition 1.9

K. To Stabilize 1.9

L. Stabilized 1.10

M. Transfer 1.10

N. Within the Capability of the Facility 1.10

1 Overview of Patient Anti-Dumping Laws

I. EMTALA OVERVIEW AND HISTORY

A. The EMTALA Statute

The Emergency Medical Treatment and Labor Act (EMTALA) was enacted by Congress as a part of the Consolidated Omnibus Budget Reconciliation Act of 1986 to ensure access to emergency services. The statute was amended in 1988, 1989, 2003 and 2011. EMTALA applies to anyone who presents for emergency services to a hospital that participates in the Medicare program (including psychiatric hospitals). The EMTALA statute is included as Appendix A.

EMTALA was enacted in response to studies that found that indigent emergency patients had been turned away from hospitals for necessary services or transferred (i.e., "dumped") to public and charity hospitals in an unstabilized condition. Although EMTALA was passed to mandate access to emergency services by the indigent, Congress applied the EMTALA requirements to all patients regardless of financial or insurance status. In general, both the federal regulatory agencies and the courts have defined the primary objectives of EMTALA as twofold: to enhance access by all persons to emergency services and to prohibit discrimination in the provision of emergency services to persons presenting with the same or similar types of conditions.

B. The EMTALA Regulations

The initial EMTALA regulations were published in draft form in 1988, and issued as interim final regulations on June 22, 1994. On April 7, 2000, the regulations were amended to apply the EMTALA obligations to off-campus hospital services. In September 2003, the Centers for Medicare & Medicaid Services (CMS) published further changes to the EMTALA regulations, repealing part of the 2000 regulations and clarifying the application of EMTALA to emergency patients, outpatients and inpatients. Since 2004, CMS has amended the EMTALA regulations in piecemeal fashion in 2006, 2007, 2008 and 2009. The current regulations are included as Appendix B.

C. The EMTALA *Interpretive Guidelines*

CMS has adopted *Interpretive Guidelines* as part of the *Medicare State Operations Manual* to provide guidance for federal and state surveyors in their enforcement of EMTALA. Although the *Interpretive Guidelines* are not regulations, they are considered the official interpretation of EMTALA by CMS and are used by California Department of Public Health (CDPH) surveyors and CMS regional offices in enforcement of the EMTALA obligations. The most recent update to the *Interpretive Guidelines* was July 16, 2010; the *Interpretive Guidelines* are included as Appendix C.

NOTE: The *Interpretive Guidelines* are organized by "tag numbers," each of which corresponds to a CMS regulation that establishes the rules for EMTALA. The tag numbers

beginning with the letter "A" are applicable to hospitals and the tag numbers beginning with the letter "C" are applicable to critical access hospitals. Each tag number has four digits, with the number "2" at the beginning of each tag number.

D. Special Advisory Bulletins and Other Guidance

In November 1999, CMS and the Office of Inspector General (OIG) released a final Special Advisory Bulletin on EMTALA and managed care. The Bulletin discusses the rules on seeking health plan authorization prior to the medical screening examination (which were added to the EMTALA regulations in 2003), dual staffing of emergency departments and recommended patient registration practices to minimize violations of EMTALA. The Bulletin is discussed in chapter 4, "Financial Considerations — EMTALA and Managed Care," and is included as Appendix H.

From time to time, CMS issues Program Memoranda on various subjects relating to EMTALA obligations. Most of these memoranda have been incorporated into the *Interpretive Guidelines (see Appendix C)*. This manual includes the latest CMS guidance on Critical Access Hospital on-call compliance with EMTALA (Appendix Y), conflicting payor requirements (Appendix X), and Ebola implications for EMTALA (Appendix AA). These memoranda are also described in detail in applicable chapters of this manual.

E. Enforcement and Penalties

The EMTALA obligations are a condition of the Medicare provider agreement (rather than a Condition of Participation), thereby permitting CMS to terminate a provider upon a confirmed violation of EMTALA. As described in chapter 13, "Regulatory Enforcement of EMTALA," the federal agencies charged with ensuring EMTALA compliance are CMS and the OIG.

CMS has the authority to conduct complaint and enforcement surveys for EMTALA compliance, and to terminate a hospital's Medicare provider agreement upon confirming one or more violations of EMTALA.

Under the EMTALA statute (Appendix A), the OIG has the authority to impose civil money penalties up to $50,000 against hospitals and physicians ($25,000 for hospitals with less than 100 beds), and/or to exclude a hospital or physician from the Medicare and Medicaid programs for violations of EMTALA that are "gross and flagrant or repeated." In December 2016, the OIG issued final regulations updating the amount of civil money penalties, including EMTALA fines. Effective in 2017, the OIG may now impose civil penalties up to $104,826 against hospitals and physicians ($52,414 for hospitals with less than 100 beds) for an EMTALA violation. The maximum amount of the fines is subject to annual adjustment for inflation.

The regional quality improvement organization (QIO) is responsible for assisting CMS and OIG review patient stabilization and other medical matters pertaining to the delivery of emergency care and services.

For hospitals that have community service obligations under the Hill-Burton Act, the Office for Civil Rights (OCR) will follow up on violations of EMTALA confirmed by CMS with a request for copies of EMTALA compliance, transfer, admission and other hospital policies.

F. EMTALA Committees and Reports

Since 2001, there have been a number of committees and governmental agencies that have issued reports on EMTALA, including reports regarding compliance by hospitals and physicians with EMTALA standards, the enforcement process and the overall effect of the law.

Office of Inspector General

In January 2001, the OIG released two reports on EMTALA: "Survey of Hospital Emergency Departments" and "The Enforcement Process."

The OIG's "Survey of Hospital Emergency Departments" made the following findings:

1. Emergency department personnel are familiar with the EMTALA requirements, but many are unaware of recent policy changes.
2. Training increases EMTALA familiarity for all staff; unfortunately, on-call specialists and staff in high-volume emergency departments are less likely to receive training.
3. Hospital staff report that hospitals generally comply with EMTALA, but some express concerns about compliance.
4. Hospital staff believe that some aspects of EMTALA are unclear or questionable.
5. Hospital staff believe that while EMTALA may help protect patients, it also may contribute to a hospital's administrative and financial problems.
6. Investigations, many of which do not confirm violations, often prompt changes in forms and procedures.
7. Managed care creates special problems for hospitals in complying with EMTALA.
8. Hospitals have difficulty staffing on-call panels for some specialists.

The OIG report made three conclusions:

1. CMS should use a variety of methods to communicate important policy changes, including e-mail and the Internet.
2. CMS should support legislation that compels managed care plans to reimburse hospitals for EMTALA-related services, including screening exams that do not reveal the presence of an emergency medical condition.
3. Uncompensated care and on-call panels are very complex problems that may require action at the federal, state and local levels as well as by private entities.

The OIG reported that CMS concurred with its recommendations.

In "The Enforcement Process" report, the OIG issued the following findings on the EMTALA enforcement process:

1. The EMTALA enforcement process is compromised by long delays and inadequate feedback.
2. The number of EMTALA investigations and their ultimate disposition vary widely by CMS region and year.
3. Poor tracking of EMTALA cases impede oversight.

4. Peer review is not always obtained before CMS considers terminating a hospital for medical reasons.

The OIG report recommended that CMS increase its oversight of the regional offices, improve collection and access to EMTALA data, ensure that peer review occurs for cases involving medical judgment, and establish an EMTALA technical advisory group. The OIG reported that CMS concurred with its recommendations.

General Accountability Office

In June 2001, the U.S. General Accountability Office (GAO) released its own report entitled "EMTALA Implementation and Enforcement Issues." Among other findings, the GAO reported that providers generally support the goals of EMTALA, but are uncertain about the extent of their obligations and have concerns about its effects on emergency care. In Table 1 of the report, the GAO listed seven issues identified as provider uncertainties:

1. Scope of the medical screening exam
2. Definition of patient stability for transfer
3. Obligations for post-hospital care
4. Application of the 250-yard rule
5. Obligations related to patients in other hospital departments
6. Requirement for on-call coverage
7. Compliance with local emergency medical systems for routing of ambulances

The comments by CMS on those issues are addressed in various sections of this manual.

Regarding the enforcement of EMTALA, the GAO reported that most EMTALA violations involve failure to screen, stabilize or transfer appropriately. They noted that although hospitals have concerns about CMS enforcement, CMS usually accepts corrective action plans and rarely terminates hospitals from the Medicare program. Finally, the GAO found that the OIG focuses on future compliance in assessing fines for EMTALA violations, and generally does not pursue a physician in the absence of clearly culpable behavior. The GAO endorsed many of the OIG recommendations in the two earlier reports discussed above.

In April 2009, the GAO issued a report entitled "Hospital Emergency Departments — Crowding Continues to Occur, and Some Patients Wait Longer than Recommended Time Frames." The report looked at indicators of emergency department crowding, including ambulance diversion, wait times and patient boarding. The report determined that the primary factor for emergency department crowding is the lack of inpatient beds, with the following secondary factors: lack of access to primary care, a shortage of available on-call specialists and difficulties with transferring or discharging psychiatric patients. The report, "GAO 09- 347," can be accessed on the GAO website at www.gao.gov/new.items/d09347.pdf.

EMTALA Technical Advisory Group

In the 2003 Medicare reform legislation, Congress directed the Secretary of HHS to establish a Technical Advisory Group (TAG) to solicit advice concerning the EMTALA regulations and enforcement. The Secretary signed the charter establishing the TAG on May 11, 2004; the tag had a term of 30 months. The TAG was composed of 19 members, including four hospital representatives and seven physicians. The final meeting of the TAG was Sept. 17-18, 2007.

The TAG had the following responsibilities:

1. Review the EMTALA regulations;
2. Provide advice and recommendations to the Secretary concerning the regulations and their application to hospitals and physicians;
3. Solicit comments and recommendations from providers and the public regarding the implementation of the regulations; and
4. Disseminate information on the EMTALA regulations to providers and the public.

During its tenure, the TAG issued seven reports and made several recommendations to CMS, some of which resulted in changes to the regulations and others in updated guidance issued in Program Memoranda. At its final meeting, the TAG adopted a series of recommendations related to accepting hospital obligations, clarification of conditions that constitute an "emergency medical condition," clarification of the term "stabilization" (including a proposed concept of "temporary stabilization"), and procedures and criteria for transferring patients with stabilized conditions to physician offices for follow-up evaluation and care. It is uncertain whether these recommendations will be accepted by CMS, and if so, whether there will be any changes.

Further information on the TAG, including meeting agendas and reports, is available on the CMS website at www.cms.hhs.gov/EMTALA/03_emtalatag.asp.

II. EMTALA COMPLIANCE

Hospitals should adopt a hospital-wide policy that commits the facility to comply with EMTALA as well as quality improvement, risk management and corporate compliance programs to monitor adherence with EMTALA standards. A model policy is included as Appendix O. Other recommended EMTALA policies are discussed throughout this manual and are listed in Appendix N.

III. STATE LAWS

The EMTALA statute expressly provides that the federal obligations do not preempt state and local emergency laws unless they conflict with the EMTALA obligations.

Some states have adopted emergency services statutes or regulations. Readers of this manual should consult with their legal counsel as to the effect of these laws. (Relevant California laws are discussed in this manual.)

In 1987, the California Legislature amended the hospital licensing laws to enact state patient anti-dumping laws. The California emergency medical service requirements are similar to EMTALA requirements, with some exceptions that are discussed in this manual. The following are some examples:

1. California law applies to hospitals that are licensed to provide emergency services; EMTALA applies to all hospitals that provide emergency services, even if they do not have licensed emergency departments.
2. California law expressly prohibits discrimination in the provision of emergency services by hospitals and physicians.

3. EMTALA focuses on whether a patient with an emergency condition is "stabilized" for transfer or discharge; California law primarily focuses on transfers that are made for nonmedical reasons (such as insurance or financial reasons), which apply to patients with emergency conditions that are considered to be stabilized. California law does not apply to a transfer that is made for medical reasons (although other state requirements pertaining to the transfer of patients may apply).

The California licensing laws on "emergency services and care" are included as Appendix D.

The EMTALA regulations contain a series of defined terms that are essential to the regulatory scheme. The key terms defined below are based on definitions in the EMTALA statute or regulations, except for a number of terms defined by California law that are so indicated. Readers of this manual in other states should consult with their legal counsel as to state laws and regulations that define other terms that are applicable to emergency services rendered in their state.

IV. DEFINITIONS

A. Campus of a Hospital

(See H. "Hospital Property (also referred to as the "Campus of a Hospital")," page 1.8.)

B. Capacity

"Capacity" refers to the ability of a hospital to accommodate a transfer patient. Capacity encompasses such things as the number and availability of qualified staff, beds and equipment, and the hospital's past practices of accommodating additional patients in excess of its occupancy limits.

C. Comes to the Emergency Department

An individual who **"comes to the emergency department"** is defined as any one of the following:

1. An individual who presents to a dedicated emergency department and:
    a. Requests examination or treatment for a medical condition; or
    b. Has a request made on the individual's behalf for examination or treatment for a medical condition; or
    c. A prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs examination or treatment for a medical condition.
2. An individual who presents on hospital property (other than a dedicated emergency department) and:
    a. Requests examination or treatment for what may be an emergency medical condition; or
    b. Has a request made on the individual's behalf for examination or treatment for what may be an emergency medical condition; or
    c. A prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs examination or treatment for an emergency medical condition.

- An individual who is in an air or ground ambulance owned and operated by a hospital for purposes of examination or treatment for a medical condition at the hospital's dedicated emergency department, regardless of the location of the ambulance. However, EMTALA does not apply to the individual in the following circumstances:

d. The ambulance is operated under community-wide emergency medical service protocols that direct the ambulance to transport the individual to another hospital (for example, the closest available facility); or

e. The ambulance is operated at the direction of a physician who is not employed or otherwise affiliated with the hospital that owns the ambulance.

- An individual who is in a nonhospital-owned air or ground ambulance that is on hospital property for presentation for examination or treatment for a medical condition at a hospital's dedicated emergency department.

D. Consultation

A **"consultation"** is defined in California law as the rendering of an opinion or advice, prescribing treatment, or the rendering of a decision regarding hospitalization or transfer that is communicated by telephone or another means of communication. A consultation may include review of the patient's medical record, examination, and treatment of the patient in person by a physician, or by other appropriate licensed persons acting within their scope of licensure under the supervision of a consulting physician, who is qualified to give an opinion or render the necessary treatment in order to stabilize the patient.

E. Dedicated Emergency Department

A **"dedicated emergency department"** is defined as a hospital department or facility that is located on the hospital campus or off-campus, and meets at least one of the following requirements:

1. The department or facility is licensed by the state in which it is located as an emergency room or department;
2. The department or facility is held out to the public (by name, signs, advertising or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or
3. The department or facility, based on a representative sample of patient visits within the preceding calendar year, provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

F. Emergency Medical Condition

An **"emergency medical condition"** is defined as:

1. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse), such that the absence of immediate medical attention could reasonably be expected to result in:

a. Placing the individual (or, with respect to a pregnant woman, the woman or her unborn child) in serious jeopardy;

b. Serious impairment to bodily functions; or

c. Serious dysfunction of any bodily organ or part.

Or:

2. A pregnant woman who is having contractions when:

a. There is inadequate time to effect a safe transfer to another hospital before delivery; or

b. Transfer may pose a threat to the health or safety of the woman or unborn child.

G. Emergency Services and Care

California law defines **"emergency services and care"** as medical screening, examination and evaluation by a physician (or other appropriate licensed persons under the supervision of a physician) to determine the existence of an emergency medical condition, active labor or a psychiatric emergency condition, and, if one exists, the care, treatment and surgery (if within the scope of that person's license) necessary to relieve or eliminate the emergency medical condition within the capability of the facility. The term "emergency services and care" is not a defined term in the EMTALA regulations.

H. Hospital Property (also referred to as the "Campus of a Hospital")

"Hospital property" is defined in the CMS provider-based and EMTALA regulations as including the following:

1. The physical area immediately adjacent to the hospital's main buildings;
2. Other areas and structures that are part of the hospital and are not strictly contiguous to the main buildings, but are located within 250 yards of the main building; and
3. Any other areas that are determined by the CMS regional office on an individual basis to be part of the hospital campus.

Hospital property includes sidewalks, driveways and parking lots that are part of the main hospital campus. However, hospital property does not include areas and structures within 250 yards of the main building that are not part of the hospital. Excluded areas and structures include:

1. Private physician offices, rural health clinics, skilled nursing facilities and other entities that participate in the Medicare program under separate provider numbers; and
2. Privately owned businesses such as restaurants and shops, private residences and other nonmedical facilities.

I. Labor

The EMTALA regulations define **"labor"** as including the "latent or early phase of labor and continuing through the delivery of the placenta." The regulations further provide that labor is an emergency medical condition unless a physician, certified nurse-midwife or another

qualified person acting within the scope of his/her practice (and the medical staff bylaws or rules and regulations) certifies that, after a reasonable period of observation, the woman is in false labor.

California law incorporates the EMTALA definition of "emergency medical condition" in defining "active labor" as labor at a time at which "[t]here is inadequate time to effect safe transfer to another hospital prior to delivery" or "[a] transfer may pose a threat to the health or safety of the patient or the unborn child." While California law continues to use the term "active labor," the word "active" is not used in the EMTALA definition.

(See V. "Application of EMTALA to Labor and Delivery Departments," page 3.17 for further information on staffing requirements for labor patients.)

J. Psychiatric Emergency Medical Condition

The EMTALA regulations do not define the term "psychiatric emergency medical condition." In the *Interpretive Guidelines*, CMS has stated that "an individual expressing suicidal or homicidal thoughts or gestures, if determined dangerous to self or others, would be considered to have an emergency medical condition."

In 2009, California law was amended to add the following definition of psychiatric emergency medical condition:

> **"Psychiatric emergency medical condition"** means a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:
>
> (A) An immediate danger to himself or herself or to others.
>
> (B) Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

The primary difference between the EMTALA guidance and the state definition is that California recognizes that an individual with a mental disorder who is "gravely disabled" has an emergency medical condition. The definition of psychiatric emergency condition is discussed in chapter 6.

K. To Stabilize

As defined by EMTALA, **"to stabilize"** means:

1. With respect to an emergency medical condition, to provide medical treatment as necessary to assure, within reasonable medical probability, that no material deterioration to the condition is likely to result from, or occur during, the transfer; or
2. With respect to a pregnant woman who is having contractions, to deliver the infant and placenta.

L. Stabilized

As defined by EMTALA, **"stabilized"** means:

1. With respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer; or

2. With respect to a pregnant woman who is having contractions, that the woman has delivered the infant and placenta.

The *Interpretive Guidelines* provide that an emergency medical condition is deemed "stabilized" when the condition, within reasonable clinical confidence, is "resolved." The guidance is discussed in chapter 5, "Transferring or Discharging an Emergency Patient."

California law uses the same definition of "stabilized" as EMTALA, except that California law states that a finding that an emergency condition is "stabilized" must be made by a physician or other appropriate licensed person acting with the scope of licensure under the supervision of a physician.

M. Transfer

As defined by EMTALA, a **"transfer"** is the movement (including discharge) of an individual outside the hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, excluding removal of a deceased individual's body and individuals leaving without permission or direction to do so.

N. Within the Capability of the Facility

California law defines **"within the capability of the facility"** as "those capabilities which the hospital is required to have as a condition of its emergency medical services permit and services specified on Services Inventory Form 7041 filed by the hospital with the Office of Statewide Health Planning and Development."

☞ **References:**

EMTALA statute, Social Security Act Section 1866 (Appendix A)

EMTALA regulations, 42 C.F.R. Sections 413.65; 489.20(l) and 489.24(a) and (b) (Appendix B)

42 C.F.R. Sections 489.53 and 1003 et seq.

Interpretive Guidelines, tag nos. A-2400/C-2400, A-2405/C -2405, A-2406/C-2406, and A-2 407/C-2407 (Appendix C)

California Licensing Laws on Emergency Services and Care, California Health and Safety Code Sections 1317, 1317.1 (Appendix D)

Special Advisory Bulletin (Appendix H)

Office of Inspector General, Survey of Hospital Emergency Departments, January 2001(OEI-09-98-00220)

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2 When and Where Does EMTALA Begin and End?

I. Overview 2.1

II. When And Where EMTALA Applies 2.1

III. When And Where EMTALA Does Not Apply 2.3

IV. Requirements of Dedicated Emergency Departments 2.5

A. What is a "dedicated emergency department" under EMTALA? 2.5

B. How will CMS determine if a hospital department is a dedicated emergency department under the one-third test? 2.5

C. Are labor and delivery and psychiatric services considered dedicated emergency departments under EMTALA? 2.6

D. Are hospital urgent care centers and other ambulatory departments dedicated emergency departments under EMTALA? 2.6

E. How does EMTALA apply to a hospital that does not have a dedicated emergency department? 2.7

V. What Is "Hospital Property" Under EMTALA? 2.8

A. Main Hospital Facility 2.9

B. Freestanding On-Campus Buildings and Services 2.9

C. Other Areas on the Hospital Property 2.9

VI. What Areas Are Excluded From Hospital Property? 2.10

VII. Application Of Emtala To Off-Campus Hospital Departments 2.10

VIII. Application Of Emtala To Specific Types Of Patients 2.11

A. Does EMTALA apply to an individual who makes a request for nonemergency services? 2.11

Presentation to a Dedicated Emergency Department 2.11

Presentation to an On-Campus Hospital Department That is Not a Dedicated Emergency Department 2.11

B. Does EMTALA apply to an individual who has an appointment for hospital services? 2.11

Presentation to a Dedicated Emergency Department 2.11

Presentation to an On-Campus Hospital Department That is Not a Dedicated Emergency Department 2.12

C. Does EMTALA apply to visitors, vendors and hospital employees who request or may need emergency services? 2.13

D. Does EMTALA apply to patients presenting to a dedicated emergency department for injections or other pharmaceutical services? ... 2.13

E. Are there any other persons presenting to the dedicated emergency department who are not subject to EMTALA? ... 2.14

Preventive Care Services ... 2.14

Blood Pressure Checks ... 2.14

Blood Alcohol Tests and Sexual Assault Cases ... 2.15

Other Nonemergency Tests ... 2.15

F. Does EMTALA apply to persons who telephone a hospital? ... 2.16

IX. Application Of Emtala To Patients In Ambulances ... 2.16

A. Does EMTALA apply to patients who are en route to a hospital emergency department in an ambulance? ... 2.16

Hospital-Owned Ambulance ... 2.16

Nonhospital-Owned Ambulance ... 2.16

B. Does EMTALA apply when hospital-owned ambulances are directed to transport patients to a regional trauma facility? ... 2.17

C. Does EMTALA apply if an ambulance is on hospital property to access a helipad? ... 2.17

X. Application Of Emtala To Inpatients ... 2.18

A. Does EMTALA apply to the treatment, transfer and/or discharge of hospital inpatients? ... 2.18

B. Does EMTALA apply to an individual in a dedicated emergency department who is waiting for an inpatient bed? ... 2.19

2 When and Where Does EMTALA Begin and End?

I. OVERVIEW

Under the EMTALA statute, the EMTALA obligations begin when any person comes to a "hospital with an emergency department" and requests examination for a medical condition. However, the questions as to when and where a hospital's EMTALA obligations begin and end have been a continuing source of controversy since the adoption of the EMTALA regulations in 1994.

The 1994 EMTALA regulations defined the phrase **"hospital with an emergency department"** to apply to any hospital "that offers services for emergency medical conditions within its capacity to do so." The regulations expanded the term "emergency department" from a typical licensed or organized emergency department to include other points of entry in a hospital that may provide emergency services (i.e., labor and delivery, psychiatric and chemical-dependency programs, and, in certain instances, urgent care centers).

In 2003, CMS limited the scope of EMTALA by:

1. Creating the concept of a "dedicated emergency department" *(see IV. "Requirements of Dedicated Emergency Departments," page 2.5)*,
2. Clarifying the application of EMTALA within the hospital and on the hospital property *(see III. "When And Where EMTALA Does Not Apply," page 2.3 and V. "What Is "Hospital Property" Under EMTALA?," page 2.8)*, and
3. Eliminating the application of EMTALA to off-campus facilities except for an off-site location operated as a dedicated emergency department of the hospital *(see VII. "Application Of Emtala To Off-Campus Hospital Departments," page 2.10)*.

The EMTALA *Interpretive Guidelines* also discuss the application of EMTALA to specific types of patients *(see VIII. "Application Of Emtala To Specific Types Of Patients," page 2.11)*, as well as ambulances *(see IX. "Application Of Emtala To Patients In Ambulances," page 2.16)* and inpatients *(see X. "Application Of Emtala To Inpatients," page 2.18)*.

II. WHEN AND WHERE EMTALA APPLIES

Under the 2003 amendments to the EMTALA regulations, CMS attempted to set bright lines on the beginning and end, as well as the locations, of the EMTALA obligations. These amendments addressed individuals who present to a hospital-owned ambulance or emergency department (or to other locations on or off the hospital campus), and hospital inpatients and outpatients who may have emergency conditions.

Under the current regulations, EMTALA is triggered when an individual comes to a hospital that has an emergency department in one of four circumstances.

1. An individual who presents to a dedicated emergency department seeking or needing examination or treatment for a medical condition.

   EMTALA begins when an individual presents to a dedicated emergency department *(see A. "What is a "dedicated emergency department" under EMTALA?," page 2.5)* of a hospital and:

   a. Requests examination or treatment for a medical condition;

   b. Has a request made on the individual's behalf for examination or treatment for a medical condition; or

   c. A prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs examination or treatment for a medical condition.

2. An individual who presents on hospital property seeking or needing examination or treatment for an emergency medical condition.

   EMTALA begins when an individual presents on hospital property (other than a dedicated emergency department) and:

   a. Requests examination or treatment for what may be an emergency medical condition;

   b. Has a request made on the individual's behalf for examination or treatment for what may be an emergency medical condition; or

   c. A prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs examination or treatment for an emergency medical condition.

3. An individual who is in an air or ground ambulance owned and operated by the hospital.

   EMTALA begins when an individual is in an air or ground ambulance that is owned and operated by a hospital for purposes of examination or treatment for a medical condition at the hospital's dedicated emergency department, regardless of the location of the ambulance.

   However, EMTALA does not apply to an individual in a hospital-owned ambulance in the following circumstances:

   a. The ambulance is operated under community-wide emergency medical service protocols that direct the ambulance to transport the individual to another hospital (for example, the closest available facility); or

   b. The ambulance is operated at the direction of a physician who is not employed or otherwise affiliated with the hospital that owns the ambulance.

4. An individual who is in a nonhospital-owned air or ground ambulance that is on hospital property.

EMTALA begins when an individual is in a nonhospital-owned air or ground ambulance only if the ambulance is on hospital property for presentation for examination or treatment for a medical condition at a hospital's dedicated emergency department.

☞ **Reference:**

42 C.F.R. Section 489.24(b) (Appendix B)

III. WHEN AND WHERE EMTALA DOES NOT APPLY

EMTALA does not apply to an individual in the following four circumstances.

1. An individual who presents to an off-campus department or facility of a hospital that is not a dedicated emergency department.

   The 2003 regulations repealed the 2000 rules extending EMTALA to all off-campus departments of a hospital. Now, EMTALA applies only to an off-campus dedicated emergency department of a hospital. Therefore, if an individual presents to an off-campus department of a hospital that is not a dedicated emergency department, the EMTALA obligations *do not apply* to the patient visit. The obligations of off-campus departments that are not dedicated emergency departments are discussed later in this chapter.

2. An individual who is an outpatient in the course of an encounter in the hospital.

   The EMTALA obligations do not apply to an individual who has begun to receive outpatient services as part of a patient encounter[1] other than an encounter that triggers the EMTALA obligations (i.e., a visit to the emergency department). This exception is intended to cover outpatients who come to a hospital department (other than a dedicated emergency department) for nonemergency services (such as physical therapy or diagnostic imaging) during the time that they are receiving services.

   If an outpatient develops an emergency condition during the course of his or her outpatient encounter, the hospital's response is governed under the Medicare Conditions of Participation, not EMTALA (even if the patient is moved to a dedicated emergency department for follow-up examination and stabilizing treatment).

   However, EMTALA may apply to an outpatient if he or she is seeking or in need of examination or treatment of a potential emergency condition before the commencement of the outpatient encounter or after the completion of the outpatient encounter.

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1 The Medicare definition of **"encounter"** is a "direct personal contact between a patient and a physician, or other person who is authorized by State licensure and, if applicable, by hospital or CAH staff bylaws, to order or furnish hospital services for diagnosis or treatment of the patient." [42 C.F.R. Section 410.2]

3. An individual who is an inpatient.

   The regulations expressly state that EMTALA does not apply to inpatients. The application of EMTALA by CMS to inpatients is discussed further in this chapter in X. "Application Of Emtala To Inpatients," page 2.18. The courts continue to be split on whether EMTALA applies to inpatients. *(See chapter 14, "Private Actions to Enforce EMTALA.")*

4. An individual who presents to a facility or service that is not considered part of the hospital for Medicare purposes.

   The EMTALA obligations extend only to the departments or facilities of a hospital that are billed to the Medicare program under the hospital provider number and are considered to be part of the hospital under applicable Medicare regulations. If a hospital has outpatient clinics that are listed on and operated under the hospital license (often referred to in California as 1206(d) clinics), the clinics are considered to be part of the hospital and are subject to EMTALA if they are located on hospital property.

   EMTALA does not apply to skilled nursing facilities, home health agencies, or rural health clinics that are operated by hospitals, even if the facilities or clinics are listed on the hospital license. These services are billed to the Medicare program under separate provider numbers that are different from the provider number used to bill hospital services. In addition, EMTALA does not apply to hospital-owned suppliers of Medicare services that are billed separately from hospital services.

   In some instances, a hospital company may operate clinics that are separately licensed or exempt from licensing. Examples of licensed clinics in California include "community clinics" and "surgical clinics," both of which are subject to clinic licensing laws, and are listed on the hospital license or subject to hospital regulations. Examples of clinics that are exempt from licensing include primary care clinics operated by counties or other public agencies, clinics affiliated with teaching institutions, medical care foundation clinics and imaging centers. Licensed and exempt clinics are typically excluded from treatment as a provider-based department of the hospital, even if they are located on hospital property and owned or controlled by the company operating the hospital.

Practice tip: A hospital should review its license and billing practices to determine whether its clinics are part of the hospital for billing and cost reporting purposes. Even if the clinics are not subject to EMTALA, these departments and facilities may be subject to other state and federal rules, as well as accepted risk management practices, for responding to emergency situations.

☞ **Reference:**

42 C.F.R. Section 489.24(b) (Appendix B)

IV. REQUIREMENTS OF DEDICATED EMERGENCY DEPARTMENTS

A. What is a "dedicated emergency department" under EMTALA?

The term "dedicated emergency department" was added to the EMTALA regulations in 2003. The term intended to distinguish between hospital departments that are held out as services for persons with urgent and emergency medical problems and other hospital departments that primarily serve scheduled outpatients for diagnostic and therapeutic procedures. As discussed below, the distinction is not always clear to providers and patients.

A **"dedicated emergency department"** is defined in the EMTALA regulations as a hospital department or facility that is located on the hospital campus or off-campus, and meets any one of the following tests:

1. **License Test.** The department or facility is licensed by the state in which it is located as an emergency room or department;
2. **Holding Out Test.** The department or facility is held out to the public (by name, signs, advertising or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or
3. **One-Third Test.** The department or facility, based on a representative sample of patient visits within the preceding calendar year, provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

B. How will CMS determine if a hospital department is a dedicated emergency department under the one-third test?

In the *Interpretive Guidelines*, CMS has provided guidance to the CMS regional offices and state survey agencies to determine whether a hospital department meets the one-third test. The surveyor is directed to select a sample of patient visits to the department that occurred during the previous calendar year. The surveyor will review the facility log, appointment roster and other appropriate information to identify the patients seen in the department or facility. The surveyor will then review 20 to 50 medical records of patients for diagnoses or presenting complaints; in consultation with the CMS regional office, the surveyor may expand the sample size in order to conduct an adequate investigation. The patient sample will be selected by the surveyor, not the hospital.

The surveyor must then determine the number of patients who "had an emergency medical condition and received stabilizing treatment." If one-third of the sample cases were for the treatment of emergency conditions on an urgent basis without requiring a previously scheduled appointment, the department or facility will be considered to be a dedicated emergency department. The Investigative Procedures for EMTALA Surveyors portion of the *State Operations Manual* (Appendix K) notes that this procedure will apply to specialty hospitals (such as psychiatric facilities), hospitals without a traditional emergency department, and urgent care centers. In addition, the procedure may apply to both on-campus and off-campus departments and facilities of the hospital.

C. Are labor and delivery and psychiatric services considered dedicated emergency departments under EMTALA?

In the preamble to the 2003 regulations, CMS reaffirmed that a dedicated emergency department includes not only what is generally considered to be a hospital's "emergency room," but also other departments of hospitals, such as labor and delivery and psychiatric units. As stated by CMS:

> Any area of the hospital that offers such medical services to treat individuals in labor to at least one-third of the ambulatory individuals who present to the area for care, even if the hospital's practice is to admit such individuals as inpatients rather than listing them on an outpatient basis, ***would*** be considered a dedicated emergency department. (Emphasis in original) [68 Fed. Reg. 53229]

In recent years, CMS has been closely looking at freestanding acute psychiatric hospitals to determine whether they operate dedicated emergency departments for "walk-in" or other non-scheduled patients.

D. Are hospital urgent care centers and other ambulatory departments dedicated emergency departments under EMTALA?

In the preamble to the 2003 regulations, CMS rejected a request to exclude hospital urgent care centers from the EMTALA requirements, stating:

> We believe that it would be very difficult for any individual in need of emergency care to distinguish between a hospital department that provides care for an 'urgent need' and one that provides care for an 'emergency medical condition' need…. As we have discussed above, if the department or facility is held out to the public as a place that provides care for emergency medical conditions, it would meet the definition of dedicated emergency department. An urgent care center of this kind would fall under this criterion for dedicated emergency department status [68 Fed. Reg. 53431].

However, other guidance from CMS suggests that urgent care and other hospital departments that provide drop-in services for urgent and non-urgent conditions are not automatically considered to be dedicated emergency departments. For example, as noted above, the Investigative Procedures for EMTALA Surveyors portion of the *State Operations Manual* states that the procedure to apply the "one-third test" may apply to an urgent care center or other hospital department only if more than one-third of the center's or department's patients presented for the treatment of "emergency" conditions on an urgent basis without requiring a previously scheduled appointment. The guidance suggests that patients presenting only for treatment of "urgent" or "non-urgent" conditions on a drop-in basis will not result in the classification of the urgent care center or other department as a dedicated emergency department.

In addition, the *Interpretive Guidelines* adopted to implement the Medicare Conditions of Participation for hospital outpatient services [42 C.F.R. Section 482.55] note that urgent care clinics may be organized as part of an outpatient department or an emergency department. The *Interpretive Guidelines* then state that an urgent care clinic will be evaluated for compliance with the integration standards for outpatient services (rather than the integration standards for emergency departments) if three conditions are met:

1. The urgent care clinic is held out to the public as providing only urgent care services and possibly other services;

2. The hospital clearly advises the public that the urgent care clinic is not an emergency department; and
3. The urgent care clinic does not meet the definition of a dedicated emergency department under EMTALA.

In some states, urgent care centers and similar departments are licensed as outpatient services. For example, in California, an outpatient service is defined as "the rendering of nonemergency health care" to patients [Title 22, California Code of Regulations, Section 70525].

As indicated in this discussion, there is some confusion as to whether urgent care centers and similar drop-in hospital departments (such as an occupational medicine clinic) that are not licensed or operated as typical emergency departments are dedicated emergency departments within the meaning of EMTALA. How an urgent care center is held out to the public may be a critical factor in whether an urgent care center is treated as a dedicated emergency department or excepted from EMTALA. This is illustrated in a 2016 court decision that focused on the signage for a hospital operated urgent care center. The hospital argued that its website clearly stated that its urgent care center was for non-emergency needs. However, the court noted that the on-site signage for the urgent care center did not distinguish between urgent care and emergent care; therefore, a person driving by the urgent care center (in this instance, with chest pains) would be unlikely to check the website before entering the urgent care center. As a result, the court declined to rule in favor of the hospital based on the patient's perception from the signage that the clinic would be an appropriate place to receive emergency care. This case, *Friedrich et at. v. South County Hospital Healthcare System, et al.*, is discussed in chapter 14.

Compliance Tip: The broad definition of dedicated emergency department requires a hospital to evaluate all of its ambulatory care departments (on- and off-campus) to identify the services that meet the definition of a dedicated emergency department. In addition to reviewing the volume of drop-in patients, the hospital should also review its website, signage, advertising, other promotional materials, and information disseminated to the public regarding the availability of drop-in services.

E. How does EMTALA apply to a hospital that does not have a dedicated emergency department?

The first subsection of the EMTALA statute triggers the medical screening obligation for an individual who comes to a "hospital that has an emergency department." However, the second subsection of the EMTALA statute triggers the obligations for further examination and stabilizing treatment and transfers for an individual "who comes to a hospital."

The EMTALA regulations define a **"hospital with an emergency department"** as "a hospital with a dedicated emergency department." The *Interpretive Guidelines* indicate that hospitals that do not provide emergency services must meet the standards of the Medicare Conditions of Participation [42 C.F.R. Section 482.12(f)(2); *see Appendix E*], which require all participating hospitals to have written policies and procedures for the appraisal of emergencies, initial treatment within the capability and capacity of the hospital, and

appropriate referral of emergency patients to hospitals that are capable of providing the necessary emergency services. The *Interpretive Guidelines* for Section 482.12(f) require that staff at any hospital location know how to respond to individuals (patients, staff, visitors and others) seeking or in need of medical and psychiatric emergency services.

The *Interpretive Guidelines* state that a hospital with a dedicated emergency department must comply with the medical screening, stabilizing treatment, transfer and other obligations of EMTALA. However, all hospitals participating in the Medicare program, regardless of maintaining a dedicated emergency department, are subject to the Medicare receiving hospital obligation, and must accept an appropriate transfer of an individual with an emergency medical condition who requires specialized capabilities not available at the transferring hospital.

Hospitals (including critical access hospitals) that do not have a physician present in the hospital on a full-time basis must provide a written notice to all patients at the beginning of their hospital stay or outpatient visit stating that a physician is not present in the hospital 24 hours a day, 7 days a week. The notice must explain how the hospital will meet the medical needs of a patient who develops an emergency medical condition during the course of an inpatient stay or outpatient encounter at a time when no physician is present in the hospital. The law states that an inpatient stay or outpatient encounter is considered to begin with the provision of a package of information regarding scheduled preadmission testing and registration for a planned hospital admission for inpatient care or outpatient service. Prior to admitting the patient or providing an outpatient service, the hospital must receive a signed acknowledgment from the patient indicating the patient's understanding that a physician may not be present in the hospital at all times. The notice is a condition of the Medicare provider agreement, a violation of which may result in termination of the agreement.

If a hospital does not have a dedicated emergency department, it is recommended that the hospital consult with its legal counsel to determine:

1. The scope and extent of its EMTALA obligations; and
2. The language and process for dissemination of a disclosure notice, if the hospital does not have a physician in-house at all times. Additional guidance on the disclosure notice is discussed in chapter 11 of CHA's *Consent Manual*.

☞ **References:**

42 C.F.R. Sections 482.12(f), 489.20(w), and 489.24(b) (Appendix B) Interpretive Guidelines, tag no. A-2406/C-2406 (Appendix C)

Interpretive Guidelines for Hospitals, Medicare Conditions of Participation (42 C.F.R. Sections 482.12(f) and 482.55(a)(2)) (Appendix E)

Investigative Procedures for EMTALA Surveyors (Appendix K)

V. WHAT IS "HOSPITAL PROPERTY" UNDER EMTALA?

As discussed above, the EMTALA obligations are triggered not only when an individual presents to a dedicated emergency department seeking or in need of examination or treatment for a medical condition, but also when an individual presents on "hospital property" (other than a dedicated emergency department) seeking or in need of examination

or treatment for a potential emergency medical condition. Since 1994, CMS has gradually expanded the scope of "hospital property."

In 2003, CMS attempted to clarify the extent of "hospital property" to give providers greater certainty as to the areas and structures on and surrounding the hospital campus that are considered to be hospital property. For the purpose of determining when the EMTALA obligations are triggered for an individual who presents on the hospital campus, **"hospital property"** is defined as the main hospital buildings and the areas within 250 yards of the main hospital buildings (unless the hospital has obtained approval from CMS for an alternative description of the hospital property). Although the regulations do not define what are the "main hospital buildings," a general rule of thumb is to measure the 250 yards from the perimeter of the main building(s) in which inpatient services are provided by the hospital.

A. Main Hospital Facility

EMTALA applies to any person who enters the main inpatient building(s) of a hospital seeking or in need of services for what may be an emergency medical condition, even if the patient does not present to a dedicated emergency department. Therefore, all areas of the main inpatient building(s) are potential points of entry for triggering the EMTALA obligations.

B. Freestanding On-Campus Buildings and Services

EMTALA applies to any department or service operated by a hospital under its Medicare provider number that is located within 250 yards of the perimeter of the main hospital building(s) (although the CMS regional office may, on a case-by-case basis, include other structures/areas in the hospital campus). As discussed in the next question ("What areas are excluded from hospital property?"), there are some services and buildings on hospital property that may not be subject to EMTALA.

C. Other Areas on the Hospital Property

The term "hospital property" includes hospital structures and areas, such as parking lots, driveways and sidewalks that are within 250 yards of the perimeter of the main hospital building(s). The applicability of EMTALA to hospital parking lots and access ways was emphasized by a nationally announced enforcement action against a hospital for failing to respond to a patient in crisis on the sidewalk in front of the hospital.

Compliance Tip: Hospitals should adopt policies and procedures for responding to emergencies occurring on hospital property outside of the main hospital building. The policies should address who should respond to on-campus emergencies, procedures for moving patients to the emergency department or calling for emergency transport, documentation of the occurrence and a quality improvement review of the hospital's handling of the emergency situation. The policies should be reinforced by in-service training programs, including security personnel who are often the first responders to the scene of an emergency on the hospital campus.

☞ **References:**

42 C.F.R. Sections 413.65(a)(2) and 489.24(b) (Appendix B)

Interpretive Guidelines, tag no. A-2406/C-2406 (Appendix C)

VI. WHAT AREAS ARE EXCLUDED FROM HOSPITAL PROPERTY?

The regulations provide that "hospital property" does not include areas and structures within 250 yards of the main hospital building(s) if they are not part of the hospital for Medicare purposes. The examples given in the regulations include the following:

1. First, EMTALA does not apply to individuals who present to departments or services that participate separately in the Medicare program under their own provider number, even if they are owned and operated by the hospital. These include skilled nursing facilities, home health agencies and rural health clinics (even if they are located in the main hospital building). The excluded locations also include private physician offices, and separately-licensed and exempt clinics that are operated and billed independent of the hospital.
2. Second, EMTALA does not apply to businesses and structures that are not owned by the hospital. These include restaurants, shops and private residences within 250 yards of the main hospital building(s).

VII. APPLICATION OF EMTALA TO OFF-CAMPUS HOSPITAL DEPARTMENTS

EMTALA applies only to an off-campus provider-based department or facility of a hospital if the department or facility is determined to be a dedicated emergency department.

All other off-campus hospital departments and facilities are subject to the Medicare Conditions of Participation for hospitals [42 C.F.R. Part 482], and must maintain policies and procedures for the appraisal of emergencies and referral when appropriate. The *Interpretive Guidelines* clarify that off-campus hospital departments that are not dedicated emergency departments may adopt policies directing staff to call 9-1-1 for emergency patient management and transport to a hospital emergency department (which is not required to be the emergency department of the hospital that operates the off-campus department).

In 2008, CMS published guidance for "freestanding" emergency departments that offer emergency services at an off-campus location. The guidance requires a "freestanding" emergency department that is operated as a provider-based department of a hospital to meet the Medicare Conditions of Participation and the EMTALA obligations. A copy of the guidance (S&C 08-08) is included in Appendix Q.

☞ **References:**

42 C.F.R. Sections 482.12(f)(3) and 489.24(b) (Appendix B)

Interpretive Guidelines, tag no. A-2406/C-2406 (Appendix C)

CMS Memorandum, Requirements for Provider-based Off-campus Emergency Departments and Hospitals that Specialize in the Provision of Emergency Services (Appendix Q)

VIII. APPLICATION OF EMTALA TO SPECIFIC TYPES OF PATIENTS

A. Does EMTALA apply to an individual who makes a request for nonemergency services?

In the 2003 regulations, CMS attempted to clarify how the EMTALA obligations apply to individuals who are seeking nonemergency services from a dedicated emergency department, such as blood tests or removal of sutures. The answer depends on where the individual presents for the services.

Presentation to a Dedicated Emergency Department

If an individual presents to a dedicated emergency department seeking examination or treatment for a medical condition, the EMTALA obligations apply, even if the request is for what appears to be nonemergency services. If the presenting medical condition is not of an emergent nature, the hospital is still required to perform a medical screening examination that would be appropriate for any individual presenting in similar circumstances to confirm that the individual does not have an emergency medical condition. The scope of the medical screening for these types of patients is described in chapter 3.

However, CMS has issued guidance that certain patients presenting to a dedicated emergency department for certain services may not trigger the EMTALA obligations. This is discussed under the question on page 2.14, "Are there any other persons presenting to the dedicated emergency department who are not subject to EMTALA?"

Presentation to an On-Campus Hospital Department That is Not a Dedicated Emergency Department

If an individual presents to an on-campus hospital service that is not a dedicated emergency department, EMTALA applies only if the individual is seeking or in need of examination or treatment for what may be an emergency medical condition. In those cases, the hospital must provide a medical screening examination (either in the dedicated emergency department or in another hospital department) to determine if the patient has an emergency medical condition.

☞ **References:**

42 C.F.R. Section 489.24(b) and (c) (Appendix B)

B. Does EMTALA apply to an individual who has an appointment for hospital services?

Presentation to a Dedicated Emergency Department

As noted above, the EMTALA obligations apply to any individual who presents to a dedicated emergency department seeking an examination or treatment for a medical condition. In some instances, individuals may have appointments to be seen in a dedicated emergency department, such as scheduled visits to labor and delivery, an urgent care clinic or another hospital service that meets the definition of a dedicated emergency department.

The *Interpretive Guidelines* state that "a hospital may be exempted from its EMTALA obligations to screen individuals presenting to its dedicated emergency department if the individual has a previously scheduled appointment." Unfortunately, the *Interpretive Guidelines* do not explain the types of scheduled patients presenting to an emergency department who do not trigger the EMTALA obligations.

Some hospitals have implemented emergency department appointment reservation programs for patients to sign up for a time slot when they may be seen in the emergency department. Hospitals should consult with their legal counsel regarding how the appointment programs implicate the EMTALA obligations. In the absence of guidance from CMS regarding the effect of appointment reservation programs in the emergency department, the best practice for hospitals is to comply with the EMTALA requirements for patients who sign up for an appointment at a dedicated emergency department.

Presentation to an On-Campus Hospital Department That is Not a Dedicated Emergency Department

If an individual has a scheduled appointment to receive care from a hospital service that is not a dedicated emergency department (such as an imaging procedure, laboratory test, physical therapy session or cardiac rehabilitation program), EMTALA does not apply to the patient once he or she has begun an "encounter" with a health care professional in the department. For purposes of EMTALA, an "encounter" is a "direct personal contact" between a patient and a physician or other caregiver who may order or furnish hospital diagnostic or treatment services.

In addition, EMTALA does not apply if the patient, during the course of his or her outpatient encounter, requests or is in obvious need of emergency services (for example, the patient has a cardiac arrest while on the treadmill), even if the patient is moved to a dedicated emergency department for further examination and stabilizing treatment. Instead, CMS will apply the Medicare Conditions of Participation to the examination and treatment rendered to the outpatient if the need for emergency care arises during his or her encounter.

As an example, CMS has described the hypothetical case of an outpatient who comes to the physical therapy department for a scheduled appointment. During the encounter, the patient experiences chest pains and lightheadedness, and is taken to the dedicated emergency department for follow-up examination and treatment. Although personnel in the dedicated emergency department may (and should) provide emergency services to the patient in the same manner as any other patient presenting to the department with similar signs and symptoms, the EMTALA obligations will not apply to the patient since the need for emergency care arose during the outpatient encounter in the physical therapy department. Instead, the response by the hospital is subject to the standards of the Medicare Conditions of Participation.

Although not expressly stated in the regulations, it appears that EMTALA applies to an outpatient if he or she requests or is in need of emergency services prior to the encounter or after the encounter is completed (for example, the patient faints or has a medical crisis while leaving the hospital or in the parking lot).

☞ **References:**

42 C.F.R. Section 489.24(b) (Appendix B)

Interpretive Guidelines, tag no. A-2406/C-2406 (Appendix C)

C. Does EMTALA apply to visitors, vendors and hospital employees who request or may need emergency services?

In the preamble to the 2003 regulations, CMS noted that EMTALA applies to individuals who are on the hospital campus for other than outpatient services and may experience an emergency medical condition; examples include visitors, guests, vendors and hospital employees.

D. Does EMTALA apply to patients presenting to a dedicated emergency department for injections or other pharmaceutical services?

Patients are often referred by their primary care physicians to a hospital emergency department (including labor and delivery or other departments that are a dedicated emergency department) for injections or other procedures. In some cases, the referring physician has seen the patient immediately preceding the patient's arrival at the hospital; in other cases, the physician has not seen the patient prior to his or her arrival at the hospital, but may have provided an ongoing course of treatment to the patient. Occasionally, a patient is directed to meet his or her primary care physician in the emergency department for examination or treatment.

In the preamble to the 2003 regulations, CMS reaffirmed that EMTALA applies to any individual who presents to a dedicated emergency department seeking examination or treatment for any medical condition. As noted by CMS, pharmaceutical services in a dedicated emergency department may be for medical conditions, and are therefore subject to EMTALA [68 Fed. Reg. 53235]. EMTALA will apply if an individual presents for injections or other treatment for a medical condition, even if the individual arrives with orders from an attending staff member. Therefore, hospitals should record these patients in the central log, open a medical record and provide a medical screening examination.

This position expressed by CMS in the preamble is reinforced in the *Interpretive Guidelines*. CMS states that if a patient presents to a dedicated emergency department for pharmaceutical services for a medical condition, the hospital "generally" has an EMTALA obligation.

The CMS position, however, implies that not all requests by patients presenting to a dedicated emergency department for pharmaceutical services implicate EMTALA, and therefore require a medical screening examination. However, the *Interpretive Guidelines* do not provide sufficient guidance to determine the categories of medication requests that do not trigger the EMTALA obligations. Hospitals and their medical staffs should also consider regulatory and risk management issues when deciding whether to administer medication in the absence of a medical screening examination for patients presenting to an emergency department for pharmaceutical services. Therefore, the best practice is for hospitals to provide a medical screening examination, and other EMTALA-required services, to patients presenting for pharmaceutical services.

It is noted that EMTALA does not require a hospital to provide medication to patients who, as a result of the medical screening examination, are determined not to have an emergency medical condition. As stated by CMS, EMTALA does not require a hospital to provide medication to a non-emergent patient "because the individual is unable to pay or does not wish to purchase the medication from a retail pharmacy or did not plan appropriately to secure prescription refills."

If an individual comes to a hospital department that is not a dedicated emergency department with a prescription or seeking pharmaceutical services, the EMTALA obligations will not apply to the request unless the individual requests or is in obvious need of examination or treatment for what may be an emergency medical condition. In these cases, hospitals should follow their standard policies and procedures for pharmacy services requested by nonemergency patients.

Although the EMTALA obligations apply to all individuals who present to a dedicated emergency department, hospitals may tailor their medical screenings for patients who present at a dedicated emergency department for nonemergency services. The scope of the examination is discussed in chapter 3, "Medical Screening Examinations."

☞ **Reference:**

Interpretive Guidelines, tag no. A-2406/C-2406 (Appendix C)

E. Are there any other persons presenting to the dedicated emergency department who are not subject to EMTALA?

Virtually every person who presents to a dedicated emergency department seeking or in need of some type of medical examination or treatment for a medical condition is potentially covered by EMTALA. However, CMS has indicated that EMTALA does not apply to individuals who present to a dedicated emergency department and request services that are not an examination or treatment for a medical condition. Some examples of these situations include the following.

Preventive Care Services

In the preamble to the 2003 EMTALA regulations, CMS, without explanation, listed "preventive health services" as one example of a request for services that does not trigger the requirement for a medical screening examination [68 Fed. Reg. 53235]. The *Interpretive Guidelines* provide three examples of "preventive care services" — immunizations, allergy shots and flu shots.

However, if a person presenting for these types of preventive care services requests or is in need of an examination for a medical condition, EMTALA may apply and the patient should be treated in the same manner as other patients presenting for emergency services.

Blood Pressure Checks

In the past, CMS Region IX has suggested that EMTALA probably does not apply to persons presenting to an emergency department for routine blood pressure checks offered as a community service to all area residents.

The *Interpretive Guidelines* qualify this past advice. As explained by CMS, a hospital may have a policy or protocol (or, as applicable, a standardized procedure) permitting a qualified professional in a dedicated emergency department to conduct medical screenings within his or her scope of practice. As an example, CMS cites a request for a blood pressure check. If a person presenting for a routine blood pressure check, upon screening, has a reading within normal limits and there are no other signs or symptoms indicating the presence of an emergency medical condition, the hospital is not required under EMTALA to provide services beyond what was needed to determine the absence of an emergency condition.

However, if a person presenting for a routine blood pressure check also requests or is in need of an examination for a medical condition, EMTALA may apply and the patient should be treated in the same manner as other patients presenting for emergency services.

Blood Alcohol Tests and Sexual Assault Cases

In the preamble to the 2003 regulations, CMS stated that requests by law enforcement personnel for medical clearance of incarcerated patients, or blood alcohol or other tests to be used as evidence in criminal proceedings, would be reviewed on a case-by-case basis to determine whether the hospital is required to provide a medical screening and other required EMTALA services [68 Fed. Reg. 53235].

The *Interpretive Guidelines* provide additional direction for hospitals in law enforcement cases. In general, the "gathering of evidence for criminal law cases (e.g., sexual assault, blood alcohol test)" does not trigger the requirements for a medical screening examination or other EMTALA required services. However, the *Interpretive Guidelines* qualify this exemption from EMTALA:

> If an individual is brought to the ED and law enforcement personnel request that emergency department personnel draw blood for a BAT only and [do] not request examination or treatment for a medical condition, such as intoxication, and a prudent layperson would not believe that the individual needed such examination or treatment, then the EMTALA's screening requirement is not applicable to this situation because the request made on behalf of the individual was for evidence. However, if for example, the individual in police custody was involved in a motor vehicle accident or may have sustained injury to him or herself and presents to the ED, a MSE would be warranted to determine if an EMC exists.

The *Interpretive Guidelines* further clarify that requests for pre-jail clearance trigger the EMTALA obligations, and that hospitals should provide a medical screening examination to determine whether the individual has an emergency medical condition.

With respect to rape and sexual assault cases, the *Interpretive Guidelines* state that the same principle described above for blood alcohol testing also applies to individuals presenting to a dedicated emergency department in connection with rape or sexual assault.

In summary, the *Interpretive Guidelines* direct surveyors to review each case on its own merits to determine whether EMTALA applies to law enforcement requests. In conducting staff in-service training, hospitals should consider that even if law enforcement personnel do not request medical care for a patient in custody, the EMTALA obligations will be triggered if a prudent layperson would believe that the patient's behavior or appearance indicates the need to provide examination or treatment for a medical condition.

For further guidance on medical procedures requested by law enforcement, California hospitals should review chapter 6 of CHA's *Consent Manual*.

Other Nonemergency Tests

In the *Interpretive Guidelines*, CMS states that the presentation by an individual to a dedicated emergency department for the collection of evidence (such as a lab test) does not trigger the EMTALA obligations so long as the request does not include analysis of the lab

results or an examination or treatment of the individual. As an example, CMS cites a patient who has consulted with his or her physician, who then refers the patient to the emergency department for a nonemergency test.

☞ **Reference:**

Interpretive Guidelines, tag no. A-2406/C-2406 (Appendix C)

F. Does EMTALA apply to persons who telephone a hospital?

No. A person who telephones a hospital regarding the need for an examination or treatment is not an EMTALA patient. However, the *Interpretive Guidelines* note that the failure to accept a telephone or radio request for transfer or admission may violate other federal or state law requirements; licensing surveyors are directed to refer suspected violations of related laws to the responsible agency.

☞ **Reference:**

Interpretive Guidelines, tag no. A-2406/C-2406 (Appendix C)

IX. APPLICATION OF EMTALA TO PATIENTS IN AMBULANCES

A. Does EMTALA apply to patients who are en route to a hospital emergency department in an ambulance?

Hospital-Owned Ambulance

An individual who is in a hospital-owned ambulance that is coming to the hospital for examination and treatment of a medical condition is considered to have triggered the EMTALA obligations, unless the ambulance is operating under community-wide protocols or under the direction of a physician who is not employed or affiliated with the hospital that owns the ambulance.

In the *Interpretive Guidelines*, CMS states that an individual in a hospital-owned ambulance may not be diverted while en route to the hospital unless the ambulance is operating under community-wide Emergency Medical Services (EMS) protocols. Similar to nonhospital-owned ambulances, the ambulance cannot be diverted once it arrives on hospital property.

Nonhospital-Owned Ambulance

If a nonhospital-owned ambulance advises a hospital of its intent to transport an individual to the hospital, the EMTALA regulations permit the hospital to deny access if it is on "diversionary status" (i.e., it does not have the staff or facilities to accept any additional emergency patients). If the ambulance still brings the individual to the hospital, the patient is considered to have "come to the emergency department" and the hospital must accept the person and provide a medical screening examination.

In a 2001 9th Circuit Court of Appeal decision, *Arrington v. Wong*, the court interpreted the EMTALA regulations to mean that a hospital cannot refuse a patient who is en route to a hospital in a nonhospital-owned ambulance unless the hospital is on diversion. In the *Arrington* case, a patient with "severe respiratory distress" was in a nonhospital-owned ambulance on the way to a hospital when the ambulance personnel contacted the hospital. The emergency physician asked the name of the patient's physician and told the ambulance personnel that he believed that "it would be okay" to redirect the ambulance to

the patient's aligned facility (in this case, an Army medical center). The total ambulance time with change in direction was 16 minutes. As discussed in chapter 14, "Private Actions to Enforce EMTALA," the court interpreted the phrase "comes to the emergency department" as including an individual who is en route to the hospital. Since the hospital was not on diversion, the court ruled that the hospital could not redirect the ambulance.

CMS has informally indicated that it does not consider the *Arrington* decision to be consistent with the EMTALA regulations or binding on EMTALA enforcement. However, the decision is the law of the 9th Circuit (which includes California and other western states), and has been adopted by other courts with respect to private lawsuits brought by patients seeking damages under EMTALA.

☞ **References:**

42 C.F.R. Section 489.24(b) (Appendix B)

Interpretive Guidelines, tag no. A-2406/C-2406 (Appendix C)

Arrington v. Wong, 237 F.3d 1066 (9th Cir. 2001)

B. Does EMTALA apply when hospital-owned ambulances are directed to transport patients to a regional trauma facility?

The EMTALA obligations originally applied to an individual in an air or ground ambulance owned and operated by a hospital. The 2003 regulations modified this requirement by stating that the EMTALA obligations do not apply if the ambulance is operated under:

1. Community-wide EMS protocols that direct the ambulance to transport the individual to a hospital other than the hospital that owns the ambulance; or
2. The direction of a physician who is not employed or affiliated with the hospital that owns the ambulance.

☞ **References:**

42 C.F.R. Section 489.24(b) (Appendix B)

Interpretive Guidelines, tag no. A-2406/C-2406 (Appendix C)

C. Does EMTALA apply if an ambulance is on hospital property to access a helipad?

For many years, CMS Region IX has stated that EMTALA does not apply to an individual in an ambulance that comes onto hospital property to access the hospital's helipad as a part of a prearranged transfer between two other hospitals or to a regional trauma facility. The *Interpretive Guidelines* address the use of hospital helipads under EMTALA.

CMS states that the use of a hospital helipad by local ambulance services or other hospitals to transport a patient to a tertiary (or trauma) hospital does not trigger an EMTALA obligation for the hospital that owns the helipad if two conditions are met:

1. The helipad is being used for the purpose of transit; and
2. The sending hospital has conducted a medical screening of the patient prior to transporting the patient to the helipad.

However, the Guidelines state that if the ambulance crew or the patient (while on-site at the hospital with the helipad) requests the medical assistance of the hospital (for example, the patient's condition has deteriorated or the patient requires intubation), the hospital must provide emergency services consistent with its EMTALA obligations. Some EMS agencies have adopted policies that include standards for a non-destination hospital to which an ambulance may divert during the course of an arranged transport to a trauma center or other facility. These policies do not override the EMTALA obligations. If the ambulance crew or the patient requests examination or treatment at a non-destination hospital, the EMTALA obligations may apply, and the hospital must enter the patient in the central log, open a patient record, conduct a medical screening, provide treatment within its capability and reconfirm the transfer to the destination facility. In some instances, this may be a very short visit. However, there is risk of an EMTALA violation if the non-destination hospital provides a quick evaluation or treatment of the patient without following the EMTALA requirements.

NOTE: CMS has issued two memoranda on the use of emergency transport personnel on hospital property to hold and monitor an emergency patient pending the availability of services in the emergency department. The memoranda are discussed in chapter 3 under the question J. "Can emergency departments request emergency medical technicians (EMTs) and paramedics to stay with a patient transported to the hospital emergency department when the department is saturated?," page 3.9.

X. APPLICATION OF EMTALA TO INPATIENTS

A. Does EMTALA apply to the treatment, transfer and/or discharge of hospital inpatients?

The EMTALA statute does not specifically apply the EMTALA obligations to hospital inpatients. For several years, there has been a split in opinion between the federal circuit courts of appeal as to whether EMTALA applies to inpatients, including the transfer and discharge of inpatients in an unstabilized condition. Prior to the 2003 EMTALA regulations, the 1st and 6th Circuit Courts of Appeal applied EMTALA to inpatient discharges and transfers. In contrast, the 4th and 9th Circuit Courts of Appeal declined to extend EMTALA to the treatment, transfer or discharge of inpatients. These cases are discussed in chapter 14, "Private Actions to Enforce EMTALA."

In *Roberts v. Galen of Virginia, Inc.*, the 6th Circuit Court of Appeals applied EMTALA to the transfer of an inpatient in an allegedly unstabilized condition to a long-term care facility after a two-month hospital stay. During oral argument on an appeal of the Court's decision to the U.S. Supreme Court, the Solicitor General (on behalf of the federal government) advised the Court that the U.S. Department of Health and Human Services would adopt regulations clarifying whether EMTALA applied to inpatients.

In 2003, CMS addressed the "inpatient" issue by providing that the EMTALA obligations are terminated when an individual is admitted in good faith for inpatient care in order to stabilize an emergency medical condition. The regulations adopt the definition of "inpatient" in the Medicare Hospital Manual: "a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services." However, CMS warned

that EMTALA will apply if a hospital admits an emergency patient in bad faith (i.e., to avoid EMTALA requirements), and then inappropriately transfers or discharges the individual without meeting the stabilization requirement.

The EMTALA regulations apply to the interpretation and enforcement of EMTALA by CMS. They are not binding on the courts. In a 2009 decision, the 6th Circuit Court of Appeals observed that the regulation excluding inpatients from EMTALA "is contrary to the plain language" of the EMTALA statute. In the case, the inpatient stay occurred prior to the 2003 change in the regulations, so the decision did not strike down the regulation. In 2012, a district court in Texas reached a similar conclusion. The decisions, *Moses v. Providence Hospital and Medical Ctrs.* and *Liles v. TH Healthcare, LTD, et al.*, are discussed in chapter 14.

In 2008, CMS amended the EMTALA regulations to clarify that the obligation to accept the transfer of an emergency patient does not apply to the transfer of an inpatient at another hospital. The *Interpretive Guidelines* clarify that emergency patients who are placed in observation status are not inpatients, even if they occupy a bed overnight in the observation unit. Therefore, the receiving hospital obligation applies to the transfer of an emergency patient in observation status.

In 2012, CMS confirmed, in commentary, that it was maintaining its current policy that EMTALA obligations end when an individual is admitted in good faith for inpatient care in order to stabilize an emergency medical condition.

Inpatients continue to be subject to the standards and protections of the Medicare Conditions of Participation.

☞ **References:**

42 C.F.R. Section 489.24(b) (Appendix B)

Interpretive Guidelines, tag no. A-2411/C-2411 (Appendix C)

B. Does EMTALA apply to an individual in a dedicated emergency department who is waiting for an inpatient bed?

Under the 2003 regulations, EMTALA does not apply to individuals who are admitted as hospital inpatients, regardless of the location of the inpatient within the hospital building. In the preamble to the 2003 regulations, CMS stated that EMTALA would not apply to an inpatient who is in a dedicated emergency department waiting for an inpatient bed:

> … individuals who are "boarded" and admitted in the dedicated emergency department would be determined to be inpatients for purposes of EMTALA if, generally, they have been admitted by the hospital with the expectation that they will remain at least overnight and occupy beds in the hospital [68 Fed. Reg. 53247].

3 Medical Screening Examinations

I. Overview 3.1

II. Questions 3.2

A. Is triage considered a medical screening examination? 3.2

B. What is the purpose of the medical screening examination? 3.2

C. What is the scope of an appropriate medical screening examination? 3.2

Non-Discrimination 3.3

Individual and Condition-Specific 3.4

Continuous Monitoring 3.4

Documentation 3.4

D. What is the required scope of the MSE for individuals who present to a dedicated emergency department with conditions of a non-emergent nature? 3.5

E. Must a medical record be opened for every patient? 3.5

F. Who may perform the medical screening examination? 3.6

G. Is the screening requirement the same for critical access hospitals as it is for other general acute care hospitals? 3.7

H. What are the requirements for certifying nurses and other health care professionals to perform medical screening examinations? 3.8

I. What resources are considered "available" to a dedicated emergency department? 3.8

J. Can emergency departments request emergency medical technicians (EMTs) and paramedics to stay with a patient transported to the hospital emergency department when the department is saturated? 3.9

Documentation 3.10

K. Can providers establish screening protocols or use dual staffing for managed care patients presenting to a dedicated emergency department? 3.10

L. Must a medical screening be provided to minors who are seeking an examination in the absence of parental consent? 3.11

M. Does EMTALA apply to patients referred for services under telephone orders? 3.11

N. Who is responsible for treatment decisions in a dedicated emergency department? 3.11

O. Does the medical screening examination have to be performed in a dedicated emergency department? 3.12

III. Application of Emtala to On-Campus Departments 3.14

A. What are the requirements for on-campus services operated under the hospital's provider number? 3.14

B. What is the scope of services required of an on-campus facility to provide emergency services? 3.14

C. How does EMTALA apply to departments that are not dedicated emergency departments? 3.14

D. What are the requirements to move a patient who requires treatment beyond the capability of the on-campus department? 3.15

IV. Application of Emtala to Off-Campus Departments of a Hospital 3.16

A. Off-Campus Departments Operated by the Hospital that are Dedicated Emergency Departments 3.16

B. Off-Campus Departments Operated by the Hospital that are Not Dedicated Emergency Departments 3.16

V. Application of Emtala to Labor and Delivery Departments 3.17

A. What are the obligations of a labor and delivery department under EMTALA? 3.17

B. What is the scope of the medical screening for women presenting with labor- related conditions? 3.17

Documentation 3.17

C. Can a hospital discharge a woman in labor? 3.17

D. What are the requirements for certifying and discharging a patient with false labor? 3.18

E. Are there special EMTALA rules for providing a medical screening to newborns? 3.19

VI. Application of Emtala to Psychiatric Facilities and Patients 3.20

A. What are the obligations of a psychiatric hospital to provide emergency services? 3.20

B. What are the obligations of a general acute care hospital to provide a medical screening examination to a psychiatric emergency patient if it does not provide psychiatric services or have on-call coverage for psychiatric conditions? 3.20

C. How does EMTALA apply to legal holds (such 5150s) permitted under state law to detain a person with a suspected mental disorder who may be dangerous to self or others, or gravely disabled? 3.21

3 Medical Screening Examinations

I. OVERVIEW

If an individual comes to a hospital that has an emergency department, the hospital must provide an appropriate medical screening examination (MSE) within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine if the individual has an emergency medical condition (EMC).

As discussed in chapter 2, "When and Where Does EMTALA Begin and End?" the medical screening requirement applies with respect to any individual who:

1. Comes to an on-campus or off-campus dedicated emergency department seeking or in need of examination or treatment for a medical condition; or
2. Is at any other location on hospital property seeking or in need of examination or treatment for what may be an emergency medical condition *(see discussion under V. "What Is "Hospital Property" Under EMTALA?," page 2.8)*.

The MSE is defined in the *Interpretive Guidelines* as a process required to reach a decision as to whether, within reasonable clinical confidence, an individual has an EMC. The MSE must be provided in the same manner to all individuals presenting with similar signs and symptoms.

The MSE is the entry point of EMTALA-mandated services. As discussed in chapter 13, "Regulatory Enforcement of EMTALA," a recent study found that the failure to provide an appropriate MSE was cited by CMS in 55 percent of EMTALA administrative enforcement actions between 2005 and 2014.

NOTE: The initial section of this chapter addresses general questions and issues regarding the conduct of the MSE. There are subsequent sections on requirements for off-campus services and labor and delivery (including newborns). Medical screening of psychiatric patients is briefly discussed in this chapter, and more fully described in chapter 6, "EMTALA and Psychiatric Emergency Patients." In addition, chapter 2, "When and Where Does EMTALA Begin and End?" includes a discussion of when, where and to whom a MSE must be provided.

II. QUESTIONS

A. Is triage considered a medical screening examination?

No. The scope of triage performed in most hospitals does not qualify as an appropriate MSE under EMTALA. The *Interpretive Guidelines* require that patients presenting for emergency services must receive a MSE beyond initial triage:

> Triage is not equivalent to a MSE. Triage merely determines the "order" in which patients will be seen, not the presence or absence of an emergency medical condition.

Compliance Tip: Hospitals should ensure that their triage classifications are based on nationally- or industry-recognized standards and that the decisions on triage classifications for emergency patients are consistent with hospital triage policies. In an EMTALA survey in California, CMS cited a hospital for inappropriate triage classification of emergency patients, finding that certain patients were classified in lower triage classifications than the reviewers believed were appropriate based on their presenting complaints, signs and symptoms.

☞ **References:**

42 C.F.R. Section 489.24(a) (Appendix B)

Interpretive Guidelines, tag no. A-2406/C-2406 (Appendix C)

B. What is the purpose of the medical screening examination?

The *Interpretive Guidelines* define a "medical screening examination" as "the process required to reach, within reasonable clinical confidence, the point at which it can be determined whether a medical emergency does or does not exist."

The clinical outcome of the patient's condition is not the determining factor as to whether a hospital has provided an appropriate MSE or whether a patient was stabilized (although it may indicate the need for further investigation). The *Interpretive Guidelines* note that if a misdiagnosis occurred, but the hospital used all of its resources, there is no violation of EMTALA.

☞ **References:**

42 C.F.R. Section 489.24(a) (Appendix B)

Interpretive Guidelines, tag no. A-2406/C-2406 (Appendix C)

C. What is the scope of an appropriate medical screening examination?

CMS has declined to define the elements of an appropriate MSE. Instead, CMS has stated that an appropriate MSE will vary according to the patient's presenting complaint, history and medical condition, as well as the capabilities of the hospital.

In general, an EMTALA enforcement survey team is instructed to identify the scope of MSEs and patterns of care of a hospital in evaluating compliance with EMTALA. The factors described below — non-discrimination, individual and condition-specific, continuous monitoring and contemporaneous documentation — will be considered in determining whether a MSE is appropriate.

Non-Discrimination

The *Interpretive Guidelines* state that:

> The MSE must be the same MSE that the hospital would perform on any individual coming to the hospital's dedicated emergency department with those signs and symptoms, regardless of the individual's ability to pay for medical care. If a hospital applies in a nondiscriminatory manner (i.e., a different level of care must not exist based on payment status, race, national origin, etc.) a screening process that is reasonably calculated to determine whether an EMC exists, it has met its obligations under EMTALA.

The tests described in the *Interpretive Guidelines* are generally consistent with the standards adopted by the federal courts for providing an appropriate medical screening. In Jackson v. East Bay Hospital (discussed in chapter 14, "Private Actions to Enforce EMTALA"), the court adopted the "comparative test" that has been followed by other judicial circuits:

> A medical screening must be comparable to the screening provided to patients presenting with similar signs and symptoms, unless the examination is so cursory that it is not designed to identify acute or severe symptoms alerting the physician to a possible emergency condition.

Although most EMTALA claims for inadequate medical screening focus on whether the examination differed from the screening performed on other patients with similar presenting complaints, signs and symptoms, an unpublished 2007 court decision[1] (*Lewellen v. Schneck Medical Center*, also discussed in chapter 14, "Private Actions to Enforce EMTALA"), found that a screening of an intoxicated, injured driver with a burst fracture failed to meet the "cursory screening" test.

The *Interpretive Guidelines* require that the screening must be provided regardless of diagnosis (such as labor or AIDS), financial status (such as insured or Medicaid), race and color, national origin, disability or other nonmedical factors. California law expressly requires that:

> In no event shall the provision of emergency services and care be based upon, or affected by, the person's ethnicity, citizenship, age, preexisting medical condition, insurance status, economic status, ability to pay for medical services, or any other characteristic listed or defined in subdivision (b) or (e) of Section 51 of the Civil Code, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental disability is medically significant to the provision of appropriate medical care to the patient.[2] [Health and Safety Code Section 1317(b)]

In performing EMTALA enforcement surveys, the surveyors are instructed to look for possible discrimination based on nonclinical factors as to the manner in which the hospital conducts MSEs. If discrimination based on nonmedical factors (i.e., patient financial status, race or other nonclinical factor) is detected, the surveyors are directed to report the information to the Office for Civil Rights of the U.S. Department of Health and Human Services.

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1 As an unpublished opinion, Schneck does not have the force of law, although its reasoning and application of EMTALA may be instructive for compliance purposes.

2 Civil Code Section 51(b), known as the Unruh Civil Rights Act, prohibits discrimination in the State of California based on sex, race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, sexual orientation, citizenship, primary language or immigration status.

Individual and Condition-Specific

The scope of an appropriate MSE must be tailored to the presenting signs and symptoms and the medical history of the individual. The *Interpretive Guidelines* describe the screening examination as a process that may range from a simple examination (such as a brief focused history and examination) to a complex examination that may include laboratory tests, MRI or diagnostic imaging, lumbar punctures and/or other diagnostic tests and procedures. In some cases, the MSE may require a reasonable period of observation and monitoring, or consultation with an on-call specialist, to determine whether the individual has an EMC.

Continuous Monitoring

The *Interpretive Guidelines* emphasize that a MSE is not an isolated event; it is an ongoing process. The medical record must reflect ongoing monitoring in accordance with the individual's needs, and must continue until the individual is stabilized or appropriately transferred or discharged.

The *Interpretive Guidelines* provide that the medical record should contain evidence of an evaluation prior to discharge or departure from the hospital for a transfer to another facility.

Documentation

The determination of the appropriateness of the MSE is based on the documentation of the examination. In the Investigative Procedures for EMTALA Surveyors portion of the State Operations Manual, CMS has directed surveyors to determine whether the medical record contains, as appropriate, documentation of the screening, tests, mental status, impressions and diagnosis (supported by a history and physical examination, laboratory tests and other tests and procedures).

The importance of documentation is critical to demonstrating that the hospital provided an appropriate MSE or other required treatment. In some cases, the charting is incomplete or is missing relevant data, test results and clinical findings. In unusual cases, the medical record should explain the sequence of events, rather than random notes throughout the record or no notes at all. Many hospitals have been cited for failure to provide an adequate MSE or required treatment because of inadequate documentation. Hospitals are therefore encouraged to review a sample of emergency patient medical records, and take corrective action as may be appropriate.

☞ **References:**

42 C.F.R. Section 489.24(a) (Appendix B)

Interpretive Guidelines, tag no. A-2406/C-2406 (Appendix C)

Health and Safety Code Section 1317(b) (Appendix D)

Investigative Procedures for EMTALA Surveyors (Appendix K)

Jackson v. East Bay Hospital, 246 F.3d 1248 (9th Cir. 2001)

Lewellen v. Schneck Medical Center, S.D. Ind., 2007 (unpublished opinion)

D. What is the required scope of the MSE for individuals who present to a dedicated emergency department with conditions of a non-emergent nature?

In the preamble to the 2003 amendments to the EMTALA rules, CMS reaffirmed its view that a hospital has an EMTALA obligation with respect to any individual who comes to a dedicated emergency department seeking or in need of examination or treatment for a medical condition, even if the request for the examination or treatment pertains to a condition that is likely non-emergent. However, CMS also emphasized that all MSEs do not have to be "equally extensive."

CMS therefore added a subsection to the EMTALA regulations to address the hospital's obligations to a non-emergent patient who presents to a dedicated emergency department seeking examination or treatment:

> If an individual comes to a hospital's dedicated emergency department and a request is made on his or behalf for examination or treatment for a medical condition, but the nature of the request makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner to determine that the individual does not have an emergency medical condition [42 C.F.R. Section 489.24(c)].

As an example, CMS described a hypothetical case of an individual who presents to a dedicated emergency department seeking the removal of sutures. The analysis by CMS of the hypothetical case noted that the patient visit implicated the EMTALA obligations since the individual came to a dedicated emergency department seeking examination and treatment for a medical condition.

CMS indicated that the hospital may have an emergency nurse, who has been designated by the hospital and medical staff as a qualified professional to perform an MSE, conduct the MSE examination by obtaining the individual's history, examining the sutures and determining whether the wound is healing appropriately. If the nurse concludes that the patient does not have an EMC, CMS stated that the EMTALA obligations would be satisfied.

In the preamble to the final regulations, CMS noted, however, that if it is later found that the individual who requested the removal of sutures in fact had an EMC, the extent and quality of the MSE by the nurse would be subject to review to determine whether the MSE was adequate [68 Fed. Reg. 53237].

Hospitals that propose to use registered nurses to perform the MSE should review the discussion under H. "What are the requirements for certifying nurses and other health care professionals to perform medical screening examinations?," page 3.8, as well as Appendix M.

☞ **Reference:**

42 C.F.R. Section 489.24(b) and (c) (Appendix B)

E. Must a medical record be opened for every patient?

A medical record must be opened for every patient who presents to the hospital for emergency medical services. CMS has cited as EMTALA violations the use of triage slips, rather than opening a medical record, to record the results of triage or the MSE examination. Even if a patient leaves the hospital after triage and before receiving a MSE, the hospital must open a medical record for the patient and record the results of the visit.

Records should be retained in accordance with applicable state laws and hospital policies, but in no event less than five years from the date of service. The *Interpretive Guidelines* indicate that medical records may be retained in original or legally reproduced form in hard copy, microfilm, microfiche, optical disks, computer disks or computer memory banks.

In California, the licensing regulations for all emergency departments require that medical records must be maintained on all patients presenting for emergency services. The records must become part of the hospital's medical record. In addition, prior medical record information on a patient must be available to the emergency department. *(See CHA's* Record and Data Retention Schedule *for complete information about record retention requirements for hospitals.)*

☞ **References:**

42 C.F.R. Section 489.20(r)(1) (Appendix B)

Interpretive Guidelines, tag no. A-2403/C-2403 (Appendix C)

Title 22, California Code of Regulations, Sections 70413(g) (basic emergency medical service), 70453(g) (comprehensive emergency medical service) and 70651 (standby emergency medical service)

F. Who may perform the medical screening examination?

The MSE must be conducted by individuals who are determined to be qualified by the hospital and the medical staff. There is no requirement that a physician must perform the MSE.

However, the medical staff must establish the categories of personnel who are designated to perform MSEs. The categories must be listed in the medical staff bylaws or rules and regulations, and approved by the hospital governing body. Although the EMTALA regulations permit a hospital and medical staff to determine the categories of personnel qualified to perform MSEs, CMS has stated that the surveyors are not required to accept the hospital and medical staff's determination.

The determination of who may perform the MSE is a hospital and medical staff decision. This determination cannot be delegated to the medical director of an emergency service or to a medical staff committee. Rather, the designations:

1. Must be set forth in the medical staff bylaws or rules and regulations; and
2. Apply to each department (e.g., emergency, labor and delivery, psychiatric, urgent care, etc.) that provides MSEs for patients.

The *Interpretive Guidelines* further provide that a hospital and its medical staff must develop a screening procedure or protocol for non-physicians who perform MSEs. The procedure or protocol must define when a physician must be contacted for consultation or take responsibility for the patient.

California law is similar: an MSE must be performed by a physician, or to the extent permitted by applicable law, such as scope-of-practice laws, by other appropriate licensed persons under the supervision of a physician, if within the scope of that person's license.

Compliance Tip: It is recommended that the designations and policies approved by the medical staff and the hospital set forth the basic qualifications for personnel designated to perform MSEs. As appropriate, the rules and regulations should also list any limitations on the ability of designated personnel to perform certain types of examinations (for example, hospitals may have different designation standards for personnel who are authorized to screen normal-risk and high-risk labor patients). The training and in-service requirements for screening personnel should be set forth in standardized procedures or policies. The hospital must maintain records of personnel who complete in-service education programs. Additional standards must be met for designation of registered nurses to perform MSEs *(see discussion below)*.

☞ **References:**

42 C.F.R. Section 489.24(a) (Appendix B)

Interpretive Guidelines, tag no. A-2406/C-2406 (Appendix C)

Health and Safety Code Section 1317.1(a) (Appendix D)

An Explanation of the Scope of RN Practice Including Standardized Procedures (Appendix M)

G. Is the screening requirement the same for critical access hospitals as it is for other general acute care hospitals?

Critical access hospitals (CAHs) are required to have a physician, physician assistant, nurse practitioner or a clinical nurse specialist, with training or experience in emergency care, available within 30-60 minutes (depending on the CAH's location) to see a patient in the emergency department. Some CAH personnel noted that this language seemed to require a hospital response for patients with non-emergent conditions.

In response to this concern, in 2006, CMS amended the Medicare Conditions of Participation for CAHs to permit a registered nurse, with training and experience in emergency care, to conduct specific MSEs if two conditions are met:

1. The nurse is on-site and immediately available at the CAH when a patient requests medical care; and
2. The nature of the patient's request for medical care is within the scope of practice of a registered nurse and consistent with applicable state laws and the CAH's bylaws or rules and regulations.

In 2013, CMS issued supplemental guidance that a qualified medical person (QMP) on-site at a CAH may be assisted or directed by a qualified telemedicine practitioner in conducting the medical screening examination. Under the guidance, when a non-physician practitioner on-site at a CAH is assisted or directed by a qualified telemedicine physician in the diagnosis or treatment of a patient in a CAH ED, there is no requirement or expectation that the CAH must always require a local on-call physician to come to the ED. However, if hands-on treatment is required beyond the capability of the on-site practitioner, a request for local on-call physician could be required.

☞ **Reference:**

42 C.F.R. Section 485.618 (Appendix B)

CMS Survey and Certification Memorandum 13-38: Critical Access Hospital Emergency Services and Telemedicine (Appendix Y); the letter is also discussed in Chapter 11, "Physician On-Call Responsibilities"

H. What are the requirements for certifying nurses and other health care professionals to perform medical screening examinations?

Each hospital is permitted to determine who may provide the MSE, subject to the limitations of the state's professional practice acts. As discussed above, the EMTALA regulations require that the medical staff bylaws or rules and regulations designate the categories of personnel by service (for example, obstetrics (OB), Emergency Department (ED), psychiatry, etc.) who are authorized to perform MSEs. The process for certifying health care professionals designated to perform MSEs is generally set by state professional practice acts and facility licensing laws.

A review of the certification process for hospitals in California to use in certifying registered nurses to perform an MSE is included as Appendix M.

Compliance Tip: CMS has cited hospitals for failure to provide an appropriate MSE when the presenting complaint or signs and symptoms exceed the scope of practice for a registered nurse or other non-physician practitioner who is designated to perform MSEs. For example, if a patient presents to labor and delivery with a complaint of pain and a designated registered nurse rules out labor-related conditions associated with the pain, it may be necessary to contact an on-call physician or send the patient to the emergency department to ensure that the individual is seen by a physician or other designated professional who has a broader scope of practice.

☞ **References:**

42 C.F.R. Section 489.24(a) (Appendix B)

Interpretive Guidelines, tag no. A-2406/C-2406 (Appendix C)

An Explanation of the Scope of RN Practice Including Standardized Procedures (Appendix M)

I. What resources are considered "available" to a dedicated emergency department?

The resources considered by CMS to be "available" to a dedicated emergency department include:

1. Ancillary services routinely available to the department;
2. On-call physicians; and
3. The staff and resources of a hospital routinely available for hospital patients.

A hospital is not required to expand its resources or offer more services to meet its EMTALA obligations. However, the Investigative Procedures for EMTALA Surveyors portion of the State Operations Manual directs surveyors to consult with the CMS regional office if "it appears that a hospital with a dedicated ED does not have adequate staff and equipment to meet the needs of patients." The regional office will determine whether the surveyor should expand the survey to assess compliance with the Medicare Condition of Participation for emergency departments (42 C.F.R. Section 482.55), found in Appendix E.

Under California law, the resources of the hospital are defined as the services required for licensing an emergency service, as well as the services specified by the hospital on the Office of Statewide Health Planning and Development (OSHPD) Form 7041.

The CMS 2013 guidance for critical access hospitals on the use of telemedicine and on- call compliance clarified the obligations for on-call coverage for CAH emergency patients. The guidance is discussed in G. "Is the screening requirement the same for critical access hospitals as it is for other general acute care hospitals?," page 3.7, and in Chapter 11, "Physician On-Call Responsibilities."

☞ **References:**

42 C.F.R. Section 489.24(a) and (b) (Appendix B)

Interpretive Guidelines, tag nos. A-2406/C-2406 and A-2407/C-2407 (Appendix C)

Health and Safety Code Section 1317.1(h) (Appendix D)

Investigative Procedures for EMTALA Surveyors (Appendix K)

J. Can emergency departments request emergency medical technicians (EMTs) and paramedics to stay with a patient transported to the hospital emergency department when the department is saturated?

In two program memoranda issued in 2006 and 2007 (Appendix Z), CMS provided guidance to emergency department personnel regarding the use of emergency transport personnel to hold and monitor an emergency patient pending availability of services in the emergency department. The memoranda were subsequently incorporated into the *Interpretive Guidelines*.

In the first memorandum (S&C 06-21; July 13, 2006, now included in tag no. A-2406/C-2406 of the *Interpretive Guidelines*; see Appendix C), CMS addressed situations where emergency department personnel prevent EMTs from transferring patients from the ambulance to a hospital gurney or bed, sometimes leaving patients in the ambulance for extended periods of time (referred by CMS as "parking" patients). CMS responded that this practice could result in possible violations of EMTALA and the Medicare Condition of Participation for emergency services (42 C.F.R. Section 482.55), as well as raise serious concerns for the patient and the community. The memorandum reminded hospitals that the EMTALA obligations begin when the ambulance arrives on hospital property and the EMTs request treatment for the patient, not when the hospital "accepts" the patient from the EMT personnel.

In a subsequent memorandum (S&C 07-20; April 27, 2007, also now incorporated in tag no. A-2406/C-2406 of the *Interpretive Guidelines*; see Appendix C), CMS, at the request of the EMTALA Technical Advisory Group, clarified the July 13, 2006 memorandum. The EMTALA TAG reportedly advised CMS that some emergency medical service (EMS) organizations had cited the memorandum as requiring hospitals to take instant custody of all individuals arriving by EMS transport at the emergency department. In the second memorandum, CMS

acknowledged that an emergency department may lack capacity or capability for immediate movement of the patient from the ambulance to a hospital bed. As explained by CMS:

So, if the EMS provider brought an individual to the dedicated ED at a time when ED staff was occupied dealing with major multiple trauma cases, it could under those circumstances be reasonable for the hospital to ask the EMS provider to stay with the individual until such time as there were ED staff available to provide care to that individual.

However, CMS cautions hospitals that even if the hospital cannot immediately provide an MSE for an ambulance patient awaiting entry to the emergency department, it must provide triage of the patient's condition "immediately upon arrival to ensure that an emergent intervention is not required and that the EMS provider staff can appropriately monitor the individual's condition."

As with all EMTALA cases, ambulance cases will be reviewed (upon complaint) on a case-by-case basis, with a full review of all relevant facts and circumstances.

Documentation

Emergency department policies should address procedures for department saturation, including holding patients in ambulances when the department lacks capacity or capability to bring the patient into the treatment area. For all ED patients held by EMS personnel, the hospital should ensure the following actions are taken in a timely manner and documented:

1. The patient is entered in the ED central log;
2. A medical record is opened for the patient;
3. The triage nurse provides a triage assessment of the patient; and
4. The patient is provided an MSE based on his/her triage status and the immediacy of the patient's medical needs.

The emergency department staff should also coordinate monitoring and treatment with the EMTs, work together to minimize deterioration of the patient's condition, and expedite moving the patient to the treatment area so that the EMTs may depart the hospital.

☞ **References:**

Interpretive Guidelines, tag no. A-2406/C-2406 (incorporating "EMTALA – 'Parking' of Emergency Medical Service Patients in Hospitals," S&C 06-21, July 13, 2006 and "EMTALA Issues Related to Emergency Transport Services," S&C 07-20, April 27, 2007)

K. Can providers establish screening protocols or use dual staffing for managed care patients presenting to a dedicated emergency department?

One of the purposes of EMTALA is to require that all individuals who receive emergency services are provided the same scope of services as other patients with the same or similar clinical signs and symptoms, without discrimination based on ability to pay, payment status or other nonmedical factors that are not relevant to the patient's clinical needs. Although hospitals and their medical staffs may establish policies for MSEs and emergency services, the policies must be applied to all patients who present with similar signs and symptoms, regardless of payment status. Therefore, a medical group, managed care plan or other payer cannot require a hospital to implement screening policies for its members if the policies establish a different scope or level of care for managed care patients than for other patients presenting with similar conditions.

In 1990, CMS and the OIG issued a Special Advisory Bulletin that reviewed proposed dual staffing arrangements (e.g., separate ED physician panels for managed care and non-managed care patients), and expressed concerns as to whether dual staffing violated the EMTALA requirements for uniform treatment of all emergency patients. (For a discussion of the issues involving dual staffing, see the Special Advisory Bulletin included as Appendix H.)

☞ **References:**

42 C.F.R. Section 489.24(a) (Appendix B)

Interpretive Guidelines, tag nos. A-2406/C-2406 and A-2407/C-2407 (Appendix C)

Special Advisory Bulletin (Appendix H)

L. Must a medical screening be provided to minors who are seeking an examination in the absence of parental consent?

In the *Interpretive Guidelines*, CMS has stated that minors who present to a dedicated emergency department can request examination or treatment for an EMC. According to CMS, the hospital may not delay the MSE for a minor by waiting for parental consent. If the examination indicates that the minor does not have an EMC, the *Interpretive Guidelines* permit a hospital to wait for consent from a parent or other responsible adult before providing further examination or treatment (although the hospital must continue to monitor the patient's condition, and if necessary, render treatment as may be appropriate to stabilize an EMC).

Additional guidance on consent to emergency care for minors can be found in CHA's *Consent Manual* and *Minors & Health Care Law* manual.

☞ **Reference:**

Interpretive Guidelines, tag no. A-2406/C-2406 (Appendix C)

M. Does EMTALA apply to patients referred for services under telephone orders?

As discussed in chapter 2, "When and Where Does EMTALA Begin and End?" EMTALA applies to a patient who presents to a dedicated emergency department for medication (e.g., injections) or other treatment under orders from the patient's physician, even if the physician requests that the patient receive treatment without an MSE.

Compliance Tip: Hospitals should review their policies for telephone orders to the dedicated emergency department, and ensure that patients presenting to a designated emergency department subject to telephone orders are provided an MSE, and further examination and stabilizing treatment as may be clinically indicated if the patient is determined to have an EMC.

N. Who is responsible for treatment decisions in a dedicated emergency department?

CMS has consistently taken the position that the physician treating an emergency patient is the responsible physician for purposes of EMTALA compliance (and imposition of civil money sanctions in the event of an EMTALA violation). A treating physician may be any on-site physician, including an emergency physician, an obstetrician who is attending a patient in

labor, an on-call physician who assumes responsibility for an emergency patient, or any other member of the hospital medical staff who attends an emergency patient in the dedicated emergency department.

The *Interpretive Guidelines* declare that the treating physician has the primary responsibility for making patient-care decisions:

> Once an individual has presented to the hospital seeking emergency care, the determination of whether an EMC exists is made by the examining physician(s) or other qualified medical person actually caring for the patient at the treating facility.

If a disagreement occurs between the treating physician and the patient's primary care or gatekeeper physician, the primary care physician or a managed care plan physician (if credentialed to provide services in the hospital) may come to the hospital and assume responsibility for the patient's continuing course of care and treatment. Although the assumption of the patient's care by a primary care or plan physician may absolve the emergency or other treating physician from liability for an EMTALA violation by the primary care or plan physician, it does not absolve the hospital from liability. As with any other emergency patient, the primary care or plan physician must follow the hospital's emergency care policies and comply with EMTALA. If the primary care or health plan physician discharges the patient in an unstabilized condition or initiates a transfer that does not meet EMTALA requirements, then the primary care or health plan physician and the hospital are potentially liable for a violation of EMTALA.

☞ **References:**

42 C.F.R. Section 489.24(a) (Appendix B)

Interpretive Guidelines, tag nos. A-2406/C-2406 and A-2407/C-2407 (Appendix C)

Health and Safety Code Section 1371.4 (Appendix D)

O. Does the medical screening examination have to be performed in a dedicated emergency department?

Under the *Interpretive Guidelines*, an individual must be "initially screened" in the dedicated emergency department before he or she can be moved to another hospital department for further screening and stabilizing treatment.

Therefore, an individual who has been triaged in the dedicated emergency department, but has not received an initial medical screening, cannot be referred to another hospital department. CMS Region IX has indicated that unless the individual presents to the dedicated emergency department seeking directions to another department (such as an occupational medicine clinic), the individual must receive an initial medical screening before he or she may be moved to another department for further services.

However, Region IX has also indicated that women presenting to a dedicated emergency department with labor-related conditions may be directed or otherwise moved to the labor and delivery service without an initial screening in the emergency department, because labor and delivery is also considered to be a dedicated emergency department for purposes of EMTALA.

However, a hospital may not perform triage of patients in the dedicated emergency department, and then refer defined categories of patients (such as "nonurgent" patients) to another on-campus hospital department (that is not a dedicated emergency department) to conduct the MSE, unless an initial screening is first completed in the dedicated emergency department.

In addition, a patient who "comes to the emergency department" cannot be moved to a rural health clinic or a private physician's office for the MSE or stabilizing treatment, even if the rural health clinic or office is located on the hospital campus.

Following the completion of an initial screening in the dedicated emergency department, a hospital may move patients to another on-campus department if all of the following conditions are met:

1. All persons with the same medical conditions are moved to the department, regardless of their ability to pay for treatment.
2. There is a "bona fide medical reason" to move the patient.
3. "Appropriate" medical personnel accompany the patient to the on-campus location.

The use of the term "appropriate" medical personnel (which replaced "qualified" medical personnel in a prior version of the *Interpretive Guidelines*) appears to give hospitals more flexibility in assigning personnel to accompany a patient who is moved to another location for the MSE.

The same guidance about moving patients from the dedicated emergency department also applies to patients who first present to an on-campus hospital department outside of the dedicated emergency department. In that case, the individual cannot be moved to another hospital department for further examination or treatment before the individual receives an initial screening. An internal movement of a patient within departments of the hospital that are on the hospital campus is not considered to be a "transfer" within the meaning of EMTALA.

Each hospital should adopt policies and written directions for the movement of patients to other hospital departments that are on the hospital campus for further screening or necessary stabilizing treatment. A reasonable interpretation of the *Interpretive Guidelines* suggests that an attendant or a qualified professional should accompany patients who may need assistance (e.g., for medical reasons or physical or mental disability) to access the on-campus service; as appropriate, patients should be provided escort service, wheelchairs or other assistance to ensure they arrive safely at the on-campus service and that their condition will not be jeopardized by relocation to another department of the hospital.

Compliance Tip: If a hospital decides that certain classes of patients do not need personal assistance to access another hospital department for further screening or treatment, the hospital should adopt measures to ensure that patients actually reach the on-campus service. Such measures include written instruction sheets, campus maps, notification to the on-campus service of the patient referral, and follow-up verification of the patient's arrival. Hospitals may be at risk for an EMTALA violation if a patient decides en route to another department to leave the hospital without notifying hospital personnel. As appropriate, hospitals should consider contacting an eloped patient to determine why the patient left and his or her health status.

☞ **References:**

42 C.F.R. Section 489.24(a) (Appendix B)

Interpretive Guidelines, tag no. A-2406/C-2406 (Appendix C)

III. APPLICATION OF EMTALA TO ON-CAMPUS DEPARTMENTS

A. What are the requirements for on-campus services operated under the hospital's provider number?

A hospital may utilize the resources of its services provided on the main hospital campus to provide further examination and treatment of an emergent patient who has received an initial screening. However, EMTALA applies to an individual who presents to any hospital department (that is not a dedicated emergency department) on hospital property seeking or in need of examination or treatment for what may be an EMC. The application of EMTALA to all departments on the hospital property requires the facility to develop policies and procedures for all of its ambulatory care or on-campus departments; these policies and procedures must provide guidance in handling patient emergencies and individuals seeking emergency services.

B. What is the scope of services required of an on-campus facility to provide emergency services?

The application of EMTALA to all on-campus facilities means an individual who drops in or presents at any hospital department seeking or in need of examination or treatment of what may be an emergency condition is entitled to an MSE and, if the individual has an EMC, further examination and stabilizing treatment. If an individual presents to an on-campus hospital department for a possible EMC, CMS will consider that all of the resources of the hospital should be available to provide emergency services and care to the individual. Hospitals should have policies and procedures for on-campus departments to respond to emergency situations.

C. How does EMTALA apply to departments that are not dedicated emergency departments?

As discussed in chapter 2, "When and Where Does EMTALA Begin and End?" hospital departments that are not dedicated emergency departments are not subject to the same rules as dedicated emergency departments. However, these departments must have policies and procedures for evaluating and responding to individuals seeking or in need of examination or treatment for potential emergency conditions.

As discussed in chapter 2, "When and Where Does EMTALA Begin and End?", an outpatient who is in the course of an encounter in a hospital department is covered by the Medicare Conditions of Participation during the course of the encounter, even if the patient develops an EMC during the encounter. The Medicare Conditions of Participation require the medical staff to have written policies for appraisal of emergencies, initial treatment and referral for all hospital patients.

However, the EMTALA obligations apply to an individual who requests or is in need of services for a potential EMC that occurs prior to the commencement of the outpatient encounter or after the completion of the outpatient encounter.

Compliance Tip: Each hospital department in the main hospital and on campus should have policies and provide in-service education to department personnel on how to handle a person seeking or in need of examination or treatment for a potential EMC.

D. What are the requirements to move a patient who requires treatment beyond the capability of the on-campus department?

If a patient presents to an on-campus department of the hospital outside of the dedicated emergency department with a possible EMC, the hospital may move the patient to the dedicated emergency department (or another appropriate location on the hospital campus) after an initial screening in order to render further screening and necessary stabilizing treatment. An internal movement of a patient within departments on the hospital campus is not a "transfer" within the meaning of EMTALA.

However, the movement of the patient from an on-campus department to the dedicated emergency department, labor and delivery, or another hospital department must be accomplished in the same manner as moving a patient who has received an initial screening from the main emergency department to another on-campus service. Hospital policies should include the following:

1. All patients with the same medical conditions are moved to the department or service, regardless of their ability to pay for treatment.
2. There are bona fide medical reasons to move the patients.
3. Appropriate medical personnel accompany the patients to the on-campus location.

The *Interpretive Guidelines* do not address the on-campus relocation of a patient with an EMC who cannot be moved without emergency personnel and secure transport. Due to the multi-block size of many hospital campuses, including crossing public streets between "campus buildings," it may be unsafe in certain circumstances to move an emergency patient without an ambulance and appropriate personnel and equipment.

Hospitals should develop policies and procedures for moving patients between freestanding buildings on the hospital campus to a dedicated emergency department (including, as necessary, calling 9-1-1 for patient assistance and transport), and provide in-service education to applicable personnel. The policies should address the procedures to be followed if the ambulance takes the patient to another hospital. The procedures should include contacting the receiving facility and explaining the circumstances of the ambulance transport (in order to avoid the presumption of a possible EMTALA violation) and notification of the event to hospital administration (compliance officer, risk management, etc.)

☞ **References:**

42 C.F.R. Sections 489.20(q) and (r), 489.24(a) and (b) (Appendix B)

Interpretive Guidelines, tag nos. A-2402/C-2402 to A-2406/C-2406 (Appendix C)

IV. APPLICATION OF EMTALA TO OFF-CAMPUS DEPARTMENTS OF A HOSPITAL

A. Off-Campus Departments Operated by the Hospital that are Dedicated Emergency Departments

The 2003 EMTALA regulations repealed the extension of EMTALA to off-campus hospital departments and facilities, except for hospital departments or facilities that meet the definition of a dedicated emergency department. As with an on-campus dedicated emergency department, the off-campus dedicated emergency department must comply with all of the EMTALA obligations.

In 2008, CMS published guidance for "freestanding" emergency departments that offer emergency services at an off-campus location. The guidance requires freestanding emergency departments that are operated as provider-based departments of a hospital to meet the Medicare Conditions of Participation and the EMTALA obligations. A copy of the guidance (S&C 08-08) is included in Appendix Q.

B. Off-Campus Departments Operated by the Hospital that are Not Dedicated Emergency Departments

An off-campus department or facility that is not a dedicated emergency department is not subject to EMTALA. However, emergency services provided in these departments and facilities are subject to a Medicare Condition of Participation requiring written policies and procedures to be adopted by the hospital governing body for appraisal of emergencies and referral when appropriate.

The *Interpretive Guidelines* adopted by CMS to implement the Medicare Condition of Participation (Appendix E) for off-campus departments require the following:

1. The policies and procedures must apply to patients, staff, visitors and others at off-campus locations who are seeking or in need of emergency care.
2. Department staff are expected to know how to respond to individuals seeking or in need of emergency services.
3. The department must provide initial treatment and stabilization of patients needing emergency care in accordance with the complexity of services, types and qualifications of staff and other resources available at the location of the department.

The *Interpretive Guidelines* clarify that off-campus departments may direct staff to call 9-1-1 for patient care management and transport to an emergency department (which may be the closest available emergency department rather than the hospital's emergency department). In addition, off-campus departments are not required to be staffed with professionals with experience handling patients presenting emergency conditions. In the preamble to the 2003 rules, CMS also stated that the policies and procedures for appraisal and referral will apply only within the hours of operation and normal staffing capability of the facility.

☞ **References:**

42 C.F.R. Sections 482.12(f), 489.20(q) and (r), 489.24(a) and (i) (Appendix B)

Interpretive Guidelines, tag nos. A-2402/C-2402 to A-2406/C-2406 (Appendix C)

Interpretive Guidelines for Hospitals, Medicare Conditions of Participation (42 C.F.R. Section 482.12(f)(3)) (Appendix E)

V. APPLICATION OF EMTALA TO LABOR AND DELIVERY DEPARTMENTS

A. What are the obligations of a labor and delivery department under EMTALA?

As discussed in chapter 2, "When and Where Does EMTALA Begin and End?" a labor and delivery service is considered by CMS to be a dedicated emergency department. Therefore, the labor and delivery service must comply with all of the EMTALA obligations. These include signage, central log, opening of medical records and on-call coverage, as well as policies for MSEs, necessary stabilizing treatment and an appropriate transfer (if required) for any individual who presents to the department seeking or in need of examination or treatment for any EMC.

B. What is the scope of the medical screening for women presenting with labor-related conditions?

The scope of the MSE for women presenting with labor-related conditions is to determine whether the patient is experiencing contractions or has another type of EMC unrelated to her pregnancy.

If the hospital designates registered nurses to conduct the labor examination, the hospital should define the scope of practice for the labor nurses in the standardized procedure adopted by the medical staff and the hospital board in accordance with guidelines issued by the California Board of Registered Nursing (BRN). The hospital should review "An Explanation of the Scope of Practice Including Standardized Procedures" that may be found on the BRN website (www.rn.ca.gov) or in Appendix M.

If the patient presents to labor and delivery with a condition that is nonlabor-related (for example, abdominal pain of unknown origin), the examination may be beyond the scope of the RN's standardized procedure or scope of practice. Hospitals should have policies requiring that the patient be seen by a physician or other qualified professional in labor and delivery, or moved to the emergency department for examination by the emergency physician.

Documentation

In the Investigative Procedures for EMTALA Surveyors portion of the State Operations Manual, CMS has instructed surveyors to review the medical record to determine whether the MSE included ongoing evaluation of fetal heart tones, regularity and duration of uterine contractions, fetal position and station, cervical dilation, and the status of membranes (i.e., ruptured, leaking or intact).

☞ **References:**

Investigative Procedures for EMTALA Surveyors (Appendix K)

Business and Professions Code Section 2725 (standardized procedures)

An Explanation of the Scope of RN Practice Including Standardized Procedures (Appendix M)

C. Can a hospital discharge a woman in labor?

One of the most difficult compliance issues with EMTALA is whether a hospital may discharge a woman who is having contractions. As applied to a pregnant woman having contractions, the EMTALA regulations define an "emergency medical condition" as a

condition in which there is inadequate time to effect a safe transfer to another hospital before delivery, or when a transfer may pose a threat to the health and safety of the woman or the unborn child. The regulations define "stabilized" as the delivery of the child and placenta.

If a woman is in labor, the *Interpretive Guidelines* require that the hospital must deliver the infant or transfer the patient in an appropriate manner:

> She may not be transferred unless she, or a legally responsible person acting on her behalf, requests a transfer and a physician or other qualified medical personnel, in consultation with a physician, certifies that the benefits to the condition of the woman and/or the unborn child outweigh the risks associated with the transfer.

The transfer of a woman in labor is case-specific, and a high priority for EMTALA enforcement. Therefore, CMS will review the woman's prenatal history, her condition at the time of presentation to the hospital, the condition of the unborn child at the time of transfer or discharge, the respective capabilities of the transferring and receiving facilities, the expected delivery time and the means of transport. If the hospital discharges a woman having contractions (other than a certified false labor), CMS will closely scrutinize the condition of the woman and her unborn child, the reliability of her support systems and transportation to return to the hospital, and the actions of hospital staff.

It is recommended that a hospital adopt policies and procedures describing the conditions and written instructions under which a woman having contractions may be sent home, or referred or transferred to another facility. The policies should also designate who may perform the screening and discharge or transfer of the patient, the need for physician consultation and requirements for countersigning (if applicable) determinations of false labor. Additionally, hospitals should implement quality improvement and risk management reviews of discharges and transfers of women having contractions.

☞ **References:**

42 C.F.R. Section 489.24(a), (b) and (d) (Appendix B)

Interpretive Guidelines, tag nos. A-2406/C-2406 and A-2407/C-2407 (Appendix C)

D. What are the requirements for certifying and discharging a patient with false labor?

Under EMTALA, a woman having contractions is presumed to be in labor unless a physician, certified nurse-midwife or another qualified professional, after a reasonable period of observation, certifies that the woman is in false labor. Prior to Oct. 1, 2006, the EMTALA regulations required a physician to be consulted before discharge and to countersign the certification of false labor. The categories of personnel who could certify false labor were expanded by CMS in 2006 following a recommendation from the EMTALA Technical Advisory Group.

Under California law, certified nurse-midwives, acting under the general supervision of a physician with current practice or training in obstetrics, may assist a woman in childbirth so long as the progress of the patient meets the criteria accepted as "normal," and complications are referred immediately to a physician.

If the hospital designates registered nurses to conduct labor examinations, the hospital should define the scope of practice for the labor nurses in the standardized procedure adopted by the medical staff and the hospital board (see discussion on "What is the scope of the medical screening for women presenting with labor-related conditions?," page 3.17)

The *Interpretive Guidelines* confirm that there is no requirement that the consulting physician must come to the hospital and examine the patient; that decision is left to the physician and the screening professional to determine on a case-by-case basis. Hospitals should adopt policies for certifying and discharging patients demonstrating false labor conditions. The *Interpretive Guidelines* note that telephone consultations must be documented in the medical record in accordance with the Medicare Condition of Participation for medical record entries (see 42 C.F.R. Section 482.24(c)(1)).

☞ **References:**

42 C.F.R. Section 489.24(b) (Appendix B)

Interpretive Guidelines, tag no. A-2406/C-2406 (Appendix C)

Business and Professions Code 2746.5 (certified nurse-midwives)

E. Are there special EMTALA rules for providing a medical screening to newborns?

In April 2005, CMS issued a memorandum providing guidance that the EMTALA obligations for providing a MSE and stabilizing treatment may apply to infants who are "born alive." The substance of the memorandum, entitled "Interaction of the Emergency Medical Treatment and Active Labor Act (EMTALA) and the Born-Alive Infants Protection Act of 2002," has been incorporated in tag no. A-2406/C-2406 of the *Interpretive Guidelines* (Appendix C).

Under the Born-Alive Infants Protection Act, infants are considered to be "born alive" if they are delivered by any means at any stage of development, and following complete expulsion or extraction, breathe, or have a beating heart, pulsation of the umbilical cord or definite movement of voluntary muscles regardless of whether the umbilical cord has been cut and regardless of whether the expulsion or extraction occurs as a result of natural or induced labor, C-section or induced labor.

According to the CMS memorandum, the EMTALA obligations, including medical screening and stabilizing treatment, apply to an infant who is "born alive" in a dedicated emergency department (which includes labor and delivery) if there is a request on the infant's behalf for, or a prudent layperson would conclude that the infant needs, examination or treatment for a potential EMC.

If the infant is "born alive" at a location on hospital property that is not a dedicated emergency department, an MSE is required if there is a request on the infant's behalf for, or a prudent layperson would conclude that the infant needs, examination or treatment for a potential EMC.

The CMS guidance on the application of EMTALA to the Born-Alive Infants Protection Act reaffirms that EMTALA does not apply to inpatients. Therefore, CMS has indicated that an infant who is considered to be an inpatient is covered by the Medicare Conditions of Participation rather than EMTALA.

Hospitals should have written policies and procedures for appraisal of newborns who have acute medical conditions. CHA's Consent Manual provides additional guidance on withholding or withdrawing life-sustaining treatment for infants in chapter 5, "Refusal of Treatment and End-of-Life Issues."

☞ **References:**

Born-Alive Infants Protection Act of 2002 (Public Law 107-207)

Interpretive Guidelines, tag. no. A-2406/C-2406 (incorporating CMS Memorandum, "Interaction of the Emergency Medical Treatment and Active Labor Act (EMTALA) and the Born-Alive Infants Protection Act of 2002," S&C 05-26, April 22, 2005) (Appendix C)

VI. APPLICATION OF EMTALA TO PSYCHIATRIC FACILITIES AND PATIENTS

NOTE: The application of EMTALA to psychiatric facilities and patients is discussed in chapter 6, "EMTALA and Psychiatric Emergency Services." Questions related to the medical screening obligations for psychiatric patients are briefly discussed in this chapter and referenced to chapter 6.

A. What are the obligations of a psychiatric hospital to provide emergency services?

A psychiatric hospital that offers walk-in services for patients with potential psychiatric emergencies must provide emergency services within its capability or provide for an appropriate transfer in accordance with EMTALA requirements. If a psychiatric hospital does not provide emergency or walk-in services, the *Interpretive Guidelines* for the Medicare Conditions of Participation (interpreting 42 CFR Section 482.12(f) Emergency Services) require the hospital to have appropriate written policies and procedures for appraisal, initial treatment and referral of patients.

A more detailed discussion of the obligations of psychiatric hospitals is discussed in chapter 6, "EMTALA and Psychiatric Emergency Patients."

B. What are the obligations of a general acute care hospital to provide a medical screening examination to a psychiatric emergency patient if it does not provide psychiatric services or have on-call coverage for psychiatric conditions?

If a patient presents to the dedicated emergency department of a general acute care hospital for an examination of a psychiatric condition, the hospital must record the patient's visit in the central log, open a medical record and provide a MSE within the capability of the hospital to determine whether the patient has an EMC. The MSE must include both medical and psychiatric assessments, and be performed by a physician or qualified professional designated by the hospital for performing MSEs and working under hospital policies.

A more detailed discussion of the medical screening for psychiatric patients, including documentation, is discussed on page 6.12 of chapter 6.

C. How does EMTALA apply to legal holds (such 5150s) permitted under state law to detain a person with a suspected mental disorder who may be dangerous to self or others, or gravely disabled?

Chapter 6 contains an overview of the California involuntary detention laws, including:

1. What is a 5150?
2. Who may apply a 5150 custodial hold?
3. What is a designated facility?
4. Is there a list of designated facilities?
5. What are the obligations of a peace officer or designated professional who writes a hold?
6. What is the pre-admission process for a person who is on a 5150 custodial hold?
7. How long does a 5150 custodial hold remain in effect?
8. Who can release a 5150 custodial hold?
9. When can an emergency physician detain an emergency patient on a 24-hour hold?
10. Does EMTALA recognize legal holds under state law to detain a psychiatric patient?
11. Is a person on a 5150 custodial hold considered to have an EMC?
12. What are the obligations of hospitals if there are pre-arranged state or local networks for patient screening or treatment?

4 Financial Considerations — EMTALA and Managed Care

I. Overview 4.1

II. Questions 4.2

A. When can a hospital request information on a patient's financial or insurance status? 4.2

EMTALA Requirements 4.2

State Requirements 4.3

B. When can a hospital request prior authorization? 4.3

C. When can the emergency physician contact the patient's physician to discuss the patient's course of treatment? 4.4

D. What if the patient asks about his or her financial liability for emergency services? 4.5

E. What if the patient offers a required co-payment before medical screening? 4.6

F. When should Advance Beneficiary Notices be given to patients seeking emergency services? 4.6

G. What are the Knox-Keene requirements for emergency services? 4.7

Obligation to Reimburse for Emergency Services 4.7

Prior Authorization Before Rendering Emergency Services 4.7

Prior Authorization for Post-Stabilization Services 4.7

Request for Post-Stabilization Services 4.8

If Plan Authorizes Post-Stabilization Services 4.9

If Plan Arranges Patient Transfer 4.9

If Plan Fails to Respond 4.9

Required Notice to Patient 4.10

Independent Medical Review 4.11

Strategies for Obtaining Authorization and Payment 4.11

H. What are the emergency service requirements for Medicare Advantage plans? 4.13

4 Financial Considerations — EMTALA and Managed Care

I. OVERVIEW

EMTALA mandates access to emergency services without discrimination based on financial or insurance status. Managed care plans provide coverage for emergency services, but often place limits on services or restrict payment for emergency services. These colliding imperatives have resulted in efforts by the federal and state governments to increase access to emergency services by patients covered by managed care plans, place limits on the ability of health plans to require prior authorization or control the provision of emergency services, and sanction hospitals for treating managed care patients in any manner different from other emergency patients.

Under the EMTALA regulations, a hospital may not delay providing a medical screening examination (MSE) or other emergency services in order to inquire about an individual's method of payment or insurance status. In 1999, the Centers for Medicare & Medicaid Services (CMS) and the Office of Inspector General (OIG) published a Special Advisory Bulletin (see Appendix H) to address the application of the EMTALA obligations to the provision of emergency services to managed care patients. In the 2003 revised EMTALA regulations, CMS adopted guidance set forth in the Special Advisory Bulletin prohibiting hospitals from seeking prior authorization for screening or stabilization services until the hospital has provided the MSE and initiated further examination and stabilizing treatment.

The primacy of EMTALA over managed care is emphasized in the *Interpretive Guidelines*:

> If an individual seeking care is a member of a managed care plan…the hospital is obligated to comply with the requirements of [EMTALA] regardless of the individual's payor source or financial status. The hospitals [sic] is obligated to provide the services necessary to determine if an [emergency medical condition] is present and provide stabilizing treatment if indicated. This is true regardless if the individual is enrolled in a managed care plan that restricts the enrollee's choice of health care provider. EMTALA is a requirement imposed on hospitals, and the fact that an individual who comes to the hospital is enrolled in a managed care plan that does not contract with that hospital has no bearing on the obligation of the hospital to conduct an MSE and to at lease [sic] initiate stabilizing treatment. A managed health care plan may only state the services for which it will pay or decline payment, but that does not excuse the hospital from compliance with EMTALA.

In 2013, CMS issued a Survey and Certification letter (Appendix X) that reinforced the requirement for all Medicare-participating hospitals and critical access hospitals to comply with EMTALA, regardless of any conflicting requirements of third-party payors.

Some states have adopted laws providing for access to emergency services. For example, California law requires that emergency services must be provided without first questioning a patient's ability to pay. California has also adopted several laws related to managed care and emergency services, including post-stabilization services.

II. QUESTIONS

A. When can a hospital request information on a patient's financial or insurance status?

The federal EMTALA and state laws on financial and insurance inquiries for emergency patients are not the same. The EMTALA regulations preclude delays in emergency services to make financial or insurance inquiries, and prohibit actions that discourage patients from remaining for further evaluation or treatment. California law is more restrictive, requiring that emergency services be provided without first questioning the patient's ability to pay. As discussed below, CMS has warned hospitals that aggressive financial registration practices, including collection of money before examination or treatment, may result in EMTALA sanctions.

EMTALA Requirements

As noted above, the EMTALA regulations provide that a hospital may not delay providing a MSE or other emergency services in order to inquire about an individual's method of payment or insurance status. In 2003, CMS amended the regulations to clarify that a hospital may follow reasonable registration processes for patients covered by EMTALA. Patient registration may include requests for basic demographic information (such as name, address and other pertinent nonfinancial information). It may also include requests for insurance status and plan membership, as long as the inquiry does not delay the medical screening or treatment.

CMS and the OIG historically have emphasized that inquiries or use of insurance or economic information that delay the provision of an MSE or necessary stabilizing treatment are prohibited under EMTALA. As stated in the EMTALA regulations, "Reasonable registration processes may not unduly discourage individuals from remaining for further evaluation."

In addition, the 1999 Special Advisory Bulletin recommends that, prior to performing the MSE or commencing stabilized treatment, a hospital should not ask a patient to complete financial responsibility or Advance Beneficiary Notice of Noncoverage (ABN) forms or ask patients for co-payments for services (see Appendix H).

As discussed below, the EMTALA regulations were amended in 2003 to incorporate prior CMS guidance that a hospital may not seek prior authorization before the MSE or commencement of stabilizing treatment for an emergency medical condition (EMC). Although a managed care plan may inform the hospital, physician or the patient that coverage will not be provided, the denial of coverage does not affect a hospital's obligations under EMTALA to screen the patient and provide necessary stabilizing treatment for an EMC.

In May 2012, CMS notified the major hospital associations of its concern with respect to "aggressive debt collection activities" that may have occurred in some hospitals. The CMS letter cited a specific allegation that a hospital may have tried to collect money from emergency patients before they were examined or received necessary treatments. The letter also stated:

> We would have serious concerns with the legality of any hospital policy or procedure that may discourage individuals from seeking emergency care, such as demanding that emergency department patients pay before receiving treatment. Our priority must be to ensure that hospitals do not delay screening exams or stabilizing treatment for patients in order to inquire about an individual's method of payment or insurance status. (Letter dated May 9, 2012, from Marilyn Tavenner, Interim Administrator of CMS.)

In a subsequent EMTALA survey, CMS cited a hospital for failing to use a reasonable registration process. The survey report included an allegation that patients were asked to pay copayments, co-insurance or past due amounts during the same time that they were still receiving medical screening and treatment services. The report also stated that patients were advised of the cost of care that had already been incurred prior to completion of services, which resulted in one patient declining a recommended overnight admission to the hospital for further monitoring and observation of her condition. Several of the allegations were also the subject of a separate survey under the Medicare Conditions of Participation for patient rights.

In December 2013, CMS issued Survey and Certification Memorandum 14-06: EMTALA Requirements & Conflicting Payor Requirements or Collection Practices (Dec. 13, 2013) (Appendix X) in response to the hospital debt collection activities it was observing. The guidance reiterated that "[a] request to an individual to make immediate payment for services required under EMTALA while such required services are being provided does not fall under either of the permitted exceptions" to the general prohibition on inquiring about method of payment or insurance status. CMS also reinforced the idea that

> "[a] request by the hospital for immediate payment by an individual who is protected under EMTALA goes well beyond a mere inquiry about payment method. Furthermore, a request for immediate payment risks creating the appearance that the hospital is linking provision of services required under EMTALA to the individual's ability to pay."

State Requirements

The California hospital licensing laws provide that emergency services and care must be provided without first questioning the patient's ability to pay. As described in chapter 1, "Overview of Patient-Dumping Laws," the term "emergency services and care" includes the MSE and necessary stabilizing treatment for patients who have an EMC.

☞ **References:**

42 C.F.R. Section 489.24(d)(4) (Appendix B)

Interpretive Guidelines, tag no. A-2408/C-2408 (Appendix C)

Health and Safety Code Section 1317(d)(4) and 1317.1 (Appendix D)

Special Advisory Bulletin (Appendix H)

B. When can a hospital request prior authorization?

The EMTALA regulations prohibit a hospital from directly or indirectly seeking prior authorization before conducting the MSE:

> A participating hospital may not seek, or direct an individual to seek, authorization from the individual's insurance company for screening or stabilization services to be furnished by a hospital, physician, or nonphysician practitioner to an individual until after the hospital has provided the appropriate medical screening examination…and initiated any further examination and treatment that may be required to stabilize the emergency medical condition…

The 2013 guidance discussed above warned hospitals of potential EMTALA enforcement if a hospital follows the direction of a payor to require prior authorization before conducting the MSE, initiating stabilizing treatment, or initiating or accepting an appropriate EMTALA transfer.

However, per the EMTALA regulations, once stabilizing care has been initiated by the treating physician, the hospital may call the patient's health plan for prior authorization.

In the Special Advisory Bulletin (Appendix H), CMS and OIG explained the rationale for prohibiting calls for prior authorization before the medical screening:

> Discussions initiated by a hospital staff member with a patient regarding prior authorization requirements and their financial consequences that have the effect of delaying a medical screening are per se violations of the anti-dumping statute. Moreover, the OIG and [CMS] believe that in the absence of an initial screening, the decision of a managed care plan regarding the need for treatment is likely to be ill-informed.

OIG has previously stated that it will seek civil money penalties in cases demonstrating a pattern of patients leaving the hospital after triage, but prior to the MSE if the hospital has requested prior authorization for emergency services. A representative of OIG has stated that the office will consider the routine seeking of prior authorization before screening as an aggravating circumstance, that is, a condition that may increase the cost of settlement or civil money penalties.

C. When can the emergency physician contact the patient's physician to discuss the patient's course of treatment?

In the Special Advisory Bulletin (Appendix H), CMS and OIG clarified the ability of the treating physician to call the patient's physician at any time for clinical reasons. This guidance was subsequently codified in the EMTALA regulations:

> An emergency physician or nonphysician practitioner is not precluded from contacting the individual's physician at any time to seek advice regarding the individual's medical history and needs that may be relevant to the medical treatment and screening of the patient, as long as this consultation does not inappropriately delay services required under paragraph (a) [medical screening] and paragraphs (d)(1) and (2) [stabilization, transfer or inpatient admission].

It should be noted that the broad language in the regulation suggests that the emergency physician should be able to contact any physician who can provide clinical information that will assist in providing emergency services to the patient.

In its 2013 guidance (Appendix X), CMS noted its concern with payors requiring a secondary evaluation and approval before an individual with an EMC is admitted as an inpatient or transferred to another facility, including payors directing that individuals are transferred to a specific facility. If the individual's condition is not stabilized, payor intervention in an admission or transfer decision could place the hospital at risk for an EMTALA violation.

Hospitals should expect that CMS and OIG will closely scrutinize discussions with a patient's physician (especially a gatekeeper or other managed care physician) to determine whether they are clinical or financial in nature. If an off-site physician provides necessary clinical information and other assistance to the treating physician, those discussions will be viewed as enhancing the quality or continuity of medical services, and therefore will not result in an EMTALA violation.

On the other hand, if the off-site physician attempts to limit or deny necessary emergency services for the patient or influence the treating physician to transfer or discharge the patient, CMS or OIG may later take the position that any subsequent action taken by the

hospital or the treating physician to discharge the patient was tainted by the directions of the off-site physician. As noted in footnote 4 of the Special Advisory Bulletin, if the managed care physician requests that the patient be transferred, the treating physician must provide medical screening and necessary stabilizing treatment, and if the patient is not stable, effectuate an appropriate transfer only if there is a medical necessity or an informed patient request for the transfer.

As discussed below, the *Interpretive Guidelines* and the Medicare Advantage regulations provide that the judgment of the treating physician takes precedence over the judgment of an off-site physician or the patient's health plan.

Compliance Tip: Hospitals should conduct in-service education for emergency physicians, nurses and other staff who may contact attending staff or managed care plans in the course of an emergency visit. The program should review the limitations on seeking prior authorization and the implications of relying on orders or directions from off-site physicians or health plan personnel for patient care or disposition. As appropriate, quality improvement reviews should include cases involving contacts with attending staff or managed care plans prior to the MSE or the commencement of stabilizing treatment.

☞ **References:**

42 C.F.R. Section 489.24(d) (Appendix B)

Interpretive Guidelines, tag no. A-2406/C-2406 (Appendix C) Special Advisory Bulletin (Appendix H)

CMS Survey and Certification Memorandum 14-06: EMTALA Requirements and Conflicting Payor Requirements or Collection Practices (Dec. 13, 2013) (Appendix X)

D. What if the patient asks about his or her financial liability for emergency services?

In the Special Advisory Bulletin, CMS and OIG provide the following guidance as to what a hospital should do when a patient inquires about financial liability for emergency services:

> If a patient inquires about his or her obligation to pay for emergency services, such an inquiry should be answered by a staff member who has been well trained to provide information regarding potential financial liability. This staff member also should be knowledgeable about the hospital's anti-dumping statute obligations and should clearly inform the patient that, notwithstanding the patient's ability to pay, the hospital stands ready and willing to provide a medical screening examination and stabilizing treatment, if necessary. Hospital staff should encourage any patient who believes that he or she may have an emergency medical condition to remain for the medical screening examination and any necessary stabilizing treatment. Staff should also encourage the patient to defer further discussion of financial responsibility issues if possible, until ***after*** the medical screening has been performed. (Emphasis in original.)

If a patient asks the hospital if it accepts his or her health plan, the hospital should respond to the patient. If the patient is not a member of a health plan that contracts with the hospital,

the hospital should reaffirm (and document) its offer to provide a MSE, and it should take reasonable steps to encourage the patient to remain for the examination. A number of hospitals have been cited by CMS or OIG for EMTALA violations when a patient leaves the hospital prior to the MSE after learning that the facility does not contract with his or her health plan.

Compliance Tip: In order to respond to the presumption usually held by the enforcement agencies that the patient left or was turned away for financial reasons, hospital staff should document any information that they have regarding financial or health plan discussions with the patient, the offer to provide the MSE and the reasons for the patient leaving the facility. If the patient elopes or fails to give his or her reasons for leaving, the hospital should consider a follow-up call to the patient to ascertain the reasons for leaving and the health care status of the patient.

E. What if the patient offers a required co-payment before medical screening?

Many patients routinely offer the co-payment during the registration process prior to receiving a MSE. Although the Special Advisory Bulletin did not specifically address collection of co-payments prior to medical screening, it advised that a "best practice" was not to obtain an individual's agreement for payment before stabilization. This suggests that co-payments should not be solicited or collected from the patient before the MSE has been completed.

If a patient offers a co-payment and insists that he or she does not want to defer its collection until after emergency services are rendered, then registration should note that the patient voluntarily offered the co-payment.

F. When should Advance Beneficiary Notices be given to patients seeking emergency services?

An Advance Beneficiary Notice of Noncoverage (ABN) is a Medicare-required written notice (CMS R-131) to a Medicare beneficiary that payment for services from a hospital or physician may be denied. The notice must be given to the beneficiary before the services are rendered in order to afford the beneficiary the opportunity to refuse the service.

In response to inquiries from providers about giving ABNs to patients coming to the emergency department, CMS has indicated that emergency patients should not be given an ABN before the MSE and a determination is made that the patient does not have an EMC or any emergency condition is stabilized. As explained by CMS in a prior posting on the Medicare Learning Network:

> The Centers for Medicare & Medicaid Services (CMS) has engaged physicians and their professional organizations in conversations surrounding the perceived conflict between EMTALA requirements and Advance Beneficiary Notice (ABN) instructions. Other than possible problems due to coding conventions … this problem seems to be more one of confusion than of real conflict. EMTALA does not prohibit asking payment questions entirely, rather, only doing so before screening/stabilization. After screening/stabilization, EMTALA no longer applies and ABNs may be given. Under CMS policy, an ABN should not be given to any patient under great duress, which includes patients seeking emergency services before they are stabilized. Nothing in CMS policy prohibits

giving ABNs, when otherwise appropriate, to patients who come to emergency care settings after they have received a medical screening examination and are stabilized.

G. What are the Knox-Keene requirements for emergency services?[1]

In California, the Knox-Keene Act governs the licensing of managed care plans. Hospitals located in other states should review similar statutes for specific requirements applicable to coverage and payment for emergency services provided to plan members. Pertinent provisions of the Knox-Keene Act are included as Appendix F.

Obligation to Reimburse for Emergency Services

General Rule

The Knox-Keene Act requires a licensed health plan to reimburse a provider for "emergency services and care" (see definition in chapter 1, "Overview of Patient-Dumping Laws") rendered to an enrollee until the care results in stabilization.

Exceptions

The Knox-Keene Act permits a plan to deny payment if:

1. The services were not performed, or
2. The enrollee did not require emergency services and care, and the enrollee reasonably should have known that an emergency did not exist.

Prior Authorization Before Rendering Emergency Services

Under the Knox-Keene Act, a health plan or an independent practice association (IPA) may not require a hospital to obtain authorization prior to providing emergency services and care. Health plans and IPAs may require a hospital to obtain prior authorization for care provided after the patient is stabilized.

Prior Authorization for Post-Stabilization Services

A health plan or IPA that requires prior authorization must provide 24-hour access for enrollees and providers to obtain timely authorization for medically necessary care to be provided to an enrollee who has received emergency services and is stabilized, but the treating provider believes the patient may not be transferred or discharged safely. If the prior authorization requirement involves a determination of whether the post-stabilization services are medically necessary, a request for authorization must be reviewed and processed in accordance with written criteria and guidelines that are supported by clinical principles and processes.

A decision to approve or deny authorization must be made in a timely fashion, in light of the enrollee's medical condition. For example, decisions must be made within five business days in all cases, or within 72 hours if the enrollee faces an imminent and serious threat to his or her health. Generally, a timely decision for a patient who is stable for transfer but requires an inpatient admission or transfer to a higher level of care for follow-up care should be shorter (perhaps hours), depending on the circumstances.

The plan must make a physician available for consultation and resolving disputed requests for authorization. These requirements do not apply to a health plan that does not require prior

1 The discussion of Knox-Keene requirements is limited to prior authorization and health plan communications for post-stabilization and related services. A discussion of payment for emergency services is beyond the scope of this manual.

authorization as a prerequisite for payment of necessary medical care following stabilization of an EMC. Existing regulations require the plan to respond to the provider's request for authorization to provide post-stabilization care within 30 minutes of the request. The failure of a health plan to meet this requirement is deemed to constitute authorization for the follow-up medical care to the patient.

Request for Post-Stabilization Services

NOTE: The following discussion applies only to post-stabilization services that are provided by a noncontracting hospital to a patient who is a member of a health plan that requires authorization for post-stabilization services and maintains 24-hour access for patients and providers (including noncontracting hospitals) to obtain timely authorization for medically necessary post-stabilization services. This discussion does not apply to emergency services provided to a patient who is still covered by the EMTALA obligations (i.e., the patient has an EMC that is not stabilized).

Pursuant to revisions to the California hospital licensing laws effective Jan. 1, 2009, if a patient with an EMC who is a member of a health plan that requires prior authorization for post-stabilization services (i.e., medically necessary care provided after the patient's EMC is stabilized) presents to a noncontracting hospital, the hospital, with the exception of certain minor procedures described below, must do all of the following before initiating post-stablization services:

1. Seek to obtain the name and contact information of the health plan. The efforts to obtain this information must be documented in the patient medical record, including:
    a. Requesting the patient for his/her health plan member card;
    b. Asking the patient, family member or other person accompanying the patient to identify the plan; or
    c. Taking other means known to the hospital for accurately identifying the patient's plan; and
2. If the health plan has been identified, contacting the health plan or the plan's contracting medical provider (such as an IPA). The contact must be made in accordance with instructions on the patient's health plan member card or using information provided by the health plan (as described below). The hospital is not required to make more than one telephone call to the plan or contracting medical provider, so long as the health plan or contracting medical provider can reach a representative of the hospital upon returning the call. The person calling the health plan or a contracting medical provider is not required to be a physician;
3. Upon a request of the health plan or its contracting medical provider, the hospital must provide the diagnosis and other relevant information reasonably necessary for the plan or medical provider to make a decision to authorize post-stabilization care or assume the management of the patient's care by arranging a prompt transfer to another hospital.

Authorization is not required for minor treatment procedures in the following circumstances:

1. The procedure is provided within the emergency department;
2. The procedure concludes the treatment of the presenting EMC and is related to that condition, even though the treatment may not resolve the underlying medical condition;
3. The procedure is performed according to accepted standards of practice; and
4. The procedure would result in the direct discharge or release of the patient from the emergency department following receiving the procedure.

The health plan, or its contracting medical provider, that is contacted by a noncontracting hospital to obtain authorization for post-stabilization services must, within 30 minutes from the time of the initial contact, either:

1. Authorize post-stabilization services, or
2. Inform the hospital that it will arrange for the prompt transfer of the patient to another hospital.

If Plan Authorizes Post-Stabilization Services

If the health plan or its contracting medical provider authorizes post-stabilization services, the hospital must request the patient's medical record from the health plan or contracting medical provider. The health plan or contracting medical provider, after conferring with the noncontracting hospital, must transmit appropriate portions of the patient record (if in possession of the plan) by fax or electronic mail, as may be requested by the noncontracting hospital or treating physician and consistent with applicable laws protecting patient privacy.

If Plan Arranges Patient Transfer

If the health plan or its contracting medical provider notifies the noncontracting hospital that it will arrange the transfer, the health plan or contracting medical provider must make all of the arrangements for the transfer, including finding an accepting facility. In addition, the noncontracting hospital may continue to provide services necessary to maintain the stabilization of the patient's condition before the transfer is effectuated.

If Plan Fails to Respond

Post-stabilization services requested of a health plan or its contracting medical provider are deemed authorized in the following circumstances:

1. The health plan or its contracting medical provider does not notify the noncontracting hospital of its decision on post-stabilization services within 30 minutes; or
2. The health plan or its contracting medical provider notifies the noncontracting hospital that it will arrange for a prompt transfer of the patient, but then fails to arrange for the transfer within a reasonable time. In this instance, the post-stabilization services are deemed authorized until the transfer is effectuated.

Required Notice to Patient

If the patient or his/her representative refuses to consent to the transfer, the noncontracting hospital must provide the patient or his/her representative with the following notice:

> THIS NOTICE MUST BE PROVIDED TO YOU UNDER CALIFORNIA LAW
>
> You have received emergency care at a hospital that is not a part of your health plan's provider network. Under state law, emergency care must be paid by your health plan no matter where you get that care. The doctor who is caring for you has decided that you may be safely moved to another hospital for the additional care you need. Because you no longer need emergency care, your health plan has not authorized further care at this hospital. Your health plan has arranged for you to be moved to a hospital that is in your health plan's provider network.
>
> If you agree to be moved, your health plan will pay for your care at that hospital. You will only have to pay for your deductible, co-payments, or coinsurance for care. You will not have to pay for your deductible, co-payments, or coinsurance for transportation costs to another hospital that is covered by your health plan.
>
> IF YOU CHOOSE TO STAY AT THIS HOSPITAL FOR YOUR ADDITIONAL CARE, YOU WILL HAVE TO PAY THE FULL COST OF CARE NOW THAT YOU NO LONGER NEED EMERGENCY CARE.
>
> This cost may include the cost of the doctor or doctors, the hospital, and any laboratory, radiology, or other services that you receive.
>
> If you do not think you can be safely moved, talk to the doctor about your concerns. If you would like additional help, you may contact:
>
> - Your health plan member services department. Look on your health plan member card for that phone number. You can file a grievance with your plan.
> - The HMO Helpline at 888-HMO-2219. The HMO Helpline is available 24 hours a day, 7 days a week. The HMO Helpline can work with your health plan to address your concerns, but you may still have to pay the full cost of care at this hospital if you stay.

The written notice must be provided in the patient's primary language if the primary language is considered to be one of the Medi-Cal threshold languages. A copy of the notice must be given to the patient or his/her legal representative, and may be filed in the patient medical record. Receipt of the notice and other documents required by the hospital for post-stabilization care must be signed by the patient or his/her legal representative; a copy of the signed notice must be provided to the health plan or its contracting medical provider upon request. If the patient or his/her legal representative refuses to sign the notice, the hospital must document in the patient record that the notice was provided and the refusal to sign.

Independent Medical Review

An enrollee may request the California Department of Managed Health Care (DMHC) to provide an independent medical review of a health plan's or IPA's denial of a claim for urgent or emergency services based in whole or in part on the lack of medical necessity.

As a condition of seeking the review, the enrollee must first give the health plan 30 days to resolve the grievance, or three days to do so if the services have not yet been provided and the enrollee faces an imminent and serious threat to his or her health (such as severe pain, potential loss of life, limb or major bodily function). Hospitals and other providers are not authorized to initiate the independent medical review process, but they may join with or assist the enrollee in pursuing medical review and may act as the enrollee's advocate.

Strategies for Obtaining Authorization and Payment

Although there are no surefire methods to ensure that hospitals and physicians receive authorization and/or payment in a timely manner for rendering post-stabilization care, the following measures are suggested.

Reinforce Member Responsibility

Hospitals should review their admission practices and forms to ensure that they obtain an appropriate acknowledgment and agreement of financial responsibility for each patient. If the hospital does not contract with the patient's health plan, the acknowledgment should include the patient's agreement to accept financial liability for the hospital charges that the health plan or IPA refuses to pay. If the hospital contracts with the patient's health plan, the plan contract will address the circumstances in which the patient is responsible for the hospital's charges. In most cases, the patient should acknowledge that he or she will pay for services that the health plan or IPA refuses to authorize, but which the patient requests be provided, as well as emergency services if the health plan or IPA later determines that the enrollee did not have an EMC.

Pursue Member Responsibility

The Knox-Keene Act contains more provisions protecting enrollees than provisions protecting providers. The DMHC does not have the power to resolve disputes between providers and plans (e.g., to order a health plan to pay a particular claim). However, the DMHC has the power to review and resolve grievances made by enrollees.

Moreover, if the grievance pertains to a denial based on medical necessity, the DMHC has the final authority to resolve the grievance. In consideration of hospital billing and collection practices, noncontracting hospitals may in some instances be able to pursue a health plan enrollee under his or her acknowledgment of financial responsibility in order to encourage the enrollee to submit a grievance to the health plan and/or the DMHC. Once a grievance is initiated, the hospital may participate in the grievance review and/or independent medical review process.

Make Timely Requests for Prior Authorization

A hospital should review its internal procedures for determining the need for prior authorization, and then seek any necessary authorization at the appropriate time during the patient's course of treatment. If a patient presents to the hospital with an EMC, emergency services and care may be provided without authorization; however, authorization should be obtained before proceeding with post- stabilization care. If a patient is determined by

the MSE not to have an EMC, then authorization should be obtained prior to proceeding to provide follow-up care for the patient (unless the patient's condition destabilizes before authorization is obtained).

Patient is Unstable for Transfer

If a receiving hospital is requested to accept the transfer of an emergency health plan patient who has an EMC that is not stabilized and needs a higher level of care, the hospital should accept the patient if it has the capacity and capability to provide the services. The hospital should confirm the patient's unstable condition with the transferring hospital or physician, and make sure that it obtains a copy of the physician's certification for the transfer. Following the admission of the patient at the receiving hospital, the hospital should seek authorization for services that will be required for the patient after he or she is stabilized. If the health plan or IPA fails or refuses to give an authorization for post- stabilization services, the hospital should request that the plan assume responsibility for the patient's continuing post-stabilization care (which may involve a further transfer to a plan-contracting hospital). As long as the patient is unstable, the hospital should continue to provide stabilizing treatment for the patient, and should not transfer the patient except as the result of an informed request by the patient, medical necessity or other valid clinical reasons.

Patient's Condition is Stabilized for Transfer

If a receiving hospital is requested to accept the transfer of a health plan patient whose EMC is stabilized, but the patient needs post-stabilization services at a facility providing a higher level of care, the receiving hospital is not obligated to accept the transfer unless it has a legal or contractual obligation to do so (see chapter 7, "Obligations of Receiving Hospitals"). The hospital should confirm with the transferring hospital or physician that the patient's EMC is stabilized. The hospital may then advise the transferring hospital that is willing to admit and treat the patient, subject to obtaining prior authorization for the post-stabilization services.

Consistent with its EMTALA obligations, the receiving hospital should inform the transferring hospital that, if the patient's condition destabilizes while it is seeking prior authorization, the transferring hospital should immediately call the receiving hospital to arrange for the transfer without waiting for the authorization to be received. Assuming that the patient's condition remains stabilized and authorization is obtained, the hospital may accept the transfer and provide the authorized services to the patient. If the patient later requires services that exceed the scope of the authorization, the hospital should follow the process discussed above for obtaining further authorization or request that the health plan or IPA assume responsibility for providing the additional treatment required for the patient.

Require Health Plans and IPAs to Assume Responsibility

As discussed above, if a health plan or IPA does not grant authorization for post-stabilization services within a reasonable period of time, the hospital should request (or if necessary, demand) that the health plan or IPA assume responsibility for the enrollee's plan (such as arranging for a transfer if medically appropriate).

Pursue Dispute Resolution Opportunities

To the extent feasible and prudent, a hospital should submit inappropriate denials to the health plan's dispute resolution process.

Pursue Contract Remedies

Hospitals that contract with a health plan that has denied authorization or payment should review its contract with the plan to determine its contractual remedies that are in addition to its legal remedies.

Report Unfair Payment Patterns to DMHC

Health plans are prohibited from engaging in "unfair payment patterns." If a hospital believes that a health plan is engaged in a "demonstrable and unjust pattern…of…denying complete and accurate claims" within a reasonable time, the hospital may report the unfair payment pattern to the DMHC Office of Plan and Provider Relations. The Office may be contacted at 877-525-1295 or providers@dmhc. ca.gov. Although the DMHC cannot order payment to a provider, it can impose administrative sanctions on the health plan.

☞ **References:**

Health and Safety Code Sections 1262.8, 1367, 1368; 1367.01, 1368.01, 1371, 1371.1, 1371.4, 1371.5, 1371.35, 1371.36, 1371.37, 1371.38, 1371.39 and 1374.30

Title 28, California Code of Regulations, Section 1300.71.4 (Appendix F)

The regulations on claims settlements and dispute resolution may be found at Title 28, California Code of Regulations, Sections 1300.71 and 1300.71.38

H. What are the emergency service requirements for Medicare Advantage plans?

Congress has mandated that a Medicare Advantage plan must provide coverage for emergency services without regard to prior authorization or the provider's contractual relationship with the organization. The final regulations for Medicare Advantage plans include "urgently needed services" in the list of covered services for enrollees. Pertinent provisions of the Medicare Advantage regulations are included in Appendix G.

The Medicare Advantage regulations use the following defined terms:

1. **"Emergency services"** are defined as covered inpatient and outpatient services furnished by a provider qualified to provide emergency services that are needed to evaluate or stabilize an emergency medical condition.
2. **"Emergency medical condition"** has the same definition in the EMTALA regulations, with two exceptions. First, the definition does not specifically include psychiatric and chemical-dependency emergencies. Second, the determination of an "emergency medical condition" must be made from the viewpoint of "a prudent layperson, with an average knowledge of health and medicine."
3. **"Urgently needed services"** are:

> Covered services that are not emergency services … provided when an enrollee is temporarily absent from the MA plan's service (or if applicable, continuation) area (or, under unusual and extraordinary circumstances, provided when the enrollee is in the service or continuation areas but the organization's provider network is temporarily unavailable or inaccessible)

> when such services are medically necessary and immediately required – (A) As a result of an unforeseen illness, injury, or condition; and (B) It was not reasonable given the circumstances to obtain the services through the organization offering the MA plan.

Under the Medicare Advantage regulations, plans are financially responsible for emergency and urgently needed services:

1. Regardless of whether they are obtained within or outside of the organization;
2. Without prior authorization;
3. In accordance with the prudent layperson definition of "emergency medical condition" regardless of final diagnosis;
4. For which a plan provider or other plan organization representative instructs an enrollee to seek emergency services within or outside the plan; and
5. With a limit on charges to enrollees for emergency services of the lesser of $50 or what it would charge the enrollee if he or she obtained the services through the plan. The regulations provide that the treating physician must decide when the enrollee is considered stabilized for transfer or discharge, and that his or her decision is binding on the plan.

The regulations prohibit plans from limiting access to emergency services. A plan cannot include instructions to seek prior authorization for emergency or urgently needed services in materials furnished to enrollees (including wallet cards). Enrollees must also be informed of their right to call 9-1-1. In addition, plans cannot instruct providers (in materials or contracts) to seek prior authorization before an enrollee has been stabilized.

The regulations also establish standards for plan financial responsibility of "post-stabilization care." A plan is financially responsible for "post-stabilization care" if:

1. The services are approved by the plan or a plan provider;
2. The services are rendered to maintain stabilization within one hour of a request for pre-approval of further post-stabilization services;
3. The services are rendered without authorization if to maintain, improve or resolve the enrollee's stabilized condition; and:
    a. The plan cannot be contacted;
    b. The plan does not respond within one hour to a request for pre-approval; or
    c. The plan and the treating physician cannot reach agreement for the enrollee's care and a plan physician is not available for consultation.

Additional guidance may be found in the Medicare Managed Care Manual, chapter 4, "Benefits and Beneficiary Protection" at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals (click on "Internet Only Manuals" and then locate the *Managed Care Manual*).

Reference:

42 C.F.R. Section 422.113 (Appendix G)

5 Transferring or Discharging an Emergency Patient

I. Overview 5.1

II. Stabilization of Emergency Medical Conditions 5.2

A. When can a hospital transfer an emergency patient with an unstabilized emergency medical condition to another facility? 5.2

B. When is an emergency medical condition considered to be "stabilized?" 5.2

C. If a patient is determined to be "stable," does that mean that the EMC is stabilized? 5.2

Stabilized — The EMTALA Statute Versus the Interpretive Guidelines 5.3

D. When is an individual with an emergency psychiatric condition considered to be "stabilized?" 5.4

E. Who has the responsibility to determine whether an emergency medical condition is stabilized (or resolved)? 5.4

F. What are the obligations of hospitals if there are prearranged state or local care networks for patient screening or treatment? 5.5

III. Standards for Appropriate Transfer 5.5

A. Requirements for Informed Request for Transfer 5.5

B. Requirements for Physician Certification of Transfer 5.5

C. Requirements for the Certification 5.6

D. Physician Not Present to Sign the Certification 5.7

E. Hospital Standards for an Appropriate Transfer 5.7

F. Must a transfer be hospital to hospital? 5.8

G. Standards for Transfer of a Patient with an Aerosol Transmissible Disease 5.9

IV. Communication With Receiving Hospitals 5.10

V. Transportation for an Appropriate Transfer 5.12

A. Who decides the appropriate mode of transportation for a patient transfer? 5.12

B. Can the patient be transferred by a personal vehicle? 5.12

C. Hospital Council's Patient Transfer Work Group 5.13

VI. Capability and Capacity 5.13

A. Capability to Provide Services 5.13

B. Capacity to Provide Services 5.14

C. Capacity and Nurse Staffing Ratios 5.14

D. Reserved Critical Care Beds 5.15

E. Requirement to Transfer 5.15

VII. Prior Authorization 5.15

A. Must the hospital contact a health plan before transferring or admitting an enrollee whose condition is stabilized or who requires post-stabilization inpatient care? 5.15

VIII. Transfer of an ED Patient Who Does Not Have an Emc 5.16

IX. Application of Emtala to Transfers for Off-Site Tests 5.16

X. Discharge of an Emergency Patient 5.17

A. When is an individual with an emergency medical condition "stabilized" for purposes of discharge? 5.17

B. When is an emergency psychiatric condition "stabilized" for purposes of discharge? 5.18

XI. Discharge of Emergency Patients Who are Homeless 5.18

A. Are there special requirements for discharging an emergency patient who is homeless? 5.18

B. Federal Laws on Emergency Patient Discharge 5.18

C. State Hospital Licensing Laws on Emergency Patient Discharge 5.19

Documentation 5.19

D. Litigation (City of Los Angeles) 5.20

5 Transferring or Discharging an Emergency Patient

I. OVERVIEW

If an EMTALA patient is determined to have an emergency medical condition (EMC), a hospital is obligated to provide further examination and necessary stabilizing treatment within the capabilities of the facilities and staff (including on-call physicians) available at the hospital. If the hospital does not have the capability to provide necessary stabilizing treatment, or upon an informed request by the patient, the hospital must make an appropriate transfer of the patient to another facility. In addition, if a hospital has exhausted its capability or is operating beyond its capacity, an appropriate transfer must be made if the EMC is not stabilized.

An emergency patient who has an unstabilized EMC may be transferred only if one of two conditions is present:

1. The patient makes an informed request for the transfer; or
2. The transfer is for medical reasons and the transferring physician certifies that the medical benefits reasonably expected from treatment at the receiving facility outweigh the increased risks to the patient from the transfer.

An appropriate transfer of a patient with an unstabilized EMC must meet four basic criteria:

1. Provision of treatment within the capacity of the hospital to minimize the risks of the transfer;
2. Acceptance by a receiving hospital that has available space and qualified personnel to provide treatment to the patient;
3. Transfer of all medical records related to the EMC; and
4. Use of qualified personnel, equipment and transportation to effect the transfer.

In addition, hospitals must document a timely reassessment of the patient prior to his or her departure from the hospital.

Hospitals must maintain medical and other records related to all patient transfers to or from the hospital for a period of at least five years from the date of transfer. The *Interpretive Guidelines* indicate that medical records transferred to or from the hospital must be retained in original or legally reproduced form in hard copy, microfilm, microfiche, optical disks, computer disks or computer memory.

While EMTALA does not address transfers of patients whose EMCs are stabilized, California law establishes standards for transfers of patients with stabilized conditions that are made for non-medical reasons, such as transfers to health plan contracting hospitals or transfers of patients for financial reasons.

The requirements for receiving hospitals to accept patient transfers are discussed in chapter 7, “Obligations of Receiving Hospitals.”

At the end of this chapter, there is a discussion of the requirements for discharging a patient from a dedicated emergency department. The discussion includes special requirements for discharging an emergency patient who is homeless.

CHA has developed sample transfer forms that are included in Appendix P.

II. STABILIZATION OF EMERGENCY MEDICAL CONDITIONS

A. When can a hospital transfer an emergency patient with an unstabilized emergency medical condition to another facility?

The EMTALA obligations for making an appropriate transfer apply to an EMTALA patient who has an EMC that is not "stabilized." This portion of the manual (II. "Stabilization of Emergency Medical Conditions") addresses the concept of "stabilization" as applied to EMTALA patients. If a patient has an EMC that has not been "stabilized," a hospital may not transfer the patient unless either there is an informed patient request or a physician certification for the transfer, and the transfer is implemented in accordance with EMTALA standards that are addressed in III. "Standards for Appropriate Transfer," page 5.5.

B. When is an emergency medical condition considered to be "stabilized?"

The term "stabilized" is one of the most important and most misunderstood words in the EMTALA statute and regulations. An understanding of the meaning of "stabilized" is critical since it determines:

1. When a hospital has met its EMTALA obligations to a patient who has an EMC;
2. When a hospital must follow the EMTALA standards for making an appropriate transfer of a patient; and
3. When a receiving hospital must accept, or may refuse to accept, a transfer of a patient with an EMC from another hospital.

Under the EMTALA regulations, **"stabilized"** means, with respect to an EMC, that no material deterioration of the patient's condition is likely, with reasonable medical probability, to result from or occur during the transfer or discharge of the patient from the facility, or that a woman has delivered her child and the placenta. The same definition is also used in California law.

Unfortunately, physicians often use the terms "stabilized" and "stable" interchangeably, which may not always be correct. This sometimes results in confusion on the part of staff at the transferring and receiving facilities regarding when a patient has an EMC that is "stabilized" within the meaning of EMTALA.

C. If a patient is determined to be "stable," does that mean that the EMC is stabilized?

As used by EMTALA, the term "stabilized" has a meaning that differs from the common use by physicians of the term "stable." In the St. Anthony Hospital decision *(see chapter 7, "Obligations of Receiving Hospitals")*, the court noted that the legal definition of "stabilization" in EMTALA is different from the medical use of the term "stable" to denote the status of a patient or his/her condition.

The concern regarding the use of the medical term "stable" is illustrated in a 2013 Survey and Certification Letter issued by CMS (Appendix X). In the letter, CMS cautioned hospitals that "the statutory definition of an individual's EMC being 'stabilized' does not necessarily equate to an individual being clinically stable."

> The similarity of the terms "clinically stable" and "stabilized" appears to cause confusion among hospitals, practitioners and other hospital staff. It is not uncommon for practitioners to find that an individual has become "clinically stable," often understood to mean the normalization of the individual's vital signs, and then conclude that the hospital's EMTALA obligation has ended. However, if the EMC has not been stabilized, as that term is defined … [by the EMTALA regulations], EMTALA continues to apply. For example, a patient diagnosed with appendicitis might have relatively normal vital signs, but is still in need of surgery, and therefore continues to have an EMC that has not been stabilized.
>
> Furthermore, many practitioners and some third-party payors seem to assume that if an individual can withstand the risk of a transfer, then that means the individual has been stabilized and the hospital's EMTALA obligation has ended. This also is not necessarily the case. This mistaken assumption can be reflected in the commonly used term "stable for transfer." "Stable for transfer" is not a term used in EMTALA, and it is not necessarily equivalent to the term "stabilized," as defined for EMTALA purposes. Use of this term can, therefore, be very misleading. [CMS Survey and Certification Memorandum 14-06 (Dec. 13, 2013) (Appendix X)][1]

Stabilized — The EMTALA Statute Versus the Interpretive Guidelines

In the 2004 *Interpretive Guidelines*, CMS attempted to clarify its interpretation regarding when an EMC is considered to be stabilized. The revisions to the *Interpretive Guidelines* stated that a patient's EMC is deemed stabilized if the treating physician (or other qualified professional) determines within reasonable clinical confidence that the patient's EMC has been "resolved."

The term "resolved" does not appear in the EMTALA statute or regulations, and is not defined by CMS in the *Interpretive Guidelines*. As part of clarifying the meaning of "resolved," CMS stated that patient stabilization does not require the resolution of the underlying medical condition. As an example, CMS describes a patient with an asthma attack who requires treatment under EMTALA to alleviate the acute respiratory symptoms. After the immediate EMC is resolved, the hospital may discharge the patient, admit the patient or transfer the patient depending on his or her needs (noting that the transfer is not covered by EMTALA because the EMC was resolved). CMS notes that this guidance is a clarification, rather than a change, of policy.

The *Interpretive Guidelines* warn that if there is a dispute between CMS (or a surveyor) as to whether an individual's EMC is stabilized (or resolved), the burden of proof is the responsibility of the transferring hospital. Surveyors are directed to assess patient stability and refer appropriate cases to the quality improvement organization (QIO) for review.

Despite the effort to develop a clearer meaning of the term "stabilized" or the implications of the term "resolved," the best guidance offered by CMS is as follows:

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1 In the 1998 *Interpretive Guidelines*, CMS adopted standards for determining when a patient with an EMC is "stable" for transfer. As a result of confusion related to the term "stable for transfer," CMS eliminated the term "stable for transfer" in the 2004 update to the *Guidelines*. However, CMS occasionally uses the term "stable" or "patient stability" in several places in the *Interpretive Guidelines* rather than "stabilized."

> If the treating physician is in doubt that an individual's EMC is stabilized the physician should implement an appropriate transfer … to prevent a potential violation of EMTALA, if his/her hospital cannot provide further stabilizing treatment.

☞ **References:**

42 C.F.R. Section 489.24(b) and (d) (Appendix B)

Interpretive Guidelines, tag nos. A-2407/C-2407 and A-2409/C-2409 (Appendix C)

D. When is an individual with an emergency psychiatric condition considered to be "stabilized?"

Under the *Interpretive Guidelines*, an individual who expresses suicidal or homicidal thoughts or gestures that are determined to be dangerous to self or others is considered to have an EMC. Since CMS has not adopted separate standards for psychiatric EMCs, the definition of "stabilized" for medical emergencies (i.e., no material deterioration of the condition is likely, with reasonable medical probability, to result from or occur during the transfer or discharge of a patient from a facility) also applies to whether a psychiatric EMC is stabilized.

It is important to keep in mind that there is no distinction under the EMTALA rules between the transfer of an individual with a medical EMC or an individual with a psychiatric EMC. In 2016, OIG settled with Research Medical Center (RMC) of Missouri for $360,000 to resolve RMC's:

1. Failure to provide an adequate MSE and
2. Making an improper transfer of a patient with a psychiatric EMC.

The patient arrived at RMC's ED and, without providing stabilizing treatment, RMC transported the patient to a nearby facility by private vehicle. During transport, the patient exited the vehicle and was struck by another vehicle. In the course of its investigation, OIG found 17 additional occasions where RMC failed to provide adequate MSEs and improperly transferred or discharged patients with psychiatric EMCs, without providing stabilizing treatment. A more detailed discussion of the stabilization and transfer of psychiatric patients is discussed in chapter 6.

E. Who has the responsibility to determine whether an emergency medical condition is stabilized (or resolved)?

CMS has reaffirmed that the treating physician has the responsibility to determine whether an individual has an EMC, whether it is stabilized or resolved, and whether the individual's condition is stabilized for purposes of transfer or discharge. Therefore, in the event of a disagreement between the treating physician and an off-site physician, the medical judgment of the treating physician will usually take precedence over that of the off-site physician. As noted in chapter 4, "Financial Considerations — EMTALA and Managed Care," the Medicare Advantage regulations state that the treating physician must decide when the enrollee is considered stabilized for transfer or discharge, and that his or her decision is binding on the plan.

☞ **References:**

Interpretive Guidelines, tag nos. A-2407/C-2407 and A-2409/C-2409 (Appendix C)

F. What are the obligations of hospitals if there are prearranged state or local care networks for patient screening or treatment?

The *Interpretive Guidelines* state that compliance with EMTALA overrules state, regional and local plans and networks for patient care evaluation and treatment (including trauma networks and psychiatric facilities). Therefore, a hospital must provide a medical screening examination and stabilizing treatment within its capability before the transfer of a patient to a regional facility. A more detailed discussion of regional care networks for the treatment and transfer of psychiatric patients is discussed in chapter 6.

III. STANDARDS FOR APPROPRIATE TRANSFER

A patient with an unstabilized or unresolved EMC may be transferred only if the patient has made an informed request for a transfer or the treating physician has certified the transfer, and the hospital complies with four regulatory standards (described under E. "Hospital Standards for an Appropriate Transfer," page 5.7).

A. Requirements for Informed Request for Transfer

The patient (or his or her representative) must request a transfer or discharge in writing after being informed of the hospital's obligations to provide examination and stabilizing treatment. The request must:

1. Be in writing and signed by the patient (or his or her representative);
2. Contain a brief statement of the hospital's obligations under EMTALA;
3. Indicate the reasons for the transfer;
4. Describe the benefits and risks discussed with the patient; and
5. Be filed in the patient's medical record, and a copy forwarded to the receiving hospital.

B. Requirements for Physician Certification of Transfer

A transfer that is based on physician certification requires a signed certification stating that, based on the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual (including, if she is pregnant, her unborn child) from effecting the transfer. The certification must include a summary of the risks and benefits upon which it is based. The requirements for the certification are discussed under C. "Requirements for the Certification," page 5.6.

EMTALA "requires more than a signature; it requires a signed certification." The signer need not be correct in making a certification decision; the statute requires only a signed statement attesting to an actual assessment and weighing of the medical risks and benefits of transfer. In the preamble to the 1994 EMTALA regulations, CMS stated its view that a certification will violate EMTALA if the signer:

1. Has not actually deliberated and weighed the medical risks and the medical benefits of transfer before signing the certification;
2. Uses an improper consideration as a significant factor in certifying the transfer; or
3. Concludes in the weighing process that the medical risks outweigh the medical benefits of transfer, yet signs a certification that the opposite is true.

C. Requirements for the Certification

The physician certification cannot be implied from the patient chart. Rather, the certification must:

1. State the reasons for the transfer;
2. Include a summary of the risks and benefits upon which it is based. The narrative does not have to restate information contained in the medical record; however, according to CMS, the certification "should give a complete picture of the benefits to be expected from appropriate care at the receiving facility and the risks associated with the transfer, including the time away from an acute care setting necessary to effect the transfer;"
3. Be timed and dated closely to the time and date of the transfer (the Interpretive Guidelines reaffirm that a certification cannot be backdated); and
4. Be included in the medical record forwarded to the receiving hospital with the patient.

The *Interpretive Guidelines* state that the certification should not cite state law or industry practice as the basis for a transfer.

As discussed in chapter 14, "Private Actions to Enforce EMTALA," the courts will scrutinize the sufficiency of a physician certification. In a 1992 decision, *Burditt v. U.S. HHS*, (934 F.2d 1362 (5th Cir. 1991)), the court identified four ways in which a hospital or a physician may violate the certification requirement:

1. Failure to obtain the physician's signature on the certification form;
2. Failure by the physician to deliberate and weigh the medical risks and benefits of the transfer before signing the certification;
3. Reliance by the physician on an improper consideration as a significant factor in the certification decision; and
4. Signing a certification despite a finding that the medical risks outweigh the medical benefits expected from the transfer.

In a 2009 decision, *Heimlicher v. Steele* (615 F.Supp.2d 884, 2009), a federal district court reaffirmed that the physician certification is more than a signature. In the case, the court determined that the emergency physician who signed the certification did not adequately deliberate on the risks and benefits of the transfer of a woman in labor and the unborn child to another facility:

> There is no question that Dr. Steele signed the Consent for Transfer form … However, the evidence does suggest that Dr. Steele signed the form without actually deliberating and weighing the medical risks and benefits of the transfer, and he gave improper consideration to significant factors in the certification decision.

The court concluded that the physician justified the transfer with "nonexistent 'benefits' and 'risks,'" ignored "the true foreseeable risks of the transfer" and "over-valued minimal or insignificant expected benefits" and "serious foreseeable risks." The court's analysis reinforces the importance not only of the documentation of the reasons, benefits and risks of a transfer, but also the willingness of a court to review all available information to determine the sufficiency of the physician certification.

☞ **References:**

42 C.F.R. Section 489.24(d) (Appendix B)

Interpretive Guidelines, tag nos. A-2407/C-2407 and A-2409/C-2409 (Appendix C)

Health and Safety Code Section 1317.2 (Appendix D)

D. Physician Not Present to Sign the Certification

If the transferring physician is not physically present at the time of transfer, another qualified professional in consultation with the physician may determine if a patient is "stable" for transfer and sign the certification. However, the qualified professional must consult with the responsible physician prior to signing the certification, and the consulting physician must later countersign the certification.

Compliance Tip: The types of qualified professionals who may certify a transfer should be designated in the medical staff bylaws or rules and regulations. It is recommended that hospital policies describe who may certify a transfer in the absence of a physician, the requirements for physician consultation and the timeframe for the consulting physician to countersign the certification.

☞ **References:**

42 C.F.R. Section 489.24(d) (Appendix B)

Interpretive Guidelines, tag nos. A-2407/C-2407 and A-2409/C-2409 (Appendix C)

Health and Safety Code Section 1317.2 (Appendix D)

E. Hospital Standards for an Appropriate Transfer

Under the EMTALA regulations, an appropriate transfer requires a hospital to comply with all four of the following standards:

1. The transferring hospital provides medical treatment within its capacity to minimize the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child.
2. The receiving hospital has:
    a. Available space and qualified personnel for treatment of the patient; and
    b. Agreed to accept the patient and to provide appropriate medical treatment.[2]
3. The transferring hospital sends to the receiving facility all medical records (or copies thereof) available at the time of transfer related to the EMC of the patient, including:
    a. Records related to the patient's EMC, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and vital signs at the time of transfer. Other records, including pending test results or records not available at the time of transfer, must be forwarded as soon as practicable after the transfer; the Interpretive Guidelines recommend that test results that

2 Industry custom, and California law for transfers for non-medical reasons, also require the consent of the receiving physician.

become available after the patient is transferred should be telephoned to the receiving hospital and then mailed or sent via electronic transmission;

b. The patient's informed written consent to transfer or the physician's certification (or copy thereof); and

c. The name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment.

4. The transfer is effected using proper personnel and equipment, as well as necessary and medically appropriate life-support measures.

Compliance Tips: As noted in chapter 3, "Medical Screening Examinations," the medical record should reflect the timely evaluation of a patient prior to a transfer. A number of hospitals have been cited by CMS, and settled civil money penalty claims with the Office of Inspector General (OIG), for failing to assess a patient at the time of transfer, especially in cases when there was a delay between the order for transfer and the departure of the patient. In cases where the patient's condition deteriorates during the transfer or upon arrival at the receiving facility, CMS and OIG will look closely at the patient's ongoing monitoring and care provided immediately prior to the patient's discharge to determine whether the patient's condition was stabilized for the transfer. It is strongly recommended that hospitals document a patient's vital signs and conduct a medical reassessment of the patient immediately preceding the departure of the patient from the hospital.

F. Must a transfer be hospital to hospital?

This question addresses two common inquiries — must transfers be hospital to hospital? Can a transfer be hospital to an emergency department?

With respect to the first question, the EMTALA statute and regulations, in prescribing the standards for an appropriate transfer, do not refer to the receiving facility as a "hospital." Rather, the statute and regulations refer to the receiving facility more simply as a "medical facility."

The use of the term "facility" rather than "hospital" suggests that EMTALA permits a hospital to transfer an EMTALA patient (i.e., an individual with an EMC) to a facility that is not a licensed hospital so long as the receiving facility has the capability and capacity to stabilize the EMC. As pertinent to psychiatric emergency patients, the reference to a "medical facility" could be interpreted to permit hospitals to transfer an EMTALA patient to a psychiatric health facility (PHF) or a crisis stabilization unit (CSU) even if they are not considered to be "hospitals."

In November 2009, CMS Baltimore headquarters, in a letter to the author of this manual, indicated that there are circumstances in which a hospital could transfer an EMTALA patient with a psychiatric EMC to a CSU. The circumstances and conditions under which an EMTALA transfer could be made to a CSU are discussed in chapter 6.

The response to the second question, transfer from ED to ED, is within the discretion of the receiving hospital. While a transferring physician may request admission of a patient to a

specific bed unit or department, the receiving hospital may route the patient through its ED or other bed unit or department based on clinical considerations. This is also addressed under L. "Are transfers considered to be emergency department to emergency department?," page 7.10.

G. Standards for Transfer of a Patient with an Aerosol Transmissible Disease

Under a regulation adopted in 2009 by the California Division of Occupational Safety and Health (Cal/OSHA), hospitals must follow specific standards for transferring patients who have, or are suspected to have, an airborne infectious disease (AirID)[3]. The regulation defines "AirID" as either:

1. An aerosol transmissible disease (ATD) transmitted through dissemination of airborne droplet nuclei, small particle aerosols, or dust particles containing the disease agent for which airborne infection isolation (AII) is recommended by the Centers for Disease Control and Prevention (CDC) or the California Department of Public Health (CDPH);[4] or
2. The disease process caused by a novel or unknown pathogen for which there is no evidence to rule out with reasonable certainty the possibility that the pathogen is transmissible through dissemination of airborne droplet nuclei, small particle aerosols, or dust particles containing the novel or unknown pathogen.

A hospital must admit a patient requiring AirID to an airborne infection isolation room in the hospital within 5 hours of identification, or transfer the patient to another facility within 5 hours unless the hospital documents each of the following:

1. The hospital has contacted the local health officer;
2. There is no room or area available within the jurisdiction of the local health officer;
3. The hospital has made reasonable efforts to contact facilities outside of the jurisdiction, as provided in its ATD Exposure Control Plan;
4. All applicable measures recommended by the local health officer or the infection control physician (or other designated health care professional) have been implemented; and
5. All employees who enter the room or area housing the patient are provided with, and use, appropriate personal protective equipment and respiratory protection in accordance with the rules for respiratory protection.

This documentation must be completed at the end of the five-hour period, and at least every 24 hours thereafter. However, if the treating physician determines that the transfer would be detrimental to a patient's condition, the facility must:

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3 The discussion in this manual is intended to summarize only the transfer requirements in the regulation. Hospitals should review the regulation for additional requirements for handling AirID cases and protecting hospital staff.

4 At the time of publication of this manual, those diseases are: Aerosolizable spore-containing powder or other substance that is capable of causing serious human disease, e.g. Anthrax/Bacillus anthracis; Avian influenza/ Avian influenza A viruses (strains capable of causing serious disease in humans); Varicella disease (chickenpox, shingles)/Varicella zoster and Herpes zoster viruses, disseminated disease in any patient. Localized disease in immunocompromised patient until disseminated infection ruled out; Measles (rubeola)/Measles virus; Monkeypox/ Monkeypox virus; Novel or unknown pathogens (including H1N1); Severe acute respiratory syndrome (SARS); Smallpox (variola)/Variola virus; Tuberculosis (TB)/Mycobacterium tuberculosis — Extrapulmonary, draining lesion; Pulmonary or laryngeal disease, confirmed; Pulmonary or laryngeal disease, suspected; Any other disease for which public health guidelines recommend airborne infection isolation.

1. Ensure that employees use respiratory protection when entering the room or area housing the patient;
2. Review the patient's condition at least every 24 hours to determine if transfer is safe, and record the determination as described in its ATD Exposure Control Plan; and
3. Make the transfer within the five-hour period described above, once the physician determines that the transfer is safe.

☞ **References:**

Title 8, California Code of Regulations, Section 5199

CHA Consent Manual*, Chapter 12, H. "Standards for Transfer of a Patient with an Aerosol Transmissible Disease."*

IV. COMMUNICATION WITH RECEIVING HOSPITALS

As many hospitals are faced with capacity limitations or lack the capability to provide the services necessary to stabilize an emergency patient (especially hospitals with limited on-call coverage), the need to locate accepting hospitals for a transfer has become a daily burden. The following are some tips for managing the transfer process:

1. Review III. "Communication With Transferring Hospitals," page 7.10, to gain a perspective on the process that receiving hospitals may be following in determining whether to accept a patient transfer.
2. Understand the status of the patient's condition:
   a. Does the patient have an EMC?
   b. Is the EMC stabilized (or resolved) within the meaning of EMTALA?
   c. Is the condition "unstabilized and the patient remains at clinical risk?"

   If the condition is resolved or stabilized, the transfer is not covered by EMTALA, and a receiving hospital may refuse acceptance of the transfer unless it has obligations under other laws or contractual obligations. *(See A. "Are there state laws requiring hospitals to accept patient transfers?," page 7.13.)*
3. If the patient has an EMC that is not stabilized or resolved, communicate this fact clearly to personnel at the receiving hospital. As discussed in "Stabilized — The EMTALA Statute Versus the Interpretive Guidelines," page 5.3, it is advisable to avoid using the term "stable" to describe a patient's condition.
4. Hospital staff should advise the receiving hospital as to why the patient is being transferred and the specific services required to stabilize the patient's condition that the hospital cannot provide at the time of the transfer request.
5. Hospital staff should understand the clinical information that the receiving hospital needs to know in order to make an informed decision as to whether it has the capability and capacity to meet the patient's needs.

6. The treating physician and hospital staff should call the receiving hospital, rather than an on-call physician at the receiving facility. If the receiving hospital has established a transfer center or a central number for processing requests for transfers, the sending hospital should call the transfer center or other centralized unit for handling transfers.

7. Do not call the receiving hospital emergency department and ask for the name and telephone number of an on-call physician before you have talked with staff at the receiving hospital. Under EMTALA, transfers are hospital-to-hospital, and the receiving hospital should be able to assess its bed and service capacity and capability before contacting an on-call physician. Calling the on-call physician before talking with the hospital may delay the transfer. In addition, the accepting physician may not be aware of the receiving hospital's capacity, which could result in a patient arriving for stabilizing services that are not available.

8. Have pertinent portions of the medical record available to provide orally, electronically or in hard copy to the receiving hospital. If the receiving hospital requests portions of the medical record in order to evaluate whether it can meet the needs of a patient with an unstabilized EMC, give or send only clinical information (not financial information). If the time necessary to fax or transmit the record may jeopardize the condition of the patient, advise the receiving hospital that the delay to send the records may result in further deterioration of the patient's condition.

9. If the patient's EMC is not stabilized (i.e., an EMTALA transfer), do not discuss the patient's financial status or insurance information with the receiving hospital or physician. Until the patient has been accepted, the receiving hospital and physician may not request financial status or insurance information for a patient with an EMC that is not stabilized.

10. A transferring hospital may have a transfer agreement with a receiving hospital. If so, make sure the staff is aware of the transfer procedures. A transfer agreement may expedite the transfer process and avoid communication problems between hospitals.

11. If a receiving physician or hospital staff dispute the judgment of the treating physician, CMS and the courts have reaffirmed that the judgment of the transferring physician will be granted greater weight in determining the patient's status and clinical needs *(see discussion of the St. Anthony's decision in chapter 7, "Obligations of Receiving Hospitals")*.

12. If hospital staff believe that the receiving hospital or physician is not complying with the EMTALA obligations, or there is a dispute or a communication problem, request the opportunity to speak with the administrator-on-call at the receiving hospital to try to resolve the problem.

13. If hospital staff believe that the receiving hospital or physician refused a transfer for reasons that may violate EMTALA, report the circumstances to administration, risk management or the compliance officer (or other designated staff position) to review the case and decide whether follow-up action is appropriate.

14. Have a performance improvement process for evaluation of the transfer procedures, including compliance with the standards for an appropriate transfer, review of problematic cases, and the documentation of communications with receiving hospitals.

☞ **References:**

42 C.F.R. Section 489.24(d) (Appendix B)

Interpretive Guidelines, tag nos. A-2407/C-2407 and A-2409/A-2409 (Appendix C)

Health and Safety Code Section 1317.2 (Appendix D)

V. TRANSPORTATION FOR AN APPROPRIATE TRANSFER

A. Who decides the appropriate mode of transportation for a patient transfer?

An appropriate transfer of an unstabilized patient requires the use of proper personnel and equipment, as well as medically necessary life-support measures. In the *Interpretive Guidelines*, CMS has expressed the view that the transferring physician has the responsibility to determine the appropriate mode, equipment and personnel for a transfer. As discussed in chapter 7, "Obligations of Receiving Hospitals," CMS reaffirmed the discretion granted to the treating physician by stating that conditions for accepting a transfer imposed by a receiving hospital for using air ambulance transport would violate EMTALA *(see discussion in chapter 7, G. "Can a hospital place conditions on accepting a transfer?," page 7.6)*.

CMS will review the judgment of the transferring physician in selecting the mode, equipment and personnel for a transfer. CMS has cited a hospital for failure to use proper transportation, including the use of basic life support rather than advanced life support for the transfer of a surgical patient, and the failure to ensure proper staff for an ambulance.

B. Can the patient be transferred by a personal vehicle?

In some cases (often pediatric emergencies), the patient or his or her family will request the use of a private vehicle to transport the patient to the receiving facility. The use of personal vehicles to transfer a patient whose condition is not stabilized or resolved is not expressly prohibited under EMTALA; however, it is clearly disfavored and CMS will closely scrutinize the reasons why personal transportation was used. The use of personal transportation for a patient whose EMC is not stabilized or resolved does not absolve the hospital from meeting the standards for an appropriate transfer.

If the emergency physician approves or recommends the use of a personal vehicle for the transfer, the physician should document his or her reasons in the medical record. The hospital should ensure that the patient or family has instructions for the transfer and directions to the receiving facility, and it should verify the time of the patient's arrival at the receiving facility.

If the patient or family requests the use of personal transportation for an emergent patient, the hospital should discuss the risks involved and document all information provided (such as the request to use personal transportation, the directions given to the patient or family and discussion on the risks and benefits of using a personal vehicle). If the patient or family, reaffirms the decision to use personal transportation for the transfer despite the contrary recommendation of the emergency or treating physician, the hospital should follow the

procedures for obtaining an informed refusal as described in chapter 8, "Patient Refusal of Stabilizing Treatment or Transfer."

All transfers of emergency patients by personal vehicle should be reviewed under the hospital's performance improvement program.

☞ **References:**

42 C.F.R. Section 489.24(d) (Appendix B)

Interpretive Guidelines, tag nos. A-2407/C-2407 and A-2409/C-2409 (Appendix C)

Health and Safety Code Section 1317.2 (Appendix D)

Many hospitals have entered into transfer agreements that establish additional obligations and conditions for the interfacility transfer of patients, including emergency patients. These agreements may apply to the transfer of emergency patients covered by EMTALA, except for conditions that violate EMTALA or state law.

C. Hospital Council's Patient Transfer Work Group

In 2008-2009, the Hospital Council of Northern and Central California formed a Patient Transfer Work Group of hospitals and the regional EMS agency in Fresno, Kings, Madera and Tulare counties to coordinate interfacility transfers within the four-county area, including the use of a common form of transfer agreement. The Work Group developed a standardized transfer agreement that was signed by all hospitals within the four-county area, which included a regularly updated transfer contact list and capability summary for each hospital. A copy of the sample transfer agreement, without the specific provisions related to the Work Group, is included in Appendix S.

VI. CAPABILITY AND CAPACITY

If a hospital does not have the capability or capacity to provide a service to an individual with an unstabilized EMC, EMTALA requires the hospital to arrange an appropriate transfer to another facility. In general, EMTALA focuses on the capability and capacity of the hospital as a whole, rather than the capability of the dedicated emergency department. For example, if a hospital provides obstetric services, the staff and resources of the obstetric service must be considered available to screen and treat a woman in labor who comes to the hospital.

A. Capability to Provide Services

EMTALA compliance is more difficult if a hospital does not have an organized service or medical specialty to treat the needs of a particular emergency patient. CMS will determine on a case-by-case basis whether a hospital has the capability to provide a service even if the hospital is not licensed to offer that service. For example, in the preamble to the 1994 EMTALA regulations, CMS stated that a hospital that does not offer perinatal services may not transfer a woman having contractions if the hospital has the staff and facilities to perform an uncomplicated delivery. In a 2017 settlement, the OIG determined that a South Carolina hospital that maintained a "voluntary" psychiatric unit allegedly violated EMTALA by not providing psychiatric examination and treatment in the ED, and maintained "involuntary" psychiatric patients in the ED for "days and weeks" instead of admitting the patients to its voluntary psychiatric unit for stabilizing treatment. Further details of this case are discussed in chapter 6 of this manual.

B. Capacity to Provide Services

The EMTALA regulations define **"capacity"** as the ability to admit or treat patients (e.g., staff, beds and equipment) as well as the "hospital's past practices of accommodating additional patients in excess of its occupancy limits." As noted in the *Interpretive Guidelines*, if "a hospital has customarily accommodated patients in excess of its occupancy limits … it has, in fact, demonstrated the ability to provide services to patients in excess of its occupancy limits." CMS will look at the hospital's history of absorbing emergency patients by shifting patient room assignments or calling in additional staff. If a hospital has provided services to emergency patients in excess of its service capacity, CMS may allege an EMTALA violation if the hospital denies treatment to a similar patient with an EMC.

C. Capacity and Nurse Staffing Ratios

The nurse staffing standards in California place a hospital in a Catch-22 situation when it has available beds but does not meet the staffing ratios at the time of an emergency admission. Does a hospital have "capacity" within the meaning of EMTALA to admit a critically ill individual with an unresolved EMC if the admitting unit will not meet the staffing ratios; or, should (or must) the patient be transferred?

In 2004, the Licensing and Certification Division of CDPH issued guidance in responding to "health care emergencies," which it defined as temporary overcrowding and saturation due to a rapid influx of patients. In a Jan. 9, 2004 memorandum to hospitals (AFL 04-01), CDPH stated the following:

> Hospitals are **not required to seek prior approval from [CDPH], L&C to decrease staffing levels below required ratios during a healthcare emergency**. Hospitals are expected to respond immediately to emergency situations in the most effective manner to ensure the health and safety of their patients. They will not be found in violation of the nurse-to-patient ratio regulations during a healthcare emergency, provided they can demonstrate they took appropriate steps to try to maintain required staffing levels. (emphasis in original)

CDPH has also noted that observation beds in a licensed emergency department are not counted in a hospital's licensed bed capacity. According to CDPH, "hospitals are expected to meet their obligations under state and federal laws to provide emergency services without regard to any requests to increase patient accommodations."

CDPH has not issued additional advice on how it would interpret and enforce the staffing ratios with respect to an individual emergency admission or transfer when there is no saturation or overcrowding. In the absence of guidance, the hospital must decide whether to admit the patient (and possibly violate the nurse staffing ratios) or make an appropriate transfer of the patient to another hospital.

If the hospital admits the patient when it is out of compliance with staffing ratios, a surveyor may later cite the hospital under state law, which may subject the facility to fines or other sanctions under state and federal laws, as well as litigation by the patient if there is an adverse outcome. If the hospital transfers the patient, a surveyor may later review the admission patterns at the time of the transfer (were other patients admitted or transferred?) and the historical practices of the hospital in admitting or transferring patients in similar situations. The survey could result in an EMTALA violation, as well as potential litigation if there is an adverse outcome.

CDPH has noted that hospital self-reporting for non-compliance with the staffing ratios is intended to apply only to "all occurrences that disrupt the operation of the facility," including health care emergencies that result in a failure to meet the staffing ratios despite planning for census fluctuations. Therefore, hospitals are not required to self-report all events that CDPH could cite as a violation. Self-reporting for an emergency admission (in the absence of a health care emergency) of a potential violation of the staffing ratios requires an evaluation of the needs of the patient and other facts relating to the circumstances. Hospitals are encouraged to discuss this subject with their legal counsel.

D. Reserved Critical Care Beds

Under CMS's interpretation of "capacity," a reserved intensive care unit (ICU) bed may be considered "available" for admission of a patient with an EMC, even if a nonemergency surgery scheduled for another patient who will require an ICU bed must be delayed or cancelled. However, if an ICU bed is reserved for a patient who is already in surgery and there are no other open ICU beds, the hospital will be at its capacity. Hospitals should review their policies for reserved critical care beds for guidance on admission or transfer of an emergency patient.

E. Requirement to Transfer

The *Interpretive Guidelines* require that when "a hospital has exhausted all of its capabilities in attempting to remove the EMC, it must effect an appropriate transfer of the individual." If the patient requires immediate medical stabilizing treatment and the hospital is operating beyond capacity, the *Interpretive Guidelines* state that the hospital should transfer the patient to another facility if possible.

Compliance Tip: If a hospital does not have the capability or capacity to provide services to a patient with an unstabilized EMC, the hospital should document the lack of capability or capacity in the medical record if the patient is transferred to another facility.

☞ **References:**

42 C.F.R. Section 489.24(b) and (c) (Appendix B)

Interpretive Guidelines, tag nos. A-2407/C-2407 and A-2409/C-2409 (Appendix C)

Health and Safety Code Sections 1317.1 and 1317.2 (Appendix D)

VII. PRIOR AUTHORIZATION

A. Must the hospital contact a health plan before transferring or admitting an enrollee whose condition is stabilized or who requires post-stabilization inpatient care?

Health plans may require a hospital to obtain prior authorization for care provided after the patient's EMC is stabilized. The requirements on the non-contracting hospital and the health plan are more fully discussed in chapter 4, "Financial Considerations — EMTALA and Managed Care."

☞ **References:**

42 C.F.R. Section 489.24(d) (Appendix B)

Interpretive Guidelines, tag nos. A-2407/C-2407 and A-2409/C-2409 (Appendix C)

Health and Safety Code Section 1317.2 (Appendix D)

Health and Safety Code Section 1262.8 (Appendix F) 42 C.F.R. Section 422.113 (Appendix G)

VIII. TRANSFER OF AN ED PATIENT WHO DOES NOT HAVE AN EMC

If an ED patient does not have an EMC, or has an EMC that has been determined to be stabilized, the patient may still require an acute care admission at the hospital or a transfer to another hospital. The transfer of an ED patient who does not have an EMC is not covered by EMTALA. Rather, the requirements for the transfer are addressed in state law.

Under the California emergency services law, a transfer that is made for a "nonmedical reason" is subject to eight standards. The standards apply to a transfer of an ED patient for economic reasons (i.e., inability to pay) or alignment of a patient with a contracting or in-network health plan facility. Some of the standards are similar to the EMTALA standards for an appropriate transfer of a patient with an unstabilized EMC; however, there are several additional standards including:

1. A determination that the transfer will not create a "medical hazard" (this is defined in Health and Safety Code Section 1317.1(f), included as Appendix D);
2. An accepting physician has agreed to the transfer;
3. The transfer documents include a "transfer summary" which is defined in the statute; and
4. The hospital has made and documented a reasonable attempt to notify a "preferred contact person" if known, or, if unknown, to ascertain a "preferred contact person" or next of kin, before the transfer.

These standards do not apply to transfers of a patient covered by EMTALA or transfers of a patient for medical reasons.

These standards are addressed in Appendix D (Health and Safety Code Section 1317.2) and Chapter 12 of CHA's Consent Manual, under the heading "Transfer of a Patient Without an Emergency Medical Condition."

IX. APPLICATION OF EMTALA TO TRANSFERS FOR OFF-SITE TESTS

The *Interpretive Guidelines* provide that if a hospital transfers a patient who has or may have an EMC to another hospital for a test (such as an MRI) with the intention that the patient return to the transferring facility after the test, the transferring hospital must effect the transfer in accordance with EMTALA standards. Similar requirements are likely to apply for the transfer of an emergency patient to a freestanding imaging center for an MRI or CT examination.

The *Interpretive Guidelines* express the expectation that the receiving hospital will communicate with the transferring hospital its findings and the status of the patient during and after the procedure. However, CMS does not require the receiving hospital to implement an appropriate transfer of the patient to the transferring hospital after completion of the procedure.

Compliance Tip: Hospitals should have policies for making and receiving these types of transfers. The transferring hospital should also consider the facilities, services and personnel available at a receiving facility in determining whether to send qualified staff to accompany the patient. The receiving facility should adopt policies for evaluating and documenting the stability of the patient prior to his or her return to the transferring hospital. The receiving facility should either admit the patient if he or she is not stable for transfer, or arrange for additional personnel and equipment as necessary to meet the needs of a patient during his or her return to the transferring hospital. Transfers of emergency patients for testing should also be monitored by the hospital quality improvement and risk management programs.

☞ **Reference:**

Interpretive Guidelines, tag no. A-2409/C-2409 (Appendix C)

X. DISCHARGE OF AN EMERGENCY PATIENT

A. When is an individual with an emergency medical condition "stabilized" for purposes of discharge?

An individual with an EMC may be discharged when the treating physician (or other qualified professional) determines that the EMC is stabilized. As stated in the *Interpretive Guidelines*:

> An individual is considered stable and ready for discharge, when, within reasonable clinical confidence, it is determined that the individual has reached the point where his/her continued care, including diagnostic work-up and/or treatment, could be reasonably performed as an outpatient or later as an inpatient, provided the individual is given a plan for appropriate follow-up care as part of the discharge instructions.

The *Interpretive Guidelines* also provide that hospitals "are expected within reason" to assist or provide discharged patients with the necessary information to secure follow-up care in order to prevent relapse or deterioration of the medical condition. In the past, representatives of CMS have suggested that "a plan for appropriate follow-up care" should include resources that are geographically and financially accessible to the patient, particularly if the patient's EMC is not resolved at the time of discharge.

These comments suggest that discharging a patient with instructions to obtain follow-up care may be scrutinized by surveyors to determine whether the discharge plan identifies physicians, clinics or other resources that have accepted, or are likely to accept, the patient for necessary post-emergency services. If a patient is not aligned with a local physician or the hospital does not arrange follow-up care, the hospital should consider giving the patient

instructions to return to the hospital for follow-up services if the patient is unable to find a physician or other provider.

☞ **References:**

42 C.F.R. Section 489.24(b) and (d) (Appendix B)

Interpretive Guidelines, tag nos. A-2407/C-2047 and A-2409/C-2409 (Appendix C)

B. When is an emergency psychiatric condition "stabilized" for purposes of discharge?

Under the *Interpretive Guidelines*, if a patient's psychiatric EMC is resolved, the patient may be discharged. As with a medical patient, the hospital must provide the patient with a plan for follow-up care with their discharge instructions. In California, providers are required to provide a written aftercare plan for mental health patients.

☞ **References:**

42 C.F.R. Section 489.24(b) and (d) (Appendix B)

Interpretive Guidelines, tag nos. A-2407C-2407 and A-2409/C-2409 (Appendix C)

XI. DISCHARGE OF EMERGENCY PATIENTS WHO ARE HOMELESS

A. Are there special requirements for discharging an emergency patient who is homeless?

The application of EMTALA and the state emergency medical services and patient discharge laws have become a centerpiece of efforts by the Los Angeles City Attorney to restrict the ability of hospitals to discharge homeless patients (including emergency patients) to "skid row" and other homeless shelters and providers. These laws have also been raised in other counties in California, but the enforcement actions in Los Angeles have received extensive publicity, including attention in a motion picture and by the national media.

The media, the Los Angeles City Attorney, and various homeless advocates have focused considerable attention on the problem of an appropriate destination for discharged homeless patients. Concerns have been expressed that some hospitals may send discharged homeless patients to skid row areas of town so that those patients may stay in a shelter while further recuperating from their illness or injury. Some shelters have expressed the view that they are not staffed or equipped to handle a convalescing patient, especially a patient who requires follow-up care.

This media and law enforcement attention has resulted in legislative and judicial efforts to change the procedures by which homeless patients are discharged from hospitals and to penalize hospitals for discharge decisions and/or for facilitating the transport of homeless patients to shelters or other destinations that cannot meet the needs of the patients.

B. Federal Laws on Emergency Patient Discharge

As discussed above, the EMTALA *Interpretive Guidelines* require that emergency patients who are discharged must receive a plan for appropriate follow-up, including information necessary to prevent a relapse or worsening of their medical conditions. The *Interpretive Guidelines* do not specifically address homeless patients, and CMS has not issued any specific guidance that applies the EMTALA obligations to homeless patients.

There are Medicare Conditions of Participation for hospitals that establish requirements for patient discharge plans. Although these conditions clearly apply to inpatients, CMS has expressly stated that they do not apply to emergency patients. Emergency departments are subject to the Medicare Condition of Participation for preparing a discharge summary; however, the summary is not required to be given to the patient.

☞ **References:**

42 C.F.R. Section 482.43 (Medicare CoP for discharge planning); Medicare State Operations Manual, Appendix A, Tag A-0349

42 C.F.R. Section 482.24 (Medicare CoP for medical record services)

C. State Hospital Licensing Laws on Emergency Patient Discharge

Effective Jan. 1, 2007, California law provides that a hospital may not "cause the transfer" of a homeless patient to another county for the purpose of receiving supportive services from a social service agency, health care service provider, or nonprofit social service provider in the other county, without prior notification to, and authorization from the social service agency, health care service provider, or nonprofit social service provider. [California Health and Safety Code Section 1262.4]

For purposes of this law, a **"homeless patient"** is an individual who lacks a fixed and regular nighttime residence, or who has a primary nighttime residence that is a supervised publicly or privately operated shelter designed to provide temporary living accommodations, or who is residing in a public or private place that was not designed to provide temporary living accommodations or to be used as a sleeping accommodation for human beings.

It is noted that this law does not expressly state that it applies to emergency patients. However, the broad language and history of the legislation indicate that it most likely applies to both inpatients and outpatients (including emergency patients).

Documentation

It is strongly recommended that hospitals obtain documentation from the agency/provider accepting the patient and place it in the medical record. Hospitals should also consider documenting that the patient consented to go to the agency/provider.

In correspondence and litigation by the Los Angeles City Attorney, there have been statements that another licensing law on patient discharge also applies to emergency patients: Health and Safety Code Section 1262.5. This law requires hospitals to have a written discharge planning policy and process, which includes "appropriate arrangements for posthospital care … are made prior to discharge for those patients who are likely to suffer adverse health consequences for posthospital care." These arrangements include care at a skilled nursing or intermediate care facility, hospice or at home.

Section 1262.5 clearly applies whether a patient is or is not homeless, although unlike Section 1262.4, it does not impose specific standards for homeless patients.[5] CDPH has not issued a formal interpretation as to whether the discharge planning requirements of Section 1262.5 apply to emergency patients (as well as other outpatients). The author's view is that,

5 It is noted that one version of the legislation that enacted Section 1262.4 required hospitals to "develop a protocol specific to the needs of homeless individuals" which must be included in the discharge planning policy required by Section 1262.5. This requirement was subsequently deleted from the legislation, and was not enacted into law.

in the absence of CDPH guidance or a judicial interpretation of the statute, Section 1262.5 applies only to the discharge of inpatients, and conversely, does not apply to emergency patients. This view is based on the wording of the statute and the legislative history, which indicate an intent to codify in state law the Medicare Condition of Participation for discharge planning (which, as noted above, do not apply to emergency patients).

D. Litigation (City of Los Angeles)

Beginning in December 2005, the Los Angeles City Attorney initiated enforcement efforts related to the transport of homeless patients to skid row. The initial effort involved a letter to several hospitals alerting them of possible legal action for their discharge practices involving homeless patients.

Since November 2006, the City Attorney has filed criminal and civil charges against several hospitals within and outside the City of Los Angeles for the practice of "homeless dumping." The complaints generally allege that the hospitals discharged and transported to skid row homeless patients without a plan for post-hospital care or verifying that a place could provide adequate shelter and recuperative care services. The complaints have included both criminal counts (such as false imprisonment and dependent adult endangerment), and civil complaints (such as unlawful and unfair business practices, including failure to follow state law on discharge planning).

In the complaints, the City Attorney has described "homeless dumping" as including the following elements:

1. Discharging homeless patients without proper clothing, sometimes no more than a hospital gown;
2. Discharging homeless patients on a gurney or wheelchair, with intravenous or other equipment attached to the patient;
3. Discharging homeless patients prematurely;
4. Arranging for homeless patients to be transported considerable distances, often up to 15 to 30 miles, notwithstanding the availability of a closer shelter; and
5. Transporting homeless patients to skid row without first checking to determine the availability of shelter beds or services necessary for the patients.

Since May 2007, the City Attorney has entered into several settlement agreements with hospitals that require the hospitals to develop a training program for hospital staff and a discharge protocol for all homeless patients (including emergency patients). The discharge protocol must be monitored by a third party who must approve the training program, review quarterly certifications of compliance and recommend contempt actions for violations of the settlement agreement. The settlement agreements also include funding of homeless services, fines and other costs.

Under the common form of the discharge protocol, the hospitals agree to the following practices for all homeless patients:

1. Record homeless patients on a homeless patient log.
2. Provide appropriate clothing at the time of discharge.

3. Assess patient "cognitive intactness," including living conditions and support systems; complexity of the discharge plan; orientation to person, time and place; ability to provide self-care; and access to medical care, food and shelter.
4. Perform a needs assessment, including food and shelter, treatment for substance abuse or domestic violence, vocational assistance, Medicaid enrollment and eligibility for other public services.
5. Establish discharge plans that meet patient medical and social needs, with appropriate referrals and help with eligibility for Kaiser's Financial Assistance Program to obtain drugs or equipment.
6. For a post-discharge referral to a shelter, the hospital must locate available options, assure that the patient meets the shelter's criteria for acceptance and document the consent of the patient and shelter to the placement.
7. For a patient seeking transport to a skid row shelter, the hospital administrator (or designee) must approve the discharge plan.

The hospitals also agreed to implement an in-service program for physician, clinical, social service, discharge planning and other staff involved in the care and discharge of homeless patients. The training program included the requirements of the discharge protocol; homelessness in Los Angeles County; problems faced by homeless patients; assessment of cognitive intactness; post-discharge issues; communication with homeless patients; location of shelters and services for the homeless; referral sources; the hazards of skid row; and the use of surrogate decision makers for homeless patients.

In 2008, the authority of the Los Angeles City Attorney was reinforced by the enactment of an ordinance by the Los Angeles City Council applying to the transportation by all health facilities of discharged patients. While the ordinance is directed to homeless patients, it applies to transporting all patients to a location other than their own residence or other another facility. Under the ordinance:

> A health facility may not transport or cause a patient to be transported to a location other than the patient's residence without written consent, except when the patient is transferred to another health facility following bona fide procedures in accordance with another provision of law.

For purposes of the ordinance:

1. A **"patient's residence"** is defined as the home of the patient, the fixed and regular nighttime residence or domicile of the patient, or in the case of a patient who is reasonably perceived to be homeless, the location that the patient gives as his/her principal place of dwelling.
2. **"Written consent"** is defined as knowingly, intelligently and voluntarily given written consent that is signed by the patient or his/her legal representative.

The ordinance does not apply to patients who are in the care and custody of state hospitals or correctional facilities or law enforcement.

Although the ordinance was adopted by the City of Los Angeles and clearly applies to hospitals located within city limits, the City Attorney has interpreted the ordinance as applying to any hospital located outside of the city limits that transports a patient to any

location (and especially skid row) within the City of Los Angeles in violation of the terms of the ordinance.

The City Attorney is continuing to initiate enforcement efforts in this area and to ensure that hospitals are proactively implementing guidelines regarding evaluation and discharge planning of homeless patients.

6 EMTALA and Psychiatric Emergency Patients

I. Overview 6.1

II. LPS — Summary of California Mental Health Involuntary Detention Laws... 6.2

A. What is the Lanterman-Petris-Short Act? 6.2

Summary of the LPS Pre-Admission Process 6.3

Designated Facilities 6.4

Designated Professionals 6.5

The Application of a 5150 Hold 6.6

Minors 6.8

Rights of a Person Detained under Section 5150 ..... 6.8

III. Application of Emtala to Psychiatric Facilities 6.8

A. When does a psychiatric hospital operate a dedicated emergency department? 6.9

B. What if the acute psychiatric hospital does not operate a dedicated emergency department? 6.10

C. If a psychiatric hospital or a hospital with a psychiatric service limits admissions to voluntary patients, and is not a designated facility, must it admit or accept the transfer of involuntary patients? 6.11

IV. EMTALA Requirements for Patients Presenting With Psychiatric Conditions 6.12

A. The Medical Screening Examination for a Psychiatric Emergency Patient 6.12

Documentation 6.13

B. Determination of an EMC for a Psychiatric Patient 6.13

Definition of a Psychiatric EMC 6.13

California Emergency Services Definition of a Psychiatric EMC 6.14

C. Psychiatric EMC and 5150 Detention 6.14

V. Stabilization of an Individual With a Psychiatric EMC for Purposes of Transfer 6.15

A. Does the release of a 5150 hold affect the responsibility of a physician to determine whether a psychiatric EMC is stabilized? 6.16

VI. EMTALA Obligations for Placement and Transfer of a Patient With a Psychiatric EMC 6.17

A. Alignment with designated facilities: What are the obligations of hospitals if there are pre-arranged state or local care networks for patient screening or treatment? 6.17

B. Are there different standards for a transfer of a patient with a psychiatric EMC? 6.18

C. Must a hospital transfer patients with an unstabilized psychiatric EMC to designated facilities aligned with the local county? 6.18

D. Are there different standards for accepting the transfer of a patient with a psychiatric EMC? 6.20

E. Can a hospital transfer a patient with a psychiatric EMC to a PHF or a crisis stabilization unit? 6.20

VII. Post-EMTALA Issues: Patients With Psychiatric EMCs Who are Stabilized 6.22

A. Authorization for Medi-Cal Patient Post-Stabilization Services 6.22

B. Transfer of ED Psychiatric Patients Who are Health Plan Members 6.22

VIII. Common Questions and Issues Related to the Intersection of EMTALA and LPS in Non-Designated Hospitals 6.24

A. When does the 72-hour clock begin? 6.25

B. What is the custodial status of a person on a 5150 hold if the peace officer or designated professional leaves the person in a non-designated hospital? 6.26

C. Can a 5150 hold be released by an ED physician and or other staff if they are not county-designated professionals? 6.27

D. If the 72-hour clock starts at the time of the 5150 hold, and the hold is not released, or the patient is not discharged or transferred to a designated facility within 72 hours, can a new 5150 hold be applied to the person? 6.28

E. If an ED patient on a 5150 hold is admitted for acute inpatient medical (non-psychiatric) care, does the 5150 hold continue in place during the inpatient stay? 6.28

IX. Health & Safety Code Section 1799.111 — The 24-Hour Hold 6.29

A. Application of a Section 1799.111 Hold 6.29

B. Release of a Section 1799.111 Hold 6.30

C. What are the advantages and disadvantages of a Section 1799.111 hold? 6.31

6 EMTALA and Psychiatric Emergency Patients

I. OVERVIEW

The EMTALA statute does not include psychiatric conditions in the definition of an "emergency medical condition." However, in response to comments on the adoption of the 1994 EMTALA regulations, CMS inserted "psychiatric disturbances" in parentheses within the definition of "emergency medical condition." *(See Appendix B.)* As a general rule, CMS applies EMTALA equally to psychiatric emergencies and non-psychiatric emergencies.

Compliance with EMTALA for psychiatric emergencies has proven to be a challenge for hospitals. Many facilities do not provide psychiatric services, and don't have psychiatrists or other mental health professionals on staff who are available to evaluate or treat patients with psychiatric crises. Psychiatric emergency patients may also pose treatment and other challenges, such as security concerns and elopement, that differ from patients seeking treatment for non-psychiatric emergency medical conditions (EMCs). However, the biggest challenge to hospitals has been managing psychiatric patients for hours or days while seeking the placement and transfer of psychiatric patients to specialty facilities.

The EMTALA obligations also collide with state laws permitting detention of individuals for involuntary psychiatric evaluation and treatment, alignment of patients with local networks of designated facilities, and a sometimes bewildering array of county policies and guidance for detention and placement that vary from county to county and, in some instances, may conflict with EMTALA.

Neither the EMTALA regulations nor the *Interpretive Guidelines* address involuntary holds. More than a decade ago, an EMTALA Technical Advisory Group (TAG) identified the conflict of the EMTALA requirements with state laws for involuntary detention and local networks for crisis services. In response, CMS declined to change the EMTALA regulations or the *Interpretive Guidelines* to address the conflicts, other than confirming that transferring psychiatric patients under community protocols could violate EMTALA in some cases.

The Lanterman-Petris-Short Act (LPS) enacted California's mental health involuntary detention laws in 1967. Under LPS, counties have the responsibility, with state approval, to designate facilities (designated facilities) that are authorized to detain, evaluate and treat involuntary psychiatric patients. State law authorizes law enforcement personnel to detain an individual in order to obtain evaluation and treatment of a mental health disorder. In addition, each county has the discretion to designate health professionals (designated professionals) who may write an involuntary hold. The pre-admission process for detention and treatment under LPS is summarized in II. "LPS — Summary of California Mental Health Involuntary Detention Laws," page 6.2.

Statewide oversight of LPS is assigned to the California Department of Health Care Services (DHCS). However, the implementation and administration of LPS is primarily a county function. Many counties have adopted their own interpretations of LPS, some of which vary

from the interpretations adopted by other counties. The interpretations related to transfers are discussed in VI. "EMTALA Obligations for Placement and Transfer of a Patient With a Psychiatric EMC," page 6.17 and other interpretations are discussed in VIII. "Common Questions and Issues Related to the Intersection of EMTALA and LPS in Non-Designated Hospitals," page 6.24.

The complexities of applying EMTALA to psychiatric patients and facilities, and the intersection of EMTALA and state mental health laws, treatment networks and county rules, have resulted in substantial risks to hospitals for EMTALA violations. CMS Region IX has reported that issues regarding psychiatric patients and facilities have high visibility on the CMS radar screen for potential EMTALA violations. The list of psychiatric emergency issues reported by Region IX covers the range of the EMTALA obligations:

1. The scope of triage and medical screening of psychiatric patients in all emergency departments (EDs), especially EDs in non-designated hospitals;
2. Requirements for monitoring, further evaluation and treatment of psychiatric patients in all EDs;
3. Elopement of psychiatric patients from EDs;
4. Compliance with the rules for making appropriate transfers of psychiatric patients to accepting hospitals;
5. Compliance by receiving hospitals with the EMTALA rules for accepting psychiatric patient transfers without regard to the patient's insurance or financial status, or the transfer of patients across county or state lines;
6. Whether psychiatric hospitals operate dedicated emergency departments; and
7. Whether psychiatric hospitals comply with the Medicare Conditions of Participation for providing emergency services if they do not operate dedicated emergency departments.

II. LPS — SUMMARY OF CALIFORNIA MENTAL HEALTH INVOLUNTARY DETENTION LAWS

NOTE: LPS is a comprehensive law that covers pre-admission involuntary detention as well as inpatient treatment stays that are beyond the scope of this manual. The discussion of LPS in this manual is limited to the pre-admission detention requirements that intersect with the EMTALA obligations. A complete review of LPS, and additional information and guidance on California mental health laws, are provided in CHA's *Mental Health Law Manual*.

A. What is the Lanterman-Petris-Short Act?

LPS establishes processes under which persons who are dangerous to themselves or others, or gravely disabled, due to a mental health disorder, inebriation or the use of narcotics or restricted dangerous drugs, may be involuntarily detained for specific periods of time for evaluation and treatment. LPS also establishes certain rights and procedural protections for persons who are held for involuntary evaluation or treatment.

As noted in the overview, oversight of LPS is assigned to DHCS, which assumed this responsibility in 2012 following the dissolution of the California Department of Mental Health.

LPS assigns significant responsibilities to counties, including the designation of facilities and professionals who are authorized to evaluate and treat involuntary patients. In the absence of guidance from the state, many counties have adopted their own interpretations of LPS and the application of LPS to involuntary patients, designated facilities and professionals. Therefore, each hospital should consult with its own legal counsel and its county department of behavioral health regarding the interpretations of LPS by the county.

Although amended in 2013, the LPS pre-admission process has remained largely static for the past 50 years. However, psychiatric services and the legal landscape have fundamentally changed.

1. California has experienced a decline in the number of designated facilities and psychiatric beds;[1] as noted below, 40 percent of California counties have no designated inpatient psychiatric facilities.
2. While a designated facility cannot refuse entry to a peace officer who has custody of an involuntary patient, many psychiatric facilities require that an acute hospital "medically clear" an involuntary psychiatric patient before accepting a transfer of the patient for evaluation and treatment.
3. EMTALA imposes obligations on EDs that may conflict with county policies and guidance for placement and transfer of involuntary patients with psychiatric EMCs.
4. The interpretations of LPS may vary significantly from county to county, generating conflicts and confusion about the rules for holding, releasing, managing and transferring individuals on a 5150 hold.

The questions and discussion in this section provide a brief overview of the LPS preadmission process ("Summary of the LPS Pre-Admission Process," page 6.4), the designation of LPS facilities ("Designated Facilities," page 6.4); the designation of professionals ("Designated Professionals," page 6.6); the process of taking a person into custody under a 5150 hold ("The Application of a 5150 Hold," page 6.6); the application of LPS to minors ("Minors," page 6.8); and the rights of involuntary patients ("Rights of a Person Detained under Section 5150," page 6.8). VIII. "Common Questions and Issues Related to the Intersection of EMTALA and LPS in Non-Designated Hospitals," page 6.24 addresses common questions related to LPS for which there is conflicting guidance.

Additional general information on LPS and current state of California psychiatric services are available on the CHA website at www.calhospital.org/lps-act.

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1 Psychiatric bed reduction in California was described as follows in the 2012 Report of the LPS Reform Task Force II:

> Over the past two decades, the number of acute psychiatric inpatient beds has decreased 30% throughout California. Twenty-five of California's 58 counties have no adult inpatient psychiatric beds. Based upon population, California has one psychiatric bed for every 5,651 residents; nationwide, the average number of acute care psychiatric beds is one for every 4,887 people. California's community mental health system has not been able to compensate for the loss of these beds. Many people with severe mental illnesses are too ill to be treated in a voluntary community setting and the vast majority of community mental health services are not geared to those individuals' clinical needs. Also, treatment needs have become more complicated with an increased number of those with severe mental illnesses having co-occurring medical conditions such as addictions or chronic physical health conditions coupled with a mental illness.

Summary of the LPS Pre-Admission Process

The LPS statutory scheme (Sections 5150, 5151 and 5152 of the California Welfare & Institutions Code) establishes a three-step process for an involuntary admission: detention, assessment and admission.

1. **Detention (5150).** The first step in the pre-admission process occurs when a peace officer or a designated professional takes a person into custody based on probable cause that the person, due to a mental health disorder, is dangerous to self or others, or gravely disabled.

   A 5150 hold may be applied in any location — at home, on the street, in a clinic or health facility, including an ED. The 5150 hold permits involuntary detention for up to 72 hours in order to provide assessment, evaluation and crisis intervention or placement of the person for evaluation and treatment at a designated facility. The obligations of a peace officer or a designated professional who detains a person under Section 5150 are described in "The Application of a 5150 Hold," page 6.6.

2. **Pre-Admission Assessment (5150(c) and 5151).** Assessment requires that the professional person in charge of a designated facility, a member of the attending staff or other designated professional must assess an involuntary patient to determine whether the person can be properly served without being involuntarily detained. If the professional concludes that the patient can be adequately served without being detained, the person must be provided evaluation, crisis intervention, or other inpatient or outpatient services on a voluntary basis.

3. **Admission (5151 and 5152).** If the person must be admitted for further evaluation and treatment on an involuntary inpatient basis, the initial stay may not exceed 72 hours. However, an involuntary patient may be discharged before the end of the 72-hour period.

Each of these steps, including definitions of key terms, is described with greater specificity in chapter 3 of the CHA *Mental Health Law Manual*, which also describes the procedural requirements for any continued inpatient stay after an initial 72-hour admission.

Designated Facilities

What is a designated facility under LPS?

Under LPS, each county has the responsibility, with DHCS approval, to designate facilities for the evaluation and treatment of involuntarily detained persons. While not required by LPS, some counties require a designated facility to sign an agreement with the county that describes the conditions of designation. Some county departments of behavioral health have posted on their websites the requirements for facility designation.

In 2013, the Legislature defined the term "designated facility" to include three types of designated inpatient facilities and one category of ambulatory facility.

1. The inpatient facilities are defined as general acute care hospitals with psychiatric units, acute psychiatric hospitals and psychiatric health facilities (PHFs). However, there is no legal requirement that an inpatient facility that provides psychiatric services must apply for designation. Therefore, some psychiatric facilities or inpatient units are limited to the admission of patients who voluntarily agree to receive psychiatric services.

2. The outpatient facility is defined as a certified crisis stabilization unit (CSU). A CSU is defined in the Medi-Cal mental health plan regulations as a service lasting less than 24 hours. CSU services include but are not limited to assessment, collateral services[2] and therapy (each of these terms is also defined in the Medi-Cal mental health plan regulations), which are provided to individuals for a condition that requires a more timely response than a regularly scheduled visit.

☞ Reference:

Welfare & Institutions Code Section 5008(n).

Title 9, Cal. Code of Regs., Sections 1810.210, 1840.338, 1840.348 and 1840.368

Is there a list of designated facilities?

DHCS has posted on its website (see reference below) a list of LPS designated facilities divided into three categories — inpatient facilities, outpatient clinics and other types of designated facilities.

Each list is organized by county, and includes the name, address, telephone number, facility type and number of designated beds for each facility. Some types of designated facilities, such as most PHFs and CSUs, are not subject to EMTALA, and therefore they are not required to accept the transfer of patients with psychiatric EMCs from hospitals EDs.

As of October 2017, the following designated facilities are listed on the DHCS website:

1. **150 county-designated inpatient facilities.** The inpatient facilities are located in 34 counties, meaning that there are no designated inpatient facilities in 24 counties. While the list identifies the license type of the facility (general acute, acute psychiatric or PHF), it does not identify facilities that have age limitations, such as children, adolescents or geriatric patients. In addition, the list includes several Veterans Administration facilities, a state hospital and a naval hospital.
2. **25 county-designated outpatient clinics and CSUs.** The outpatient facilities are located in 18 counties. Most of the outpatient clinics are identified as CSUs, although the list also includes one hospital emergency department and one county outpatient service; the four outpatient clinics in Los Angeles County are identified as "urgent care centers."
3. **Six "other types" of designated facilities.** All of these facilities are county jail or detention facilities.

☞ **Reference:**

www.dhcs.ca.gov/provgovpart/Pages/MH-Licensing.aspx

2 Collateral services are defined in Title 9, Cal. Code of Regulations Section 1810.206: **"Collateral"** means a service activity to a significant support person in a beneficiary's life for the purpose of meeting the needs of the beneficiary in terms of achieving the goals of the beneficiary's client plan. Collateral may include but is not limited to consultation and training of the significant support person(s) to assist in better utilization of specialty mental health services by the beneficiary, consultation and training of the significant support person(s) to assist in better understanding of mental illness, and family counseling with the significant support person(s). The beneficiary may or may not be present for this service activity.

Designated Professionals

Each county has the responsibility to establish procedures for designating professionals who are authorized in the county to detain a person under Section 5150. There are four statutory categories of professionals are listed in Section 5150 who are eligible to be designated by a county:

1. The professional person in charge of a designated facility for evaluation and treatment;
2. A member of the attending staff of a designated facility;
3. A member of a mobile crisis team; and
4. Other professionals.

The process for designation of professionals varies from county to county. Many counties require professionals to complete a training program, including an exam, prior to receiving designation. Some counties require renewal of the designation at specified intervals. Some counties delegate to designated facilities the ability to designate professionals who are on staff in the facility. Some counties may designate individuals as trainers, who may also train and designate professionals within county guidelines.

The designation of a professional is typically limited to the county making the designation. In some counties, the designation is facility-specific, and the professional does not have designation privileges outside of the facility for which he or she is designated. The same limitation may apply to other counties in which the professional may practice; if a professional is designated in one county, the designation does not apply in another county unless the professional is also designated by the other county.

In most hospitals that are designated facilities, the ED physicians are often designated professionals, and may detain a person under Section 5150. Some counties have also designated ED physicians who work in non-designated hospitals.

Some counties have posted their LPS designation policies on their behavioral health department website. For example, the designation policies for Orange County are posted at https://media.ocgov.com/gov/health/bhs/mhi/id.asp.

In addition to designated professionals, peace officers are also authorized by law to detain a person under Section 5150. The statutory authority conferred on a peace officer is considered to be independent of the discretionary designation of professionals by a county.

The Application of a 5150 Hold

What is a "5150"?

The LPS preadmission process begins with an involuntary hold (or "custody") that is described in Section 5150. The hold is commonly referred to as a "5150" and persons on a 5150 hold are commonly referred to as "5150s" or "5150 patients."

Section 5150 states that a hold may be applied by a peace officer or a designated professional, upon probable cause, that an individual, due to mental health disorder, may be a danger to self or others, or gravely disabled. The hold permits the peace officer or professional to take the person into custody, or cause the person to be taken into custody, for the purpose of obtaining involuntary mental health evaluation and services.

What is the obligation of a peace officer or designated professional who detains a person on a 5150 hold?

In 2013, Section 5150 was amended to provide alternative pathways to a peace officer or designated professional to align the detained person with psychiatric services. As amended, the peace officer or designated professional must take, or cause to be taken, the person into custody for a period of up to 72 hours for:

1. Assessment, evaluation, and crisis intervention,[3] or
2. Placement for evaluation and treatment in a designated facility.

As discussed in VIII. "Common Questions and Issues Related to the Intersection of EMTALA and LPS in Non-Designated Hospitals," page 6.24, the placement of the words "72 hours" in Section 5150, and their repetition in Section 5151, has resulted in counties taking different positions as to when the 72-hour period begins.

How is a 5150 Hold Documented?

There are several administrative requirements that must be fulfilled by the peace officer or designated professional who detains a person under Section 5150.

The 5150 Application. Section 5150(e) requires that a designated facility must receive a written application stating the circumstances under which the person's condition was called to the attention of the peace officer or the designated professional, and stating that the officer or professional has probable cause to believe that the person is, as a result of a mental health disorder, a danger to self or others or gravely disabled. DHCS has published a form to fulfill this requirement, DHCS 1801 (DMH 302), "Application for Assessment, Evaluation, and Crisis Intervention or Placement for Evaluation and Treatment," which may be found at www.dhcs. ca.gov/formsandpubs/forms/Forms/Mental_Health/DHCS1801_07142014.pdf.

The requirement that the application must be delivered to the designated facility along with the person under a 5150 hold has resulted in some controversy or confusion. Some designated facilities have required that the application to be delivered with the patient must be the original signed application. There are anecdotal reports of persons being rejected if they arrive with a copy of the signed application. However, there is no requirement in LPS that the application delivered to the designated facility must be the original signed application.

One county has addressed the signed application issue. In 2016, Orange County Behavioral Health Services adopted a policy entitled the "Use and Processing of Lanterman-Petris-Short Act (LPS) 5150/5585 Form." Under the policy, "a copy, fax, or scan of the original document [5150 application] is sufficient for the purposes of detaining and transporting an individual." The same applies to the need to make appropriately documented corrections or revisions to the application. However, the policy adopted by Orange County does not necessarily apply in other counties.

☞ **Reference:**

https://media.ocgov.com/civicax/filebank/blobdload.aspx?BlobID=51693

The 5150 Advisement. Section 5150(g) requires that the peace officer or designated professional detaining a person under Section 5150 must provide the person an oral advisement in a language or modality that is accessible to the person. The form of the advisement must be

3 These terms are defined in Welfare & Institutions Code Sections 5150.4 (assessment), 5008(a) (evaluation) and 5008(e) (crisis intervention).

substantially the same as the language of Section 5150(g)(1); the advisement must be in writing if the person cannot understand an oral advisement. The advisement is contained in the 5150 application form (DHCS 1801) described above includes the required language of the advisement. If the person is taken into custody at his or her own residence, additional information must be provided to the person.

☞ **Reference:**

Welfare & Institutions Code Section 5150(g)

There are additional duties or notices required of a peace officer or designated professional who take a person into custody under Section 5150, which are set forth in Section 5150 and described in chapter 3 of CHA's *Mental Health Law Manual*.

Minors

The Children's Civil Commitment and Mental Health Treatment Act of 1988, which is part of LPS, applies to the initial 72-hour period of mental health evaluation and treatment for minors, who due to mental disorder, are determined to be a danger to self or others or gravely disabled. These laws are set forth in Welfare & Institutions Code at Sections 5585 to 5585.9, and are described in chapter 3 of CHA's *Mental Health Law Manual*.

Rights of a Person Detained under Section 5150

Federal and state laws contain multiple provisions regarding mental health patient rights, including persons who are involuntarily detained for evaluation and treatment under LPS. DHCS has published a Handbook entitled "Rights for Individuals in Mental Health Facilities." The rights, including general rights, consent to treatment and medication, restraints and seclusion and health information privacy, are described in CHA's *Mental Health Law Manual*.

☞ **Reference:**

www.dsh.ca.gov/Publications/Patients_Rights/docs/RightsHandbook_English.pdf

III. APPLICATION OF EMTALA TO PSYCHIATRIC FACILITIES

Under California law, inpatient psychiatric services may be provided in a licensed psychiatric service of a general acute care hospital or in two types of inpatient psychiatric facilities — an acute psychiatric hospital and a psychiatric health facility, commonly referred to as a "PHF."

1. **Acute Psychiatric Hospital.** Acute psychiatric hospitals are licensed by CDPH, and are typically certified to participate as hospital providers under the Medicare and Medi-Cal programs. As of October 2017, OSHPD lists 39 acute psychiatric hospitals operating in the state (excluding state-operated facilities). Most acute psychiatric hospitals are Medicare certified and subject to the EMTALA obligations. However, the scope of the EMTALA obligations of an acute psychiatric hospital depends on whether the psychiatric hospital operates a dedicated emergency department (which is discussed below).

   If an acute psychiatric hospital does not operate a dedicated emergency department, it is not subject to the accepting hospital obligations discussed in this chapter and in chapter 7, "Obligations of Receiving Hospitals."

2. **Psychiatric Health Facility (PHF).** A PHF is an inpatient psychiatric facility that is licensed by DHCS. Most PHFs are small facilities (typically 16 licensed beds) that are subject to different requirements than acute psychiatric hospitals, including patient care, staffing, operations and physical plant standards. As of October 2017, OSHPD data indicates there are 35 PHFs operating in California.

   A PHF may apply for Medicare certification from CMS as a psychiatric hospital, but it must upgrade its staffing, services and capabilities to meet the Medicare Conditions of Participation. Medicare certification is not required for a PHF to participate in Medi-Cal as a mental health provider. As a result, only a few PHFs are certified by the Medicare program. The few PHFs that are Medicare-certified are subject to EMTALA in the same manner as acute psychiatric hospitals. PHFs that are not certified by Medicare are not subject to EMTALA.

The licensing and certification requirements for psychiatric services and facilities are independent of the county designated facility process. As a result, some licensed psychiatric services or facilities may limit admissions to voluntary patients, and are not designated facilities under LPS.

A. When does a psychiatric hospital operate a dedicated emergency department?

As discussed in chapter 2, "When and Where Does EMTALA Begin and End?", a hospital may be found to operate a dedicated emergency department if CMS determines one of the following to be present:

1. The facility operates a licensed emergency service;
2. The facility meets the "Holding Out Test" because it holds itself out to the public as providing emergency psychiatric services on an urgent basis without requiring a previously scheduled appointment; or
3. The facility meets the "One-Third Test" because, based on a representative sample of patients within the preceding year, one-third of all of its outpatient visits for the treatment of EMCs were provided on an urgent basis without requiring a previously scheduled appointment. The process by which CMS will determine whether a facility meets the "One-Third Test" is discussed in chapter 2 and described in Appendix K.

The analysis applied by CMS to acute care hospitals applies equally to an acute psychiatric facility or a general acute care hospital that maintains an outpatient treatment area for crisis intervention or other psychiatric services that are provided on a drop-in basis without a scheduled appointment.

An acute psychiatric hospital should expect surveyors, during the complaint survey process, to consider whether the hospital operates a dedicated emergency department. If CMS concludes that the hospital in fact operates a dedicated emergency department, the hospital will be required to comply with all of the EMTALA obligations — signage, central log, opening of medical records and on-call coverage, as well as policies for medical screening examination, necessary stabilizing treatment, and an appropriate transfer (if required) for any individual who presents to the department seeking or in need of examination or treatment for any medical condition.

Similarly, the courts may examine whether an acute psychiatric facility operates a dedicated emergency department. In an October 2017 federal District Court decision in Indiana, the court reviewed a claim brought by a patient alleging suicidal ideation who presented after-hours to a free-standing psychiatric facility. The patient was re-directed by an on-duty security officer to the emergency department of its affiliated hospital that was a mile away. On the way to the hospital, the patient drove his vehicle into an apartment complex in an attempt to commit suicide. The court rejected the facility's argument that it did not have a dedicated emergency department, noting that the dedicated emergency department need not be on the same campus as the hospital from which an individual may seek care. Regardless of the merits of the EMTALA claim or the court's rationale in declining to dismiss the EMTALA claim,[4] acute psychiatric facilities need to have policies and procedures to address patients presenting at all hours seeking or in need of emergency services.

☞ **Reference:**

Stewart v. Parkview Hospital, Inc., N.D. Ind., No. 1:16-cv-138 (Oct. 20, 2017)

B. What if the acute psychiatric hospital does not operate a dedicated emergency department?

If an acute psychiatric hospital that is Medicare-certified does not provide emergency or walk-in services that constitute a dedicated emergency department, the hospital is subject to standards for handling emergency patients that are set forth in the Medicare Conditions of Participation (42 C.F.R. Section 482.12(f)). Under the *Interpretive Guidelines* for Section 482.12(f), the hospital must have appropriate written policies and procedures that address the following:

1. The appraisal of emergencies, including the immediate availability at all times of a registered nurse who has training to conduct an assessment that enables the nurse to recognize the need for emergency care;
2. The provision of initial treatment needed by persons with EMCs within the hospital's capability and capacity. The hospital must have at all times a registered nurse who has training to provide the initial treatment to an individual with an EMC, with oversight or direction from an on-site or on-call physician; and
3. Referral or transfer of the individual to an appropriate facility if his/her emergency needs exceed the capability of the hospital. The policies must be designed to ensure that hospital staff recognize when an individual requires a referral or transfer and appropriate handling of the transfer, including appropriate transport of the patient. The hospital must also send the necessary medical information with the individual to the receiving hospital.

The requirements of Section 482.12(f) do not apply to a PHF, unless the PHF has been certified as a participating provider in the Medicare program.

4 The decision does not indicate that the plaintiff alleged a violation 42 C.F.R. Section 482.12(f) of the Medicare Conditions of Participation, which addresses policies and procedures required to respond to the type of situation described in this case if a facility does not have a dedicated emergency department.

Compliance Tip: CMS has indicated that it will closely scrutinize the actions of acute psychiatric hospitals that are Medicare-certified and that do not offer walk-in or other emergency services if they refuse to assist an individual seeking entrance for evaluation of a potential EMC. Even if the facility does not operate a dedicated emergency department, CMS will review the hospital's response under the Medicare Conditions of Participation

Psychiatric hospitals should also review their state law obligations to respond to emergency situations. Under California law, a hospital that does not operate an ED must exercise reasonable care to determine whether an emergency exists and direct the person to a nearby facility that can render the needed services, and assist the person in obtaining needed services, including transportation, in every way reasonable under the circumstances. In addition, hospitals that are designated facilities to evaluate and treat 5150 patients (danger to self/others or gravely disabled) may have additional obligations to provide psychiatric evaluation and treatment.

☞ **Reference:**

42 C.F.R. Section 489.24(a) and (b) (Appendix B)

Interpretive Guidelines, tag no. A-2406/C-2406 (Appendix C)

Health and Safety Code 1317(e) (Appendix D)

42 C.F.R. Section 482.12(f) and Interpretive Guidelines (Medicare Condition of Participation for Emergency Services) (Appendix E)

C. If a psychiatric hospital or a hospital with a psychiatric service limits admissions to voluntary patients, and is not a designated facility, must it admit or accept the transfer of involuntary patients?

Psychiatric facilities and services voluntarily establish limits on their service capabilities and admission policies, including designation under LPS. Dating back to 1994, CMS stated in the preamble to the EMTALA regulations that "[n]either the statute nor the regulations mandate that hospitals expand their resources or offer more services. Rather, they focus on a hospital's existing capabilities." 59 Fed.Reg. 32086 (June 22, 1994). It has therefore been generally believed that psychiatric services and facilities that admit only voluntary patients, and are not designated facilities, are not required under EMTALA to admit or accept transfers of involuntary patients.

In a June 2017 settlement, the OIG, following a CMS Region IV EMTALA investigation, determined that a South Carolina acute care hospital that maintained a "voluntary" psychiatric unit allegedly violated EMTALA by not providing psychiatric examination and treatment in the ED for emergency psychiatric patients, and maintained "involuntary" psychiatric patients in the ED and did not admit them to its voluntary psychiatric unit. The OIG reported that there were 36 incidents of individuals with psychiatric EMCs. These patients were reportedly not evaluated by on-call psychiatrists, and were involuntarily committed and kept in the ED for 6 to 38 days, despite available beds in its voluntary unit. The patients were described as ranging in age from young adults to elderly adults, and with suicidal or homicidal conditions. The hospital settled the investigation with the OIG for $1,295,000.

The hospital reportedly had limited admissions to voluntary patients for over 30 years under hospital-approved policies. The conclusions by CMS and the OIG as the hospital's capability to admit the patients appear to be contrary to the CMS guidance quoted above as to hospitals determining their own capability and not being required to expand their services.

It is difficult to evaluate whether the investigation and settlement of this case is an anomaly, or whether the investigation by CMS and the OIG reflects a change in policy or interpretation of EMTALA. In California, involuntary patients must be admitted to a designated facility for evaluation and treatment. It is unclear if CMS or the OIG would apply the same interpretation so as to require acceptance by a voluntary facility of a transfer of an involuntary patient with a psychiatric EMC, or admissions or transfers conflicting with other facility or service limitations such as age.

IV. EMTALA REQUIREMENTS FOR PATIENTS PRESENTING WITH PSYCHIATRIC CONDITIONS

A. The Medical Screening Examination for a Psychiatric Emergency Patient

If a patient presents to the ED of an acute hospital seeking or in need of examination of a psychiatric condition, whether as a voluntary or involuntary patient, the hospital must record the patient's visit in the central log, open a medical record and provide a medical screening examination (MSE) within the capability of the hospital to determine whether the patient has an EMC.

The MSE must include both medical and psychiatric assessments, including tests as may be clinically indicated, which must be performed or ordered by a physician or another qualified professional designated by the hospital and medical staff for performing screening examinations and working under hospital policies. CMS expects that the emergency physician or other qualified professional will be able to make an initial determination as to whether a patient has or may have a psychiatric EMC. (See chapter 3 for more information regarding the hospital designation of health care professionals who may provide the MSE.)

CMS has cited hospitals for failing to conduct an appropriate psychiatric screening examination for a patient with a presenting complaint of a psychiatric nature. In conducting the psychiatric screening, the ED physician or other screening professional cannot rely solely on a crisis team member or other non-hospital professional (even if a designated professional) to perform the screening. Although hospitals may utilize the resources of crisis teams and designated professionals for further examination and observation of psychiatric patients, the ED physician or other hospital personnel must provide a clinical evaluation as part of the MSE.

Compliance Tip: Hospitals must continue to screen and monitor individuals with potential psychiatric emergencies until their departure from the hospital. The monitoring must include periodic re-assessment and documentation of the patient's status during the course of the ED stay, including the risk of elopement. In a case involving a patient elopement, CMS cited a hospital for

> "failing to ensure that two … patients who presented to the … ED … with psychiatric diagnoses (including suicidal and homicidal ideations and/or altered level of consciousness) received ongoing assessments and monitoring to ensure stabilization of an emergent condition. These failures resulted in the potential for the undetected deterioration of an emergency medical condition which would place patients at risk of harm, including elopement."

Documentation

The medical record for an emergency patient with a presenting complaint, signs or symptoms of a psychiatric condition should include documentation of the screening of medical and psychiatric conditions by the ED physician or other qualified professional on staff at the hospital. The CMS Investigative Procedures for EMTALA Surveyors instruct surveyors that for individuals with psychiatric symptoms, the medical record should indicate an assessment for suicide or homicide attempt or risk, orientation, and assaultive behavior that indicates a danger to self or others. Some hospitals have developed a separate form for charting the results of a psychiatric screening examination.

☞ **References:**

42 C.F.R. Section 489.24(a) and (b) (Appendix B)

Interpretive Guidelines, tag no. A-2406/C-2406 (Appendix C)

Investigative Procedures for EMTALA Surveyors (Appendix K)

B. Determination of an EMC for a Psychiatric Patient

Definition of a Psychiatric EMC

Under the EMTALA regulations, the definition of an EMC refers to "psychiatric disturbances" in a parenthetical clarification of a "medical condition manifesting itself by acute symptoms of sufficient severity" so as to place the health of an individual in serious jeopardy. There is no definition of the terms "psychiatric disturbances" or "psychiatric emergency medical condition." However, the *Interpretive Guidelines* advise that "an individual expressing suicidal or homicidal thoughts or gestures, if determined dangerous to self or others, would be considered to have an EMC." *(See references below)*.

California Emergency Services Definition of a Psychiatric EMC

In 2009, California law was amended to define the term "psychiatric emergency medical condition" in the state emergency medical service laws that apply to hospitals:

> **"Psychiatric emergency medical condition"** means a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:
>
> (A) An immediate danger to himself or herself or to others.
>
> (B) Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

The primary difference between the EMTALA guidance and the state definition is that California includes an individual with a mental disorder who is "gravely disabled."[5]

In May 2012, the California Department of Public Health (CDPH) issued an All-Facility Letter (AFL) (Appendix U) describing the EMTALA guidance and the state law provisions for psychiatric EMCs. The AFL indicates that California hospitals "are required to comply with both state and federal requirements."

MEDI-CAL REIMBURSEMENT NOTE: The terms for a "psychiatric EMC" under EMTALA and the hospital emergency services laws are not defined in the same manner by the federal Medicaid program or the state Medi-Cal program with respect to payment. While the EMTALA definition of an EMC expressly includes "psychiatric disturbances, " the Medicaid definition omits the mention of "psychiatric disturbances." At the state level, the Medi-Cal Mental Health Plan regulations, applicable for payment purposes, define a "psychiatric EMC" in the same manner as the licensing definition that is quoted above, except it adds two further requirements for a psychiatric EMC: a determination of "medical necessity," and the need for an inpatient psychiatric admission.

C. Psychiatric EMC and 5150 Detention

While there are some similarities between a psychiatric EMC under EMTALA and detention under Section 5150, the nature of these determinations is not the same:

1. A psychiatric EMC is based on a clinical judgment by an ED physician or other qualified professional as to the nature and severity of a person's medical and/or psychiatric conditions.
2. A 5150 hold is based on probable cause by a peace officer or designated professional (who may or may not be a physician) to detain a person for psychiatric evaluation and treatment. The determination of probable cause, especially by a peace officer, does not, and is not intended to include the elements of an MSE or the professional judgment of an ED physician.

As a result, there is no bright line standard that all patients on a 5150 hold must be considered to have a psychiatric EMC. Some individuals may present to the ED on a 5150 hold written by a peace officer and may, upon medical screening and/or subsequent evaluation and monitoring, be determined by an emergency physician not to have a psychiatric EMC within the meaning of EMTALA or California law. Conversely, there is no bright line standard that a person determined to have a psychiatric EMC meets the probable

5 For reference purposes, the term "gravely disabled" is defined in Welfare & Institutions Code Section 5008(h).

cause to apply a 5150 hold, especially if the individual is voluntarily seeking treatment for his or her psychiatric condition. Each psychiatric emergency patient must be evaluated based on his/her individual signs and symptoms, without regard to whether a 5150 hold is in place or should be in place.

Notwithstanding these differences, in a 2012 CHA webinar, a CMS representative noted that an EMTALA surveyor may use a 5150 hold as a factor in determining whether there is a psychiatric EMC. However, the existence of a 5150 hold is not the sole or determining factor as to whether a person has a psychiatric EMC. The judgment of the treating ED physician, as documented in the medical record, is the basis for determining the presence or absence of a psychiatric EMC and whether the condition is stabilized. Regardless of the presence of a 5150 hold, the treating physician's judgment should override the significance of the 5150 hold if the physician, based on his or her examination of the patient, determines that the patient does not have a psychiatric EMC or that the EMC is stabilized.

Compliance Tip: The lack of clarity from CMS on the relationship of 5150 holds and EMTALA places non-designated hospitals at risk of an EMTALA violation with respect to the treatment and discharge of patients on a 5150 hold, and whether the patients are transferred in accordance with EMTALA standards. As a result, hospitals should continue to evaluate and monitor the status of the individual during his/her stay in the ED, including times that the individual is in the custody of a designated professional or in observation status. Hospitals should also consider The Joint Commission standards for boarding psychiatric patients awaiting placement at designated facilities (see reference below). Until CMS provides more definitive guidance on psychiatric transfers, it is recommended that transfers of psychiatric emergency patients on a 5150 hold comply with EMTALA standards described in Chapter 5.

☞ **References:**

Interpretive Guidelines, tag no. A-2407/C-2407 (Appendix C)

Health and Safety Code 1317.1(k) (Appendix D)

CDPH All-Facility Letter 12-17 (May 17, 2012) (Appendix U)

The Joint Commission Hospital Accreditation Standards, L.D. 04.03.11 and PC 01.01.01; See also The Joint Commission's November 2017 special report on suicide prevention in health care settings at https://www.jointcommission.org/issues/article.aspx?Article=GtNpk0ErgGF%2b7J9WOTTkXANZSEPXa1%2bKH0%2f4kGHCiio%3d

V. STABILIZATION OF AN INDIVIDUAL WITH A PSYCHIATRIC EMC FOR PURPOSES OF TRANSFER

As discussed above, the EMTALA *Interpretive Guidelines* indicate that an individual who expresses suicidal or homicidal thoughts or gestures has an EMC if those thoughts or gestures are determined to indicate a danger to self or others. Consistent with EMCs of a non-psychiatric nature, the view of CMS appears to be that a psychiatric EMC is considered

stabilized when it is determined that no material deterioration of the condition is likely, within reasonable medical probability, to result during the transfer or discharge of the patient from the facility.

There is a bit of guidance from CMS on the stabilization of psychiatric conditions. The *Interpretive Guidelines* note that the administration of chemical or physical restraints during transfer may "stabilize" a psychiatric patient for a period of time and temporarily resolve the underlying EMC, but that the condition may be exacerbated if the condition is not treated. Therefore, CMS recommends that providers "should use great care when determining if the medical condition is in fact stable after administering chemical or physical restraints."

If a patient's psychiatric EMC is resolved, the patient may be discharged, especially if the patient is not subject to a 5150 hold. As with a medical patient, the hospital must provide the patient with discharge instructions, including a plan for follow-up care.

Under California law, a patient's psychiatric EMC is considered to be stabilized if, in the opinion of the treating physician or other qualified professional, the patient's psychiatric EMC has reached the point where, within reasonable medical probability, no material deterioration of the patient's psychiatric EMC is likely to result from, or occur during, the transfer of the patient. The California law essentially follows the EMTALA test for establishing when an EMC is stabilized. In addition, California law requires providers to provide a written aftercare plan for mental health patients. Details about the required aftercare plan are found in CHA's *Mental Health Law Manual*.

If a patient has been released from a 5150 hold by a designated professional, the hospital should request that the professional provide his or her recommendations for follow-up evaluation and treatment. In one case, a hospital was cited for failing to comply with EMTALA when a patient released from a 5150 was ready for discharge late in the evening. In this instance, the patient lived a considerable distance from the hospital (e.g., over 25 miles) and refused to seek transportation assistance from a family member or a friend. The hospital was subsequently cited by CMS because it "… did not fully implement the stabilizing measures as determined by the mental health crisis worker … The stabilizing measures identified by … [the crisis worker] … were located in Patient 1's home town and Patient 1 was discharged without a means to get to her home…"

☞ **References:**

42 C.F.R. Section 489.24(b) and (d) (Appendix B)

Interpretive Guidelines, tag nos. A-2407/C-2407 and A-2409/C-2409 (Appendix C)

Health and Safety Code Section 1317.4a (Appendix D)

A. Does the release of a 5150 hold affect the responsibility of a physician to determine whether a psychiatric EMC is stabilized?

The decisions as to the stabilization of a psychiatric EMC and the release of a 5150 hold are independent of each other, and a treating physician cannot rely solely on the judgment of a designated professional to apply or release a 5150 hold.

1. A clinical determination by an ED physician or other qualified professional that a person's psychiatric EMC is stabilized does not automatically release a 5150 hold previously applied to the patient, or the need to place the person at a designated facility for further evaluation and treatment.

2. Conversely, the decision by a designated professional to release a 5150 hold on an ED patient does not directly affect the clinical determination of an ED physician or other qualified professional as to whether the patient's psychiatric EMC is stabilized. For example, a patient may have an unstabilized psychiatric EMC, but be willing to stay for voluntary evaluation or treatment, and thus not need to be on 5150 hold.

The treating physician or other qualified professional has the responsibility to make an independent determination as to whether an individual has a psychiatric EMC, whether the condition is stabilized, and whether the individual's condition is stabilized for purposes of transfer or discharge. The treating physician may consider, but cannot solely rely on, the findings of a designated professional who is not on staff at the hospital to determine whether a psychiatric EMC is stabilized. Similarly, the treating physician cannot base his or her decision to consider a psychiatric EMC to be stabilized if the designated professional who is not on staff at the hospital releases a 5150 hold.

☞ **References:**

Interpretive Guidelines, tag nos. A-2407/C-2407 and A-2409/C-2409 (Appendix C)

VI. EMTALA OBLIGATIONS FOR PLACEMENT AND TRANSFER OF A PATIENT WITH A PSYCHIATRIC EMC

A. Alignment with designated facilities: What are the obligations of hospitals if there are pre-arranged state or local care networks for patient screening or treatment?

The *Interpretive Guidelines* address the interplay of the EMTALA obligations and regional care networks for patient screening or treatment. The strongest statement in the *Interpretive Guidelines* is a warning that EMTALA supersedes inconsistent state or local networks for patient screening or treatment:

> Hospitals are not relieved of their EMTALA obligation to screen, provide stabilizing treatment and/or an appropriate transfer to individuals because of prearranged community or State plans that have designated specific hospitals to care for selected individuals (e.g., Medicaid patients, psychiatric patients, pregnant women). Hospitals located in those States which have State/local laws that particular individuals, such as psychiatric or indigent individuals, are to be evaluated and treated at designated facilities/hospitals may violate EMTALA if the hospital disregards the EMTALA requirements and does not conduct an MSE and provide stabilizing treatment or conduct an appropriate transfer prior to referring the individual to the State/local facility ... Hospitals are also prohibited from discharging individuals who have not been screened or who have an emergency medical condition to non-hospital facilities for purposes of compliance with State law. The existence of a State law is not a defense to an EMTALA violation for failure to provide an MSE or failure to stabilize an EMC therefore [sic] hospitals must meet federal requirements or risk violating EMTALA.

In a different section of the *Interpretive Guidelines*, CMS advises that patient health status frequently depends on the appropriate use of community plans (such as trauma and psychiatric hospitals). The *Interpretive Guidelines* emphasize that the appropriate transfer of an emergency patient to a trauma or other regional treatment facility in accordance with

community-wide protocols will be deemed to comply with EMTALA in instances where the hospital cannot provide stabilizing treatment.

EMTALA enforcement actions have focused on the actions of the hospital in providing the psychiatric assessment as part of the MSE and continued monitoring of psychiatric patients until departure from the hospital. The results of these surveys indicate that hospitals must conduct their own psychiatric assessment as part of the MSE and monitor the patient during the entirety of the stay in the ED.

If the patient requires stabilizing treatment beyond the capability or capacity of the treating hospital, the hospital should document compliance with the standards for an appropriate transfer under EMTALA *(see chapter 5, "Transferring or Discharging an Emergency Patient")*. As part of providing further examination and stabilizing treatment to an individual who has been determined by the treating physician to have a psychiatric EMC, the hospital may consider, but it is not bound by, county or other regional behavioral health networks for psychiatric evaluation, observation and placement. However, the hospital must maintain oversight and control of the patient until his or her departure from the hospital.

☞ **References:**

42 C.F.R. Section 489.24(a) (Appendix B)

Interpretive Guidelines, tag nos. A-2406/C-2406 and A-2407/C-2407 (Appendix C)

B. Are there different standards for a transfer of a patient with a psychiatric EMC?

The EMTALA regulations make no distinction between the transfer from an ED to another facility of an individual with a non-psychiatric EMC or an individual with a psychiatric EMC. Under the EMTALA regulations, a sending hospital may arrange an appropriate transfer of an individual with any EMC, whether medical or psychiatric, to any facility that has the capacity and capability to stabilize the individual's EMC. Conversely, an accepting hospital cannot refuse an appropriate transfer from an ED of an individual with an EMC, whether medical or psychiatric, if it has the capacity and capability to stabilize the individual's EMC.

The obligations for the transfer of patients with EMCs are described in chapter 5 of this manual, and the obligations for receiving hospitals to accept the transfer of patients with EMCs are described in chapter 7 of this manual.

C. Must a hospital transfer patients with an unstabilized psychiatric EMC to designated facilities aligned with the local county?

In some counties, a designated professional who has custody of a 5150 patient in a non-designated ED may assist or attempt to direct the hospital in the placement of the patient with a designated facility. While this effort may be helpful to hospital staff, most designated professionals, especially county personnel, are often under instructions from the county to place patients only in facilities that are designated by that county or for which the county has placement arrangements. For example, in one California county, a LPS training manual posted on its behavioral health department website states the following: "Sending 5150 detainees to hospitals NOT designated by [the department]is illegal."

Regardless as to whether the above statement is a correct statement of the LPS law, it does not override EMTALA if an ED patient has a psychiatric EMC that is not stabilized, as determined by the treating physician. Per the *Interpretive Guidelines*:

> Community plans are designed to augment physician's care if the necessary services are not within the capability of the hospital **but does not mandate patient care nor transfer patterns.** (emphasis added)

Under EMTALA, there are no geographic or designated facility limitations on the transferring physician and hospital in finding and arranging facility placement and transfer, so long as the patient is transferred to a facility located within the boundaries of the United States..

In a 2013 memorandum, CMS noted a concern as to payors requiring approval of an individual with an EMC as a condition for transfer to another facility, including directing the destination of the individual to a specific facility. The rationale of the memorandum should apply equally to counties, especially as each county operates the local Medi-Cal mental health plan, and may attempt to direct or limit facility placement.

The memorandum addresses stabilization of EMCs and transfers:

1. As to stabilization of an EMC, the memorandum warns that some payors may assume that a person who is "clinically stable" for transfer is no longer covered by EMTALA. This may be applicable to psychiatric patients who are medically clear, but are still perceived by the treating physician as having a psychiatric EMC. Per CMS, if an ED patient has an EMC, including a psychiatric EMC, that is not been stabilized as determined by the treating physician, the patient is still covered by EMTALA:

   > "Stable for transfer" is not a term used in EMTALA, and it is not necessarily equivalent to the term "stabilized," as defined for EMTALA purposes … although the individual may be "stable for transfer," he/she nevertheless has an unstabilized EMC, and remains protected under EMTALA before, during and after the transfer.

2. As to transfers, the memorandum warns hospitals as to potential third-party interference in transfers of EMTALA patients:

   > Anecdotally we have become aware of some third-party payors with policies or proposed policies that seem to assume, incorrectly, that any individual for whom a transfer is being planned has been "stabilized," and thus is no longer protected under EMTALA. As indicated above, this is incorrect, and procedures for a third-party payor to intervene in the transfer decisions regarding an individual protected under EMTALA could, if adhered to by hospitals, place them at risk of violating EMTALA.

In summary, the EMTALA transfer rules for an individual with an unstabilized EMC, whether medical or psychiatric, are the same. The transferring hospital may arrange an appropriate transfer of an individual with an unstabilized psychiatric EMC to any facility that has the capacity and capability to stabilize the individual's psychiatric EMC. The transfer of an ED patient with an unstabilized psychiatric condition may be arranged with any facility within or outside of the county in which the sending hospital is located, as well as across state lines, if necessary, in order to find a facility that has the capacity and capability to stabilize the emergency psychiatric condition.

☞ **Reference:**

CMS Survey and Certification Memorandum 14-06, EMTALA Requirements & Conflicting Payor Requirements or Collection Practices (Dec. 13, 2013)

D. Are there different standards for accepting the transfer of a patient with a psychiatric EMC?

As discussed in this chapter, CMS makes no distinction under the EMTALA rules between the transfer of an individual with a medical EMC and an individual with a psychiatric EMC.

As the flip side of the previous question, a receiving hospital cannot refuse an appropriate transfer of an individual with a psychiatric EMC, if it has the capacity and capability to stabilize the individual's EMC. In some cases, a county behavioral health department or mental health plan may seek to limit the number of admissions of involuntary patients at a contracting facility; however, if the contracting facility has an available bed and the capability and capacity to stabilize a psychiatric patient's condition, it cannot decline the transfer due to the limitations imposed by the county or health plan. Similarly, if it has the capacity and capability to stabilize the individual's EMC, it cannot refuse acceptance of an ED patient with an unstabilized psychiatric conditions who is transferred across county lines or otherwise to an out-of-network facility.

E. Can a hospital transfer a patient with a psychiatric EMC to a PHF or a crisis stabilization unit?

The EMTALA statute and regulations repeatedly apply to "hospitals" for compliance with the EMTALA obligations for providing a MSE, making an appropriate transfer and accepting an appropriate transfer of an individual with an EMC. However, the EMTALA statute and regulations, in describing the standards for an appropriate transfer, do not refer to the receiving provider as a "hospital." Rather, the statute and regulations refer to the receiving provider more broadly as a "medical facility." The use of the term "facility" rather than "hospital" suggests that EMTALA permits a hospital to transfer an EMTALA patient, i.e., an individual with an unstabilized EMC, to a facility that is not a hospital so long as the receiving facility has the capability and capacity to stabilize the EMC. As pertinent to psychiatric emergency patients, the reference to a "medical facility" could be interpreted to permit hospitals to transfer an EMTALA patient to a PHF or a CSU even if they are not considered to be "hospitals."

In November 2009, CMS Baltimore headquarters, in a letter to the author of this manual, indicated that there are circumstances in which a hospital could transfer an EMTALA patient to a CSU. The CMS letter (Appendix V) cautions that each case must be reviewed based on the following:

1. The specific facts of the case;
2. The clinical condition of the patient;
3. The certification for transfer by the transferring physician and other pertinent information; and
4. Whether the CSU has the capacity and capability to stabilize the EMC.

Based on the CMS letter, the sending physician, in addition to meeting all of the requirements for an appropriate transfer, must determine that the CSU has the capacity and capability to stabilize the EMC of each specific patient. The CMS letter recommends that hospitals seeking to transfer EMTALA patients to a CSU should develop transfer policies to assess the capabilities of the CSU to stabilize an EMC.

The number of CSUs in California has continued to grow in the past few years, and more CSUs will be opening as a result of state grant funds to expand the number of CSUs. Most CSUs are not licensed by the state or under the jurisdiction of CDPH; rather, they operate under certification by DHCS and LPS designation by the counties.

While the 2009 CMS letter indicates that a CSU may be a resource for placement of psychiatric patients, recent surveys of transfers to CSUs by some hospitals have drawn skepticism from some CDPH surveyors. Some surveyors have expressed concern whether the transfer of a patient with a psychiatric EMC should be made to an ambulatory facility that is limited to keeping the patient less than 24 hours. In two cases, statements of deficiencies have been issued by CMS to hospitals for transferring a psychiatric patient to a CSU. In one instance, the patient was subsequently transferred back to the sending hospital. In the second case, the patient was subsequently transferred to an inpatient psychiatric facility for an inpatient admission.

A CSU may be able to provide psychiatric evaluation and crisis services, which is a higher level of care than some EDs. However, the statement of deficiency reflects a view that a receiving CSU must be able to stabilize the psychiatric EMC. It cannot be an interim stop between the ED and an inpatient psychiatric admission.

The following are recommendations for CSU transfers:

1. Develop a transfer agreement with the CSU that sets forth the criteria of the CSU for accepting emergency psychiatric patients and other information that will facilitate the decision-making process by the treating physician.
2. Expect that a surveyor will query the sending hospital and treating physician as to their knowledge of the admitting criteria and the service limitations of a CSU.
3. Work closely with the CSU to identify the types of patients whose psychiatric EMCs may be stabilized by a transfer to it within the 24-hour limitation, and conversely, the signs and symptoms, or manifestations of behavior, for persons who should not be considered for the CSU placement.
4. Be selective in identifying patients for a CSU transfer and discuss the case in sufficient detail with the CSU to verify the appropriateness of the placement.
5. If a CSU transfer is implemented, document the reasons for transferring a patient with a psychiatric EMC to a CSU, including the expectation that the psychiatric EMC can be stabilized at the CSU.
6. Conduct periodic QAPI reviews of CSU transfers in collaboration with the CSU, and use the findings for improvements in patient selection and the CSU transfer process.

While the CMS letter permits, in selective circumstances, the transfer of an individual with a psychiatric EMC to a CSU, it must be remembered that a CSU is not a hospital. Therefore, the CSU has no obligation to accept the transfer of an EMTALA patient regardless of its capability and capacity.

☞ **Reference:**

Letter dated Nov. 12, 2009 from Marilyn Dahl, Director of Acute Care Services, Center for Medicaid and State Operations/Survey and Certification Group, to Steve Lipton (Appendix V)

VII. POST-EMTALA ISSUES: PATIENTS WITH PSYCHIATRIC EMCS WHO ARE STABILIZED

A. Authorization for Medi-Cal Patient Post-Stabilization Services

The rules for obtaining prior authorization for post-stabilization services rendered to members of a Knox-Keene health plan are addressed in chapter 4, "Financial Considerations — EMTALA and Managed Care."

For psychiatric patients covered by a Medi-Cal health plan (MCP) or a Medi-Cal mental health plan (MHP), hospitals should be familiar with the rules for coverage of post-stabilization services that are obtained within, or outside, the plan network. In general, coverage of post-stabilization services are covered if one of the following occurs:

1. The services are pre-approved;
2. The services are not pre-approved, but they are administered to maintain stabilization within an hour of a request to the plan for approval of post-stabilization services; or
3. The services are not pre-approved, but they are administered to maintain stabilization if (i) the plan does not respond within one hour of a call seeking approval, (ii) the plan cannot be contacted, or (iii) the treating physician and the plan representative cannot agree on the post-stabilization plan of care and a plan physician is not available for consultation.

☞ **Reference:**

42 C.F.R. Section 422.111(b) and (c).

B. Transfer of ED Psychiatric Patients Who are Health Plan Members

Effective Jan. 1, 2010, the California hospital emergency services laws were amended to address the transfer of a health plan member who has a psychiatric EMC.

The Assembly Health Committee analysis of the legislation that enacted Health and Safety Code Section 1317.4a, describes the following reasons for the legislation:

> According to the author, this bill is needed to clarify that the treatment necessary to relieve or eliminate a psychiatric emergency may include inpatient admissions. The author states that hospitals have been denied payment for claims by health plans in cases where the hospital treated a mental health emergency with an inpatient admission. The author states that there have been instances where a health plan automatically denies a claim for a psychiatric inpatient admission based on the fact that the patient did not have prior authorization. The author points out that health plans are already obligated to pay for the care and treatment necessary to alleviate the emergency, which in the case of a psychiatric emergency may include an inpatient psychiatric admission. The author argues that this bill will prohibit health plans from denying payment for appropriate treatment of a psychiatric medical emergency.

Under Section 1317.4a, the emergency services and care required to relieve or eliminate a psychiatric EMC is defined to include a possible admission or transfer to a psychiatric unit of a general acute care hospital or an acute psychiatric hospital. It is noted that the statute does not include transfers to a PHF or a CSU, each of which may be an appropriate facility for the transfer of an emergency psychiatric patient.

If the patient is on a 5150 hold, a transfer cannot be made in a manner that conflicts with the requirements of the involuntary detention and treatment rules of LPS that are described in this chapter.

Section 1317.4a permits a hospital to transfer a psychiatric emergency patient to another hospital in accordance with the procedures described below.

1. Section 1317.4a applies only if, "in the opinion of the treating provider, the patient's psychiatric emergency condition has reached the point that, within reasonable medical probability, no material deterioration of the patient's psychiatric emergency condition is likely to result from, or occur during, the transfer of the patient."

   Comment: The language quoted above is virtually identical to the definition of "stabilized" under the EMTALA statute and regulations. As a result, it appears that transfers under Section 1317.4a of emergency patients with psychiatric EMCs are limited to patients who have been determined to have stabilized psychiatric EMCs. This appears to be confirmed by another subsection of Section 1317.4a that does not require authorization for emergency services if doing so is not required by law.

   Therefore, a literal reading of Section 1317.4a is that the procedures described in Section 1317.4a do not necessarily apply to the transfer of a patient with a psychiatric EMC that is not stabilized in the judgment of the treating physician.

2. If the hospital proposes a transfer of a health plan enrollee with a stabilized psychiatric EMC, the hospital must do both of the following:

   a. The hospital must document in the medical record its attempt to obtain the name and contact information of the patient's health plan. The attempt to obtain this information includes:

      - Requesting the patient's health plan member card;
      - Asking the patient, a family member or representative if he or she can identify the health plan; or
      - Using other means known to the hospital to identify the patient's health plan.

   b. If the hospital obtains the patient's health plan information, it must notify the health plan or the plan's contracting medical provider of the transfer. The hospital must provide the plan or contracting medical provider with:

      - The name of the patient;
      - The patient's member identification number, if known;
      - The location and contact information, including telephone number, for the location where the patient will be transferred; and
      - The preliminary diagnosis.

3. The notification to the health plan or the contracting medical provider must be made by:

   a. Following the instructions on the patient's health plan member card; or

   b. Using contact information provided to the hospital by the health plan.

Health plans are required to provide this information to all non-contracting hospitals to which its members may be transferred, and update the contact information as necessary, but at least annually.

4. The notification to the health plan or the contracting medical provider is required to be made only once, so long as the health plan or the contracting medical provider is able to reach a representative of the hospital if it returns the call. The call to the health plan or the contracting medical provider may be made by a representative of the hospital.

5. If the receiving hospital accepts and admits the patient, the receiving hospital must notify the health plan of the transfer. If the receiving hospital does not have a contract with the health plan, the health plan may require and make provision for the transfer of the patient to a hospital that has a contract with the health plan so long as the patient's psychiatric EMC is stabilized.

☞ **Reference:**

Health and Safety Code Sections 1317.1 and 1317.4a (Appendix D)

VIII. COMMON QUESTIONS AND ISSUES RELATED TO THE INTERSECTION OF EMTALA AND LPS IN NON-DESIGNATED HOSPITALS

When LPS was enacted in 1967, the legislature intended that individuals detained under Section 5150 would be routed directly to designated facilities. For example, the LPS pre-admission process contemplates a direct handoff from a peace officer to personnel at a designated facility. In addition, Section 5150.1 prohibits a designated facility from refusing to accept the custody of the person from a peace officer if the facility does not have available beds. Similarly, Section 5150.2 prohibits a designated facility from detaining a peace officer longer than the time necessary to complete the documentation of the detention. Further, Section 5150(c) states that the assessment by a designated professional of a person detained by a peace officer shall not be interpreted to require the peace officer to perform any additional duties other than specified in Sections 5150.1 and 5150.2.

In addition, a literal reading of Section 5150(a), as amended in 2013, suggests that a person who is involuntarily detained must be diverted either for psychiatric assessment, evaluation and crisis intervention, or placed in a designated facility for evaluation and treatment. Nothing in Section 5150(a) implies a third option or a gap in the process under which the detained individual may be taken to location (such as an ED of a non-designated hospital) that does not provide psychiatric evaluation and crisis intervention, or to a non-designated facility for psychiatric evaluation and treatment.

The diversion of individuals on a 5150 hold to non-designated hospitals is neither addressed nor contemplated in LPS. In the absence of any guidance from DHCS, counties have filled the vacuum with an array of conflicting viewpoints on the interpretation of LPS and strategies for engaging or not engaging with non-designated hospitals.

The most common questions are addressed below:

1. When does the 5150 hold clock start?

2. What is the custodial status of a person on a 5150 hold if the peace officer or designated professional leaves the person in a non-designated hospital?
3. Can a 5150 hold be released by an ED physician and other staff personnel if they are not designated professionals?
4. If the 5150 clock starts at the time of the hold, and a patient is not transferred within 72 hours, can a new 5150 hold be applied to the person?
5. If the patient is admitted for acute inpatient medical care, does the 5150 hold continue in place?

The questions above do not include another frequent question, which is whether counties can restrict or direct transfers of non-designated hospital ED patients to specific facilities. That question is addressed above.

The reason these questions continue to arise is that there are no definitive answers, either in LPS, or in judicial decisions or Attorney General opinions. The discussion of these questions below is therefore intended to explain the issues and provide what little guidance there is available in an effort to assist non-designated hospitals in managing involuntary patients.

A. When does the 72-hour clock begin?

This should be an easy question to answer since the 72-hour period has been in LPS for 50 years. Alas, there is not a clear answer that is universally accepted by all stakeholders in the LPS process.

The short answer is that there is a difference of opinion between counties, patient and disability rights advocates and other stakeholders as to the start of the 72-hour clock. As noted above, the reason for the disparity of views on this topic is that the 72-hour standard is mentioned twice in the preadmission sections of LPS: first, in Section 5150(a) related to the initial detention of a person, and second, in Section 5151 related to the admission of a person by a designated facility.

The alternate views on the question may be best explained by an FAQ on the website of the North Coast Emergency Medical Services Agency that serves the Counties of Del Norte, Humboldt and Lake:

> The law has two conflicting statements as to when the clock starts – one statement is found at WIC 5150 and the other (conflicting) statement is found at WIC 5151. Reasonable minds differ on this topic and until it is resolved by the legislature or a court, no one particular view is "correct." Lawmakers anticipated that little or no time would elapse between the writing of the 5150 and admittance into the designated Psychiatric Health Facility, designated Acute Psychiatric Hospital, or inpatient psychiatric unit in a General Acute Care Hospital. In the real world of today, individuals may wait 24-36 hours just to get admitted into a psychiatric facility. It may be interpreted that the 5150 clock starts when the 5150 document is written or at the time of admittance to the psychiatric facility.[6]

6 The FAQ goes on to report that the 72 hours starts: (i) in Del Norte County when the individual is admitted to a designated facility (which Del Norte County does not have); (ii) in Humboldt County when the 5150 application is written; and (iii) in Lake County when the individual is admitted to a designated facility (which Lake County does not have), although the FAQ also states that the receiving designated "facilities used often disagree and count the entire time since the 5150 application was signed and dated. See www.northcoastems.com/plansspecialty-care/5150-holds/section-3-faqs/72-hour-clock-starts/.

In general, a majority of counties start the 72-hour clock under Section 5150 at the time that a person is first taken into custody or the time written on the application for the 5150 hold.

However, several counties (such as the Counties of Los Angeles and San Bernardino, and the two counties mentioned in the North EMSA FAQ) consider that the 72-hour clock starts under Section 5151 when a person is involuntarily detained in a designated facility.[7] These counties appear to start the 72-hour clock based on the two options under Section 5150 that follow the initial detention of a person:

1. The 72-hour clock starts at the time of involuntary detention if the person is provided assessment, evaluation and crisis intervention,
2. But if the person is placed in a designated facility for evaluation and treatment, the 72-hour clock starts at the time of arrival, or assessment or admission of the person at the designated facility.

In addition to the differing views of the counties, disability rights and some patient advocates take a more restrictive view that the 72-hour clock starts at the time of the initial detention, regardless of the course taken by the peace officer or designated professional under the options above or the diversion of the person to a non-designated hospital ED.

Until the law is changed, or there is a judicial decision or Attorney General opinion, the conflicting statements by the counties about the start of the 72-hour clock are likely to remain unresolved. Each hospital should consult its own legal counsel or county department of behavioral health to verify the start-of-the-clock interpretation in the county of the hospital. Hospitals are also advised to ascertain the clock-start interpretations in adjacent counties to which 5150 patients may be transferred.

B. What is the custodial status of a person on a 5150 hold if the peace officer or designated professional leaves the person in a non-designated hospital?

While LPS applies to persons who are involuntarily detained, its provisions for evaluation and treatment apply only to services provided in designated facilities and by designated professionals. As noted above, the LPS pre-admission process does not contemplate an intervening transit of a detained person to the ED of a non-designated hospital.

There is no guidance in the law as to whether the involuntary detention of a person continues if the person having custody of the individual leaves the person in a non-designated hospital without another peace officer or designated professional assuming the custody of the person. In many counties, emergency physicians or other licensed personnel practicing in a non-designated facility are not designated professionals and are not authorized to write, enforce or release a 5150 hold.

Some counties have offered guidance on this question. In November 2016, Orange County Behavioral Health Services advised all hospitals in the county of its view that a 5150 hold on a person who is in a non-designated hospital may remain in place only so long as a designated professional (or presumably a peace officer) retains custody of the person in the hospital. The designated professional may transfer custody of the person to another designated professional who is also in the facility. Subsequent to the letter, Orange County revised its LPS designation policies to expand the categories of personnel who may be

7 For Los Angeles County, *see http://file.lacounty.gov/SDSInter/dmh/189959_LPSFAQs2015-Sep2815.pdf;* for San Bernardino County, *see Information Notice 17-05 (effective November 2017), http://wp.sbcounty.gov/dbh/wp-content/uploads/2017/09/IN_17-05.pdf*

designated professionals, which includes designated professionals practicing in a non-designated hospital. As discussed below, Orange County also indicated that an ED physician could consider a Health and Safety Code Section 1799.111 hold for up to 24 hours after the 5150 lapses.

☞ **Reference:**

https://media.ocgov.com/gov/health/bhs/mhi/id.asp

However, Orange County may be the exception. For example, Los Angeles County has stated in an FAQ that it has no authority to require personnel in a non-designated facility to continue the detention of a person under a 5150 if the detaining authority has left the facility; it recommends that hospitals consult their own legal counsel. Los Angeles County does not generally designate emergency physicians practicing in non-designated hospitals to write 5150 holds.

☞ **Reference:**

http://file.lacounty.gov/SDSInter/dmh/189959_LPSFAQs2015-Sep2815.pdf

Since there is little definitive guidance on the continuation or enforcement of a 5150 hold by a non-designated professional in a non-designated facility if a peace officer or designated professional is not present, each hospital should consult its county department of behavioral health to determine if the county has a view on this issue. Hospitals should also consult their own legal counsel as to the potential legal risks of continuing and enforcing a 5150 hold by a non-designated professional when a custodial officer or professional has left the patient in the ED.

C. Can a 5150 hold be released by an ED physician and or other staff if they are not county-designated professionals?

LPS contemplates that a person on a 5150 hold can be released by a designated professional following assessment, evaluation and crisis intervention services, or by a member of the attending staff of a designated facility at the time of the pre-admission assessment under Section 5151. In some counties, designated professionals have been authorized to re-evaluate 5150 patients in non-designated hospital EDs, and release the hold if they determine that there is no longer probable cause to detain the person involuntarily. As discussed in V. “Stabilization of an Individual With a Psychiatric Emc for Purposes of Transfer,” page 6.15, the decision by a designated professional to release a hold does not alter the hospital’s obligation to comply with the EMTALA obligations for further evaluation and treatment if the patient’s psychiatric condition has not been stabilized.

As discussed in the preceding question, there is uncertainty about whether a 5150 hold remains in effect if the person is transported to an ED of a non-designated hospital without the continuing presence of a peace officer or designated professional. If the ED physician or other staff professional working in or available to the ED is not a designated professional, there is no guidance in LPS and from most counties as whether the ED physician, if not a designated professional, can enforce the hold if the patient wants to leave the hospital. Conversely, there is no guidance in LPS and from most counties as whether the ED physician, if not a designated professional, can release the hold if he or she determines that there is no longer probable cause to maintain an involuntary hold on the person.

In the absence of a change to LPS, or a court decision or other definitive legal guidance, each hospital should consult its county department of behavioral health to determine if the county has a view on the lapse of a 5150 due to absence of a peace officer or a designated professional, or by an ED physician if he or she determines there is no longer probable cause to detain the person. Hospitals should also consult their own legal counsel about the potential legal risks to the hospital and a non-designated physician or other professional who attempts to release a 5150 hold, or deems the hold lapsed, in the absence of a peace officer or designated professional retaining custody of the person.

D. If the 72-hour clock starts at the time of the 5150 hold, and the hold is not released, or the patient is not discharged or transferred to a designated facility within 72 hours, can a new 5150 hold be applied to the person?

This question addresses the concept of the serial hold. This is another topic for which there is no law or definitive guidance, and there are arguments on both sides of the issue. The issue typically arises when a person on a 5150 hold is held in a non-designated hospital for more than 3 days awaiting placement and transfer to a designated facility.

In some counties where ED patients in non-designated hospitals cannot be placed within 72 hours, a designated professional may be authorized by the county to conduct a new probable cause determination as to whether the person, as a result of a mental health disorder, is still a danger to self or others, or gravely disabled. If there is probable cause, the designated professional may be authorized by the county write a new application for the hold.

However, patient advocates may take a more limited view. For example, a brochure published by Disability Rights California advises that at the end of the 72 hours, a person who is detained under Section 5150 must be released, have accepted evaluation or treatment on a voluntary basis, or been certified for intensive treatment on an involuntary basis.

Each hospital is advised to consult its legal counsel if ED patients in a non-designated hospital are awaiting placement and transfer to designated facilities for more than 72 hours, and may be placed on serial 5150 holds. However, even if the 5150 hold must be released as a matter of law, the release of the hold does not alter the hospital's EMTALA obligation to continue further evaluation and stabilizing treatment so long as the treating physician determines that the psychiatric EMC is not stabilized.

E. If an ED patient on a 5150 hold is admitted for acute inpatient medical (non-psychiatric) care, does the 5150 hold continue in place during the inpatient stay?

There is no definitive guidance or legal authority as to the status of a 5150 hold if a detained person presenting to an ED is admitted to an acute bed for inpatient medical (non-psychiatric) care.

However, most counties and commentators appear to adopt the view that the intervening event of an inpatient acute medical stay may impliedly break the involuntary hold. This appears to be based on a break in the LPS process, since placement and transport to a designated facility must be postponed until after the medical need for an acute inpatient stay is resolved. At the time of discharge, the hospital may need to seek a new probable cause evaluation for a 5150 if the discharge plan is to transfer the person to a designated facility for further evaluation and treatment for his or her psychiatric condition.

IX. HEALTH & SAFETY CODE SECTION 1799.111 — THE 24-HOUR HOLD

Separate and very apart from LPS, the Legislature has provided non-designated hospitals an alternative mechanism to applying or arranging for a hold for a psychiatric patient who meets probable cause for involuntary detention.

In 1996, the Legislature enacted Health & Safety Code Section 1799.111. In summary:

1. The statute applies only to non-designated hospitals, and an ED physician or certain other licensed professional staff working in a non-designated hospital;
2. The statute provides immunity from civil or criminal liability for applying a hold under the conditions described in the statute, and the subsequent release of the hold under the conditions described in the statute.
3. While the statute follows LPS for detaining a patient with a mental disorder who presents a danger to self or others or is gravely disabled, it does not include the administrative duties (application, advisement, etc.) under LPS for a peace officer or designated professional who detains a person under Section 5150.
4. The statute is located at the end of the laws governing the California Emergency Medical Services Agency and pre-hospitalization services. It is not part of LPS or hospital licensing laws, or under the oversight of DHCS or CDPH.
5. There are no reported court decisions or Attorney General opinions interpreting or applying Section 1799.111.

Section 1799.111 is an immunity statute, meaning that compliance with the conditions for applying or releasing a hold provides civil and criminal immunity from liability for the actions of the hospital and its participating physicians or professional personnel in applying a hold and, if applicable, for the actions of a person after the release of a hold. However, the immunities only apply if all conditions in the statute are met.

The statute is divided into two basic parts — subdivisions (a) and (b) establish the conditions that permit the involuntary detention of a patient in a non-designated facility, and subdivision (c) establishes the conditions under which the detention may be released while the patient is still in the non-designated hospital. There are other sections that follow subdivision (c) that are also discussed below.

A. Application of a Section 1799.111 Hold

The following conditions must be met to obtain immunity from civil or criminal liability for detaining a person under Section 1799.111:

1. The hospital must be an acute or psychiatric hospital that is not designated by a county as an evaluation and treatment facility for involuntary patients under LPS.
2. The licensed professional staff, or physician providing emergency services in any department of the hospital, who detains a person must meet the following conditions for the detention:
    a. The person cannot safely be released from the hospital because, in the opinion of the treating physician, or a clinical psychologist with staff privileges at the hospital, the person, as a result of a mental disorder, presents a danger to himself or herself, or others, or is gravely disabled; and

b. The hospital staff, treating physician or other licensed mental health professional has made and documented repeated unsuccessful efforts to find appropriate mental health treatment for the person. The telephone calls or other contacts must begin at the earliest possible time when the treating physician has determined when the person will be medically stable for transfer; and

c. The person is not detained at the hospital beyond 24 hours; and

d. There is probable cause for the detention.

3. There are two additional conditions if the person is detained beyond eight hours:

a. A discharge or transfer of the person for evaluation or treatment is delayed due to the need for continuous and ongoing care, observation or treatment at the hospital; and

b. In the opinion of the treating physician or clinical psychologist, the person, as a result of a mental disorder, is still a danger to himself or herself, or others, or is gravely disabled.

The detention of a person under Section 1799.111 does not require the completion of the application used to document a 5150 hold, the formal notice to a patient of his or her detention, or other obligations required under Section 5150. CHA has developed Form 12-12 (Appendix P) to document compliance with these conditions.

The application of a hold under Section 1799.111 does not require the participation of designated professionals, county approval or any reporting to counties of the names of persons detained.

However, a person held involuntarily under Section 1799.111 retains his/her legal rights regarding consent to treatment. Hospitals must also comply with all applicable laws pertaining to restraint, seclusion, and psychiatric medications for persons held involuntarily on a Section 1799.111 hold.

If a person is detained on a Section 1799.111 hold, the person, if later admitted for involuntary treatment at a designated hospital, must be credited the time he or she was detained at the non-designated hospital (i.e., the time must be deducted from the 72- hour clock). It is recommended that a transferring hospital provide to the receiving hospital documentation of the length of time that the person was detained on a Section 1799.111 hold in a non-designated facility.

B. Release of a Section 1799.111 Hold.

The following conditions must be met to obtain immunity from civil or criminal liability for the actions of a person detained up to 24 hours under Section 1799.111 after the person's release from detention at the hospital:

1. The hospital must be an acute or psychiatric hospital that is not designated by a county as an evaluation and treatment facility for involuntary patients under LPS.

2. The licensed professional staff, or the physician providing emergency services in the hospital (in any department, not only the ED), must meet the following conditions for release of the 1799.111 hold:

a. The person has not been admitted to an acute or psychiatric hospital for evaluation and treatment under LPS (i.e., at a designated facility); and

b. The release from the hospital is authorized by a physician, or a staff clinical psychologist who has a collaborative treatment relationship with the physician, based on a face-to-face examination of the detained person and the examining physician or psychologist determines that the person does not present a danger to self or others or is gravely disabled.

3. If the release is authorized by a staff clinical psychologist, the psychologist must:

a. First consult with the physician; and

b. If there is a dispute, the detention must be continued unless the "hospital's medical director" overrules the physician opposing the release of the patient; and

c. The psychologist and the physician must document their findings, concerns or objections in the patient record.

C. What are the advantages and disadvantages of a Section 1799.111 hold?

In addition to the civil and criminal immunities provided in the law, the following are some of the perceived advantages of applying a 1799.111 hold:

1. There is no county involvement or oversight in the detention or release process.
2. The hold does not require the application or other paperwork for a 5150 hold, provided the findings are documented in the patient record.
3. A 1799.111 hold creates less of a stigma than a 5150 hold, since there is no required reporting to public agencies about a 1799.111 hold, and no legal consequences to the person for having been held under Section 1799.111 (such as weapon possession prohibition).
4. A 1799.111 hold may provide flexibility to a treating physician if he or she believes that the psychiatric condition may be transitory, and may be resolved or sufficiently mitigated within the 24-hour period.
5. The 1799.111 hold may be released at any time, without a designated professional, if there is no longer probable cause to detain the person.
6. A 1799.111 hold and release might also help in triggering authorization and payment for post-stabilization services.

The following are some of the perceived disadvantages of applying a 1799.111 hold:

1. The 1799.111 hold is limited to 24 hours, which may not be sufficient for a person whose psychiatric condition is more acute and for whom placement at a designated facility may take longer than 24 hours.
2. There is no legal authority to continue detention under Section 1799.111 after the expiration of the 24-hour period, or to re-start the detention process with a new evaluation and hold for a second 24-hour period.
3. It is uncertain whether a county-designated professional will come to the hospital to write a 5150 hold that begins upon or after the expiration of the 24-hour detention period.

4. If the placement of the person is arranged with a designated facility, some hospitals report that ambulance companies may be reluctant to transport the person without a subsequent 5150 hold to ensure involuntary detention of the person during the transfer.
5. In the absence of a judicial interpretation of Section 1799.111, there is some uncertainty as to the application and breadth of the immunity that is provided by the statute.

At least one county has indicated that it may be appropriate to detain a person under Section 1799.111 after a person has been held under a 5150 hold. In its November 2016 letter to county facilities, the Orange County Behavioral Health Services expressed the view that a 5150 written by a peace officer or a designated professional automatically lapses in a non-designated hospital if the officer or professional leaves the hospital. The letter indicates that while the 5150 may lapse, the hospital may consider a 1799.111 hold.

☞ **References:**

For additional information on the LPS process and Section 1799.111 holds, see chapter 3 of CHA's Mental Health Law Manual *or chapter 15 of CHA's* Consent Manual*.*

7 Obligations of Receiving Hospitals

I. Overview 7.1

II. Questions 7.2

A. When does EMTALA require a hospital to accept a transfer? 7.2

B. What are the lessons of the ***St. Anthony Hospital*** case with respect to accepting patient transfers? 7.2

C. Can a receiving hospital ask why a patient is being transferred? 7.3

D. When can a hospital refuse to accept a transfer? 7.4

E. Are there different standards for acceptance of a transfer of a patient who has a psychiatric emergency medical condition? 7.5

F. Can a hospital refuse a transfer if there are hospitals closer to the transferring hospital that can provide the required services? 7.5

G. Can a hospital place conditions on accepting a transfer? 7.6

H. What is the responsibility of an on-call physician to accept an emergency patient transfer? 7.7

I. Must a hospital accept an emergency patient whose condition is reported as "stable"? 7.8

J. Must a hospital accept the transfer of an emergency patient if the hospital does not meet nurse staffing standards? 7.8

K. How does a hospital handle prior authorization by managed care plans for acceptance and admission of plan enrollees? 7.9

L. Are transfers considered to be emergency department to emergency department? 7.10

M. Does the obligation to accept transfers apply during publicly declared emergencies? 7.10

N. What documentation on requested transfers should a hospital maintain? 7.10

III. Communication With Transferring Hospitals 7.10

A. Are there state laws requiring hospitals to accept patient transfers? 7.13

Health Maintenance Organizations (HMOs) 7.13

Counties 7.13

Medi-Cal 7.13

Other Payers 7.13

Liability 7.13

7 Obligations of Receiving Hospitals

I. OVERVIEW

A hospital with specialized capabilities or facilities may not refuse to accept an appropriate transfer of a patient with an unstabilized emergency medical condition (EMC) who requires specialized capabilities or facilities if the receiving hospital has the capacity to treat the patient. The receiving hospital obligation applies to all hospitals participating in Medicare, regardless of whether they provide emergency services. The EMTALA statute captions the accepting hospital obligation with the term "nondiscrimination," implying that receiving hospitals do not have the discretion to refuse a transfer request for an emergency patient with an unstabilized EMC except in specific circumstances *(see D. "When can a hospital refuse to accept a transfer?," page 7.4)*.

CMS has suggested that any Medicare participating hospital may be considered to have specialized capabilities or facilities if it has the capability and capacity to provide a service that the transferring hospital does not have the capability to perform. Under this view of EMTALA, virtually every hospital must consider itself a receiving hospital and accept appropriate transfers of emergency patients with unstabilized EMCs from other hospitals that do not have the capacity or capability to provide stabilizing treatment. The expansive nature of the accepting hospital obligation was reaffirmed by CMS in 2006 when it amended the EMTALA regulations to clarify that any hospital with specialized capabilities must accept an appropriate transfer, even if the hospital does not operate a dedicated emergency department.

Enforcement of EMTALA by CMS and by patients in litigation cases against receiving hospitals that refuse the acceptance of an appropriate transfer has become very common. In the *St. Anthony Hospital* case *(see page 7.2)*, a federal appeals court upheld the imposition of OIG sanctions against a hospital for failure to accept an emergency patient with an unstabilized EMC. A growing number of hospitals have been cited for refusal to accept a transfer (including some cases involving individuals whose EMCs were arguably stabilized prior to transfer). Therefore, hospitals need effective policies, periodic in-service training and effective oversight of personnel and physicians who respond to requests to accept emergency patient transfers.

NOTE: This chapter is limited to legal obligations with respect to accepting patient transfers under EMTALA. Hospitals should consider ethical, philosophical and industry standards, as well as managed care obligations and transfer agreements with other hospitals, in making decisions on transfers, whether or not implicated by EMTALA or other laws.

II. QUESTIONS

A. When does EMTALA require a hospital to accept a transfer?

When a hospital is asked to accept the transfer of an emergency patient, the hospital must accept the patient if all of the following conditions are met:

1. The patient has presented for, or is in need of, emergency services and care, and is currently in:
    a. An emergency department, including an observation unit of the transferring hospital,
    b. Another department of the transferring hospital that is a dedicated emergency department, such as labor and delivery, or
    c. Another location on hospital property that is a part of the transferring hospital.
2. The individual is not an inpatient. For EMTALA purposes, a patient who has been admitted to the transferring hospital, but is boarded in the emergency department pending the assignment to an available bed is considered an inpatient;
3. The individual has been determined by the treating physician (or other qualified professional) at the transferring hospital to have an EMC;
4. The EMC has not been stabilized in the clinical judgment of the treating physician or qualified professional;
5. The treating physician has determined that the hospital does not have the present capacity and/or capability to provide further examination or treatment that is required to stabilize the individual's EMC, or the individual has made an informed request for the transfer;
6. The transferring hospital has contacted a receiving hospital seeking to arrange the transfer of the individual who has an EMC that is not stabilized. The request may be made to any hospital that may be able to provide treatment necessary to stabilize the EMC. Specifically, there is no requirement that the transferring hospital must contact the closest available hospital or a facility that is aligned with the patient's insurance or economic status, such as a county hospital; and
7. The receiving hospital has the specialized services (i.e., the higher level of care) required by the individual, and the capacity and the capability to provide those services.

B. What are the lessons of the *St. Anthony Hospital* case with respect to accepting patient transfers?

In *St. Anthony Hospital v. U.S. Department of Health and Human Services*, 309 F.3d 680 (10th Cir. 2002), the 10th Circuit Court of Appeals reviewed an appeal by an Oklahoma hospital of an U.S. Department of Health and Human Services (HHS) administrative decision to impose civil money penalties for the hospital's refusal to accept an appropriate transfer of an emergency patient. The lessons from the case are instructive as to the views of the courts with respect to the receiving hospital obligation and the handling of requests to accept patient transfers.

In the case, the patient was a 65-year old victim of an automobile accident who suffered a neurological injury. Although the transferring hospital arranged for a transfer to a university medical center, the ambulance returned to the transferring facility due to the patient's deterioration. Upon re-examination, the emergency physician determined that the patient had an injury to his abdominal aorta, and required immediate surgery that could not be performed at the hospital. The physician contacted an air-ambulance service, but could not transfer the patient to the university medical center since it had two pending emergency surgeries. The physician then contacted the emergency physician at another hospital, who referred the call to the on-call thoracic and vascular surgeon. The on-call surgeon declined to accept the case, and the transferring hospital finally located a third hospital that accepted the patient.

Following CMS review, the OIG proposed to impose monetary sanctions for the refusal by the second hospital to accept the transfer. When the parties failed to settle the case, the OIG initiated an administrative proceeding. The administrative law judge (ALJ) confirmed the EMTALA violation and imposed a $25,000 sanction. On appeal, the Departmental Appeals Board (DAB) affirmed the ALJ's decision, and, on a cross-appeal by the OIG, increased the sanction to $35,000.

The defendant hospital then petitioned the 10th Circuit Court of Appeal to overturn the decision of DAB, citing numerous procedural and substantive objections to the DAB's actions, and challenging the findings regarding the patient's instability and the hospital's refusal of the transfer.

The following are among the interpretations and conclusions made by the court:

1. "Stability," as used in the medical profession, does not carry the same meaning as "stabilized" under EMTALA.
2. A request made by an emergency physician to a receiving hospital to accept a transfer is not required to be precise, as long as the statement generally indicates the desire to arrange a transfer.
3. Although the receiving hospital argued that its on-call surgeon was not authorized to refuse a transfer, it conceded that its emergency physician had authority to accept or refuse a transfer. Therefore, the hospital was liable when the emergency physician communicated the refusal of the on-call surgeon to accept the patient.
4. The transferring physician's judgment will be accorded weight in determining the stability of the patient:

> We note that as a practical matter, however, any hospital with specialized capabilities or facilities that refuses a request to transfer an unstabilized patient risks violating [EMTALA] to the extent that it chooses to second-guess the medical judgment of the transferring hospital.

C. Can a receiving hospital ask why a patient is being transferred?

In addition to determining the patient's condition and clinical needs, an accepting hospital should be able to inquire as to the medical reason(s) for the transfer. As discussed above, the *Interpretive Guidelines* permit a hospital to decline a "lateral transfer." If the receiving hospital believes that the transferring hospital is able to provide the level of service required for stabilizing the patient's EMC, the receiving hospital should be able to inquire as to the medical reason(s) for the transfer in order to determine whether it is a lateral transfer,

including asking about the beds, services, equipment or specialty physician coverage that may be available.

However, inquiries as to the capability of the sending hospital may be viewed as delaying or discouraging a necessary transfer, or as second-guessing the decision of the sending physician. If a transferring hospital indicates that it lacks the present capability or capacity to provide the stabilizing treatment required for the patient, the receiving hospital should accept the transfer (if it has the capacity and capability to do so) and make appropriate inquiries after the patient has arrived at the receiving facility about the capacity and capability of the transferring hospital at the time of transfer.

D. When can a hospital refuse to accept a transfer?

A receiving hospital may refuse to accept a transfer of an emergency patient with an EMC in five circumstances:

1. The patient is an inpatient at the transferring hospital;
2. The transferring hospital is not located in the United States (which, for EMTALA purposes, includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa and the Commonwealth of the Northern Mariana Islands);
3. The patient's EMC is stabilized (in other words, EMTALA does not apply to the transfer), as determined by the transferring physician. If a receiving hospital is asked to accept the transfer of an emergency patient whose condition is reported by the sending physician to be stabilized, but needs post-stabilization services at a facility providing a higher level of care, the receiving hospital should confirm with the transferring physician, and document, that the patient's condition is in fact stabilized. The hospital may then advise the transferring hospital that it is willing to admit and treat the patient subject to financial or insurance clearance, including obtaining prior authorization for the post-stabilization services. In addition, the hospital may be required to accept the patient if it has a legal or contractual obligation to do so, independent of its EMTALA obligations;
4. The receiving hospital does not have the present capacity or capability to provide the emergency medical services required for the patient. If the receiving hospital's specialized services are at capacity or otherwise unavailable, CMS will examine whether the receiving hospital has historically created additional capacity by opening additional beds, moving patients, calling in staff, etc., in order to admit patients in similar circumstances; or
5. The transferring hospital has the present capacity and capability to provide the emergency medical services required for the patient (i.e., the transferring hospital provides the same level of service as the receiving hospital at the time of the transfer). The *Interpretive Guidelines* state that EMTALA permits a receiving hospital to refuse a "lateral transfer" in some instances (although state law or contractual obligations may require the hospital to accept the patient). However, if a transferring hospital is operating beyond its capacity (e.g., there are no ICU beds available) or has an equipment malfunction, then a receiving hospital may be obligated to accept a transfer because the transferring hospital, at the time of the transfer, does not have an equivalent level of care as the receiving hospital.

The obligations of hospitals under California law to accept transfers in certain situations are discussed at the end of this chapter.

E. Are there different standards for acceptance of a transfer of a patient who has a psychiatric emergency medical condition?

As discussed in chapter 6, there is no distinction under the EMTALA rules between the transfer of an individual with a medical EMC or an individual with a psychiatric EMC. Some California counties have published guidance that attempts to limit the transfer of involuntary psychiatric patients to specified facilities; for example, guidance published in 2012 and again in 2014 by a California county stated that "[s]ending patients on an involuntary hold to hospitals not designated by [_____] County is illegal." However, the EMTALA regulations do not prohibit a transferring hospital from arranging an appropriate transfer of an individual with an unstabilized EMC, whether medical or psychiatric, to **any** facility that has the capacity and capability to stabilize the individual's EMC. This expressly permits a hospital to transfer an emergency department patient with an unstabilized psychiatric condition to any hospital within or outside of the county in which the sending hospital is located, as well as across state lines if necessary to find a facility that has the capacity and capability to stabilize the emergency psychiatric condition.

Conversely, a receiving hospital cannot refuse an appropriate transfer from an emergency department of an individual with an EMC, whether medical or psychiatric, if it has the capacity and capability to stabilize the individual's EMC. In some cases, a county behavioral health department or mental health plan may try to limit the number of admissions of involuntary patients at a contracting facility. However, if the contracting facility has the capability and capacity to stabilize a psychiatric patient's condition, it cannot decline the transfer due to the limitations imposed by the county or health plan. Similarly, it cannot refuse to accept EMTALA patients with unstabilized psychiatric conditions who are transferred across county lines.

F. Can a hospital refuse a transfer if there are hospitals closer to the transferring hospital that can provide the required services?

EMTALA does not permit a receiving hospital to refuse an emergency transfer because another receiving hospital is closer to the transferring hospital and can provide the higher level of care required for the patient.

Although EMTALA requires a receiving hospital to accept the appropriate transfer of an emergency patient with an unstabilized EMC, it does not require the transferring hospital to select the closest available hospital that provides the higher level of care required by the patient. Rather, EMTALA assumes that the transferring physician will exercise good faith professional judgment in selecting the receiving hospital. This should not preclude a receiving hospital at a lengthy distance from the transferring hospital to inquire of the transferring hospital as to the availability of a closer hospital, although it should be clearly communicated to the transferring hospital that the inquiry is made for informational purposes to understand the circumstances of the transfer, and not as a condition or barrier to acceptance of the transfer.

A hospital may also not refuse a transfer because the patient is from out of state, even if there is another receiving hospital closer to the transferring hospital. In an OIG settlement reported in the OIG Semiannual Report to Congress for Oct. 1, 2015 to March 31, 2016, the

University of Mississippi Medical Center (UMMC) allegedly failed to accept the appropriate transfer of a patient who needed specialized capabilities of the hospital to stabilize her emergency medical condition. UMMC refused the transfer request because of a UMMC policy that it would not accept the transfer of Louisiana residents. The OIG reported that UMMC entered into a $50,000 settlement agreement to resolve the alleged EMTALA violation.

G. Can a hospital place conditions on accepting a transfer?

In a 2007 CMS memorandum (S&C 07-20) subsequently incorporated into tag. no. A-2411/C-2411of the *Interpretive Guidelines* (included in Appendix C), CMS declared that placing conditions on the acceptance of transfers is disfavored by CMS, and will likely subject the receiving hospital to an EMTALA violation. In the memorandum, CMS reported that the EMTALA Technical Advisory Group had received testimony regarding situations where a hospital had refused to accept a transfer unless the transferring hospital used an air medical service owned by the receiving hospital for the transfer. As stated in the *Interpretive Guidelines*:

> A hospital with specialized capabilities or facilities that has the necessary capacity to treat an individual with an emergency medical condition may not condition or attempt to condition its acceptance of an appropriate transfer of an individual protected under EMTALA on the use of a particular mode of transport or transport service.

In addition, CMS has cautioned hospitals against patient delays or disparate treatment of patients based on financial or insurance status:

> If a managed care member comes to a hospital that offers emergency services, the hospital must provide the services required under the EMTALA statute without regard for the individual's insurance status or any prior authorization requirement of such insurance. This requirement applies equally to both referring and receiving (recipient) hospitals. Therefore, it may be a violation if the receiving hospital delays acceptance of an individual with an unstabilized EMC pending receipt or verification of financial information…

For instance, if there is evidence that the receiving hospital unreasonably delayed the treatment of certain individuals and expedited the treatment of other individuals, based on their ability to pay for the services or some other form of discrimination, then the receiving hospital may be in violation of EMTALA.

Hospitals have been sanctioned under EMTALA, including receiving fines, for requesting pre-admission deposits or limiting acceptance of transfers to patients residing in the same county as the receiving hospital. A request from the receiving hospital at the time of transfer for a payment guarantee will likely be considered a possible violation of EMTALA. In addition, requests to the transferring hospital to perform additional tests or arrange for an on-call consultation may constitute a violation if the transferring physician believes that there is an immediate need for the transfer or the request of the receiving facility will delay an appropriate transfer.

Some receiving hospitals have attempted to limit their acceptance of a patient with an EMC to the provision of the specialized services that necessitated the transfer. After the specialized services have been rendered and the patient is stable, the receiving hospital plans to return the patient to the transferring hospital for further inpatient care if safe to do so. These arrangements are often contained in transfer agreements between two hospitals that are signed outside the immediacy of accepting a transfer.

A "take-back" agreement should not be raised at the time of a request to accept a transfer. In view of the position taken by CMS in the memorandum, imposing a "take-back" condition at the time of a transfer request (in the absence of a prior arrangement in a transfer agreement between the two hospitals) may place the receiving hospital in jeopardy of an EMTALA violation if the transferring hospital rejects the condition and reports the receiving hospital for refusing the transfer in the absence of accepting the "take-back" condition.

Compliance Tip: It is strongly recommended that conditions for accepting a transfer not be made on an ad hoc basis at the time of a requested transfer because the discussions could delay an appropriate transfer of an emergency patient. Instead, arrangements should be handled in advance through transfer agreements between hospitals.

H. What is the responsibility of an on-call physician to accept an emergency patient transfer?

As described above, if a hospital requests the transfer of an emergency patient with an unstabilized EMC so that the patient can access a higher level of care, the receiving facility is obligated to accept the transfer unless it does not have the capacity to treat the patient. Under EMTALA, the receiving hospital must utilize its resources, including its medical staff, to evaluate and stabilize the patient.

By extension, a physician on call to the receiving hospital has the same obligation as the hospital to accept a patient with an unstabilized EMC and to come to the hospital to treat the patient. If an on-call physician is available to accept the transfer of an unstabilized emergency patient, the receiving hospital has the capability and capacity to treat the patient and the transfer is otherwise appropriate under the circumstances. A refusal by the on-call physician to accept the patient may result in an EMTALA violation by the hospital.

As discussed above, the on-call physician in the *St. Anthony Hospital* case refused to accept a patient transfer. Although the receiving hospital argued that its on-call surgeon was not authorized to refuse a transfer, it conceded that its emergency physician had authority to accept or refuse a transfer. Therefore, the hospital was liable for an EMTALA violation when the emergency physician communicated the refusal of the on-call surgeon to accept the patient. *(See chapter 11, "Physician On-Call Responsibilities," for additional guidance about on-call physician responsibilities.)*

Compliance Tip: Many hospitals have received an EMTALA sanction where, without their knowledge, an on-call physician refuses to accept an appropriate transfer. As discussed under III. "Communication With Transferring Hospitals," page 7.10, the hospital should implement measures to manage the transfer acceptance process, including communications between transferring facilities and the receiving hospital's on-call physicians. Hospitals should advise their coverage physicians that if they receive a call from a transferring hospital regarding a transfer, they should refer the transferring hospital to a designated person or office at the receiving hospital to confirm its capability and capacity to accept the patient.

I. Must a hospital accept an emergency patient whose condition is reported as "stable"?

As noted in the *St. Anthony Hospital* decision, "stability" as used in the medical profession does not carry the same meaning as "stabilized" under EMTALA. In the 2004 *Interpretive Guidelines*, CMS deleted the concept of "stable for transfer," stating instead that an EMC must be resolved before the condition is considered to be stabilized. As discussed in chapter 5, "Transferring or Discharging an Emergency Patient," and set forth in the *Interpretive Guidelines* in Appendix C, the transfer of a patient with an unresolved EMC who is nonetheless clinically stable for transfer requires compliance with the EMTALA standards for an appropriate transfer.

In communications between sending and receiving hospitals, facility personnel need to be clear as to whether the patient has an emergency medical condition that is "unstabilized." CMS has warned that the use of the word "stable" may be misinterpreted as suggesting that the emergency condition is "stabilized."

The concerns about using "stable" are illustrated in a 2013 guidance (Appendix X) issued by CMS. In the letter, CMS cautioned hospitals that "the statutory definition of an individual's EMC being 'stabilized' does not necessarily equate to an individual being clinically stable."

> The similarity of the terms "clinically stable" and "stabilized" appears to cause confusion among hospitals, practitioners and other hospital staff. It is not uncommon for practitioners to find that an individual has become "clinically stable," often understood to mean the normalization of the individual's vital signs, and then conclude that the hospital's EMTALA obligation has ended. However, if the EMC has not been stabilized, as that term is defined ... [by the EMTALA regulations], EMTALA continues to apply. For example, a patient diagnosed with appendicitis might have relatively normal vital signs, but is still in need of surgery, and therefore continues to have an EMC that has not been stabilized.
>
> Furthermore, many practitioners and some third-party payors seem to assume that if an individual can withstand the risk of a transfer, then that means the individual has been stabilized and the hospital's EMTALA obligation has ended. This also is not necessarily the case. This mistaken assumption can be reflected in the commonly used term "stable for transfer." "Stable for transfer" is not a term used in EMTALA, and it is not necessarily equivalent to the term "stabilized," as defined for EMTALA purposes. Use of this term can, therefore, be very misleading. [CMS Survey and Certification Memo No. 14-06 (Dec. 13, 2013)]

Because CMS considers the transfer of a patient with an unresolved EMC to implicate the EMTALA transfer requirements, it is likely that the receiving hospital has a corresponding obligation to accept the patient who requires a higher level of care than the transferring facility can provide. However, a receiving hospital does not have an EMTALA obligation to accept the transfer of an emergency patient who is stabilized (i.e., the emergency is resolved) unless the hospital has an independent legal or contractual obligation to accept the transfer.

J. Must a hospital accept the transfer of an emergency patient if the hospital does not meet nurse staffing standards?

The nurse staffing standards in California place a hospital in a Catch-22 situation when it has available beds but will not meet the staffing ratios if it accepts an emergency patient transfer. Does a hospital have "capacity" within the meaning of EMTALA to accept a critically

ill individual with an unresolved EMC if the admitting unit will not meet the staffing ratios; or, should (or must) the hospital refuse to accept the transfer?

As discussed in chapter 5, "Transferring or Discharging an Emergency Patient," the California Department of Public Health has not provided advice on compliance with the nurse staffing ratios and accepting emergency patient transfers. In the absence of guidance, the hospital must decide whether to accept the transfer of the patient (and possibly violate the nurse staffing ratios) or refuse the transfer on the basis of staffing constraints.

If the hospital accepts and admits the patient when it is out of compliance with staffing ratios, a surveyor may later cite the hospital under state law, which may subject the facility to fines or other sanctions under state and federal laws, as well as litigation by the patient if there is an adverse outcome. If the hospital declines the transfer, a surveyor may later review the admission patterns at the time of the transfer (were other patients admitted or transferred?) and the historical practices of the hospital in admitting or transferring patients in similar situations; the survey could result in an EMTALA violation, as well as potential litigation if there is an adverse outcome. Hospitals are therefore encouraged to discuss this subject with their legal counsel.

K. How does a hospital handle prior authorization by managed care plans for acceptance and admission of plan enrollees?

In the *Interpretive Guidelines*, CMS warns receiving hospitals that they may not delay acceptance of an emergency patient transfer pending verification of financial information. Therefore, if a receiving hospital is asked to accept the transfer of a health plan enrollee who has an unstabilized EMC and needs a higher level of care, the hospital should accept the patient if it has the capacity and capability to provide the services. The hospital should confirm the patient's condition with the transferring hospital or physician, and ensure that it obtains a copy of the physician's certification for the transfer. Following the admission of the patient at the receiving hospital, the hospital should seek authorization for services that will be required for the patient after he or she is stabilized.

If a receiving hospital is asked to accept the transfer of a health plan emergency patient whose condition is stabilized (i.e., the EMC is resolved), but needs post-stabilization services at a facility providing a higher level of care, the receiving hospital should confirm with the transferring hospital or physician that the patient's condition is stabilized. The hospital may then advise the transferring hospital that it is willing to admit and treat the patient subject to obtaining prior authorization for the post-stabilization services.

As discussed in chapter 4, "Financial Considerations — EMTALA and Managed Care," the transferring hospital may have an obligation to contact the health plan prior to sending an enrollee to a non-contract hospital for post-stabilization services. The receiving hospital should inform the transferring hospital that, if the patient's condition becomes unstable while it is seeking prior authorization, the transferring hospital should immediately call the receiving hospital to arrange for the transfer without waiting for the authorization.

This question is addressed in greater depth in chapter 4, "Financial Considerations — EMTALA and Managed Care."

L. Are transfers considered to be emergency department to emergency department?

The EMTALA regulations and *Interpretive Guidelines* specify that transfers are hospital-to-hospital. They do not specify the location at the receiving hospital to which a transfer patient must be routed following arrival at the receiving facility. Although a transferring physician may request an ICU bed or a specific clinical procedure for a patient, the internal routing of the patient at the receiving hospital is within the discretion of the receiving facility, so long as the routing practices are based on clinical considerations. In this regard, transfers may be made from an emergency department to another emergency department, or from an emergency department directly to an inpatient unit, surgery, catheterization laboratory, imaging department or other location within the hospital that meets the patient's needs.

M. Does the obligation to accept transfers apply during publicly declared emergencies?

As discussed in chapter 16, "Application of EMTALA to Disasters and Public Health Emergencies," the obligation to accept the transfer of individuals with EMCs is not subject to a waiver during local or national emergencies.

N. What documentation on requested transfers should a hospital maintain?

Hospitals should have policies and procedures for receiving inquiries from other hospitals, including documentation of calls, the names (if known) and conditions of patients, the outcomes of the calls and the reasons if the hospital refuses to accept the transfer. To avoid an inappropriate denial or delay of a transfer, the policies should also address the routing of transfer requests to personnel who are familiar with the EMTALA regulations.

Hospitals should routinely document inquiries from other hospitals regarding patient transfers. In the absence of documentation, a hospital has no record of being called or having refused a transfer; however, staff at the transferring hospital usually document in the patient medical record the times of all calls, the persons with whom they spoke and the outcome of the calls. The types of documentation are discussed below in the discussion on communication with transferring hospitals.

Compliance Tip: Hospitals should include the review of emergency transfer requests in their performance improvement and risk management programs. It is advisable that the quality management team review all denials of emergency transfer requests, and possible violations of EMTALA should be reported to risk management, compliance and administration.

III. COMMUNICATION WITH TRANSFERRING HOSPITALS

The growing capacity limitations of hospitals and the diminution of on-call coverage at many hospitals have increased the demands on many hospitals that typically act as receiving facilities. In addition, some hospitals have been cited by CMS for an EMTALA violation for failure to accept a patient transfer where there is a dispute over the clinical status of the patient, a communication error or a refusal by an on-call physician at the receiving hospital

to accept a transfer. Many receiving hospitals are therefore reviewing their procedures in order to manage their internal acceptance process (and their bed/service capacity) and the communications with transferring hospitals and physicians.

The following are some tips for managing the transfer acceptance process:

1. Review IV. "Communication With Receiving Hospitals," page 5.10, to gain a perspective on the process that transferring hospitals should follow in implementing a patient transfer.
2. Decide which department or unit of the hospital should handle requests for patient transfers. The complexity of the EMTALA rules, and the potential disruption and sanctions for an EMTALA violation, support centralization of the transfer acceptance process with trained personnel, transfer acceptance policies and forms for documentation. This does not mean that every receiving hospital must have a transfer center; rather, there should be a designated department or unit with acceptance policies and procedures and trained staff to handle requests for transfer.
3. Communicate to other hospitals in the area and to other facilities that commonly call requesting a transfer that the hospital has centralized all calls for a transfer to a specific department or unit. As applicable, the hospital should advise transferring hospitals of the telephone number for the department or unit that handles requests for patient transfers.
4. Advise other hospitals not to contact your on-call physicians before they have communicated with hospital staff and a determination has been made that the hospital has the capacity and capability to meet the needs of the patient.[1]
5. For all telephone calls seeking a transfer, follow a script and checklist for asking and recording basic information on a standardized patient transfer request form. A sample script and checklist is located in Appendix T, "Sample Transfer Checklist and Script for Accepting Emergency Patients."
6. Determine and document whether the request for a transfer is for an EMTALA or a non-EMTALA patient by asking the questions in Appendix T and recording the answers on the transfer request form.
7. If the answers to the questions in Appendix T indicate that the transfer is an appropriate transfer under EMTALA, the receiving hospital staff, before contacting an on-call physician, should review and document the receiving hospital's capacity and capability to accept the transfer and meet the patient's needs (see sample script and checklist in Appendix T, "Sample Transfer Checklist and Script for Accepting Emergency Patients").
8. If hospital staff confirms its capacity and capability to accept the transfer, the hospital should determine whether there is an appropriate on-call physician who is available to accept the patient and facilitate the direct communication between the on-call physician and the transferring physician. It is usually preferable for the

1 As an example, one hospital sent a flyer to all of its neighbor hospitals with the telephone number of its dedicated transfer line, and instructions that all hospital employees had been directed to refer all calls for potential transfers to the unit designated to handle transfers, and that all medical staff members would no longer accept or decline a transfer until the designated unit had processed the transfer request.

hospital staff to contact the on-call physician and advise him/her of the request and the hospital's capacity to accept the transfer, before the on-call physician contacts or is contacted by the transferring physician.

9. As necessary for the hospital and the on-call physician to determine the capacity and capability to accept the patient, the receiving hospital may request that the transferring hospital send portions of the patient medical record (in electronic or hard copy form) in order to evaluate whether it can meet the needs of the patient, so long as the request is:
    a. Not for financial or insurance information; and
    b. In the judgment of the transferring physician, the request does not unduly delay the decision-making process or likely result in further deterioration of the patient's condition.
10. If the on-call physician refuses a transfer for which he/she is available and qualified to accept, trigger the hospital's chain of command process to expedite a quick review and possible reversal of the decision. *(See also the discussion under A. "What if an on-call physician refuses to accept an emergency patient or fails to come to the hospital?," page 11.14.)*
11. DO NOT REQUEST THE FINANCIAL STATUS OR INSURANCE INFORMATION OF AN EMTALA PATIENT! This information may be obtained only after the receiving hospital has accepted the patient.
12. Do not place conditions on the transfer, including requests for the transferring hospital to perform more tests, use a specific mode of transport, or take the patient back after the stabilizing services are performed.
13. If the hospital has a transfer agreement with a transferring hospital, make sure the staff is aware of the transfer procedures. A transfer agreement may expedite the transfer process and avoid communication problems between hospitals.
14. If hospital staff believes that the transferring hospital or physician is not complying with the EMTALA obligations, or there is a dispute or a communication problem, request the opportunity to speak with the administrator-on-call at the transferring hospital to try to resolve the problem. If unsatisfied with the outcome, report the circumstances to administration, risk management or the compliance officer (or other designated staff position) to review the case and decide whether follow-up action is appropriate.
15. Document the outcome of a transfer acceptance, including the date and time of acceptance, the name of the accepting physician, the bed unit or other designation of the patient, the mode of transport and the expected time of arrival.
16. If the transfer is refused, document the reasons for the refusal.
17. Have a performance improvement process for evaluation of the transfer procedures, including review of denied transfers and the documentation of transfer communications.

A. Are there state laws requiring hospitals to accept patient transfers?

California law requires that hospitals with statutory or contractual obligations accept a covered patient or, if unable to do so, make appropriate arrangements for the patient's care.

Health Maintenance Organizations (HMOs)

A hospital under a statutory or contractual obligation to provide patient care (such as an HMO contract facility) must accept the patient to the extent required by the obligation or, if unable to accept due to a medical hazard, make alternate arrangements for patient care.

Counties

A county hospital must accept a patient whose transfer will not create a medical hazard and who is eligible for county public assistance, unless the county hospital lacks appropriate bed capacity, medical personnel or equipment. If unable to accept a patient, the county must make appropriate arrangements for patient care. However, the law does not set, alter or expand county indigent care obligations nor limit county flexibility to manage county health systems within available resources.

Medi-Cal

Welfare and Institutions Code Section 14087.10 requires a contract hospital to accept a Medi-Cal patient transfer from a non-contract hospital if the contract hospital has the capability and capacity to provide the services required by the beneficiary and has a physician with staff privileges who is willing to accept the patient. Hospitals should also review their Medi-Cal contract to determine if there are conditions placed on the hospital's obligation to accept Medi-Cal patient transfers.

Other Payers

Third party payers with statutory or contractual obligations to provide or indemnify emergency services shall be liable, to the extent of the contractual obligation, for the reasonable charges of the transferring hospital and the treating physicians. There are exceptions to this requirement based on provider and subscriber contracts, and county hospitals acting as the provider of last resort.

Liability

A hospital with a legal obligation to accept patient transfers that does not accept a transfer or make alternative arrangements for medically stable patients is liable for the reasonable charges of the transferring hospital and the treating physicians. This obligation does not include a county hospital acting as the provider of last resort.

☞ **References:**

42 C.F.R. Section 489.24(f) (Appendix B)

Interpretive Guidelines, tag no. A-2411/C-2411 (Appendix C)

Health and Safety Code Section 1317.2a (Appendix D)

8 Patient Refusal of Stabilizing Treatment or Transfer

I. Overview 8.1

A. Refusal of Examination and Treatment 8.1

B. Refusal to Accept Transfer 8.1

II. Questions 8.1

A. What are the requirements to obtain an informed refusal of treatment or transfer? 8.1

B. What should the hospital do if a patient withdraws his or her request for examination or leaves the hospital before receiving a medical screening? 8.2

Patient Elopes or Leaves Without Notice 8.3

Patient Gives Reason for Leaving 8.3

Patient Departs for Financial Reasons 8.4

Documentation of Risks and Benefits 8.4

C. Is a hospital liable for a potential EMTALA violation if a patient leaves the hospital after receiving a medical screening? 8.5

8 Patient Refusal of Stabilizing Treatment or Transfer

I. OVERVIEW

Under EMTALA, the patient retains the right to refuse further medical examination and stabilizing treatment, as well as a transfer to another facility.

A. Refusal of Examination and Treatment

A hospital is deemed to meet its EMTALA obligations to provide further medical examination and stabilizing treatment to a patient if:

1. The hospital offers the patient further medical examination and stabilizing treatment and informs the patient of the risks and benefits of the examination and treatment; but
2. The patient refuses to consent to the examination and treatment.

B. Refusal to Accept Transfer

A hospital is deemed to meet its obligations to transfer the patient to another facility if:

1. The hospital offers to transfer the patient to another medical facility, in accordance with EMTALA requirements for a transfer, and informs the patient of the risks and benefits of the transfer; but
2. The patient refuses to consent to the transfer.

II. QUESTIONS

A. What are the requirements to obtain an informed refusal of treatment or transfer?

If a patient refuses treatment or a transfer, the hospital must:

1. Explain to the patient the risks and benefits of the examination and treatment or transfer; and
2. Take all reasonable steps to secure the written informed refusal of the patient (or the person acting on the patient's behalf) to the examination and treatment or transfer.

A hospital must take all reasonable steps to secure the informed refusal of a patient (or a person acting on the patient's behalf). The refusal must be in writing; document that the patient was informed of the benefits of treatment or transfer, and state the reasons for the patient's refusal. As noted by CMS, a person acting on the patient's behalf cannot refuse examination, treatment or a transfer unless the patient is incapable of making an informed decision for himself or herself. The patient's medical record must contain a description of the proposed examination, treatment or transfer that was offered by the hospital but refused by the patient. If the individual refuses to sign an informed refusal, the hospital should document

the steps taken to secure a signed refusal. CHA has developed CHA Form 9-6, "Patient Refusal of Further Medical Treatment," which can be used for this purpose and is included in Appendix P.

In addition to the EMTALA requirements, hospitals should review CHA's Consent Manual for additional guidance and documentation for situations involving refusal of medical care. CHA has developed CHA Form 5-1, "Refusal to Permit Medical Treatment," which can be used for this purpose and is included in Appendix P.

☞ **References:**

42 C.F.R. Section 489.24(d)(3) and (5) (Appendix B)

Interpretive Guidelines tag no. A-2407/C-2407 (Appendix C)

B. What should the hospital do if a patient withdraws his or her request for examination or leaves the hospital before receiving a medical screening?

One of the most common areas of EMTALA enforcement is the patient who presents for treatment to a dedicated emergency department, but then leaves the hospital prior to receiving a medical screening examination (and sometimes, even before triage). In some cases, the patient tells a nurse or clerk that he or she feels better, and leaves the hospital. In other cases, the patient tells a nurse or clerk that he or she does not want to wait for the medical screening examination or that he or she will go elsewhere (to a primary care physician or another facility). In other cases, the patient simply elopes and is not in the waiting room when called for his or her medical screening examination.

In all of these cases, the patient has presented for emergency services, but has not received a medical screening examination. Without a medical examination, the patient cannot be said to be leaving against medical advice (AMA), since the hospital does not have sufficient medical information to inform the patient of the risks of leaving the hospital. However, the triage report often documents the presenting complaint, vital signs and other preliminary findings that provide regulators with information sufficient to speculate as to whether the patient had a potential emergency medical condition.

These types of cases have been the focus of EMTALA enforcement actions. Hospitals have been cited by CMS and subject to potential OIG sanctions for failing to provide a medical screening examination to a person presenting to the emergency department for emergency services. The lack of a medical screening examination and/or inadequate documentation of the patient's reasons for leaving puts the hospital at a severe disadvantage when later explaining the circumstances for the patient's departure and defending the speculation of the regulators as to the potential condition of the patient.

In the preamble to the Special Advisory Bulletin (see Appendix H), CMS and the OIG advise that hospitals should be very concerned about patients leaving without being screened, especially if due to waiting times:

> Since every patient who presents seeking emergency services is entitled to a medical screening examination, a hospital could violate the patient anti-dumping statute if it routinely keeps patients waiting so long that they leave without being seen, particularly if the hospital does not attempt to determine and document why individual patients are leaving, and reiterate to them that the hospital is prepared to provide a medical screening if they stay.

This advice reinforces the need for hospitals to monitor waiting times for emergency services and the rate of patient departures before the provision of the medical screening examination.

Compliance Tip: Hospitals should develop quality management measures to determine the reasons for patient departures, and implement actions as appropriate to reduce unacceptable rates of patient elopement. In addition, patient registration, reception and other emergency staff should receive periodic in-service reminders of the need to document 1) early patient departures and elopements, and 2) communication to patients offering the medical screening and encouraging patients to stay for their examination. For example, some hospitals have developed information sheets to hand to patients at triage informing them of the medical screening, encouraging patients to remain for their examination by the emergency physician, and urging them to inform the triage nurse or other emergency staff if they decide to leave the dedicated emergency department or other hospital location before they receive their medical screening.

Patient Elopes or Leaves Without Notice

If a patient elopes or leaves the hospital without advising personnel in the dedicated emergency department or other location as to his or her reasons for leaving, the hospital, to the best of its ability, should document the circumstances of the patient's departure. It is recommended that hospital personnel call the patient's name in the waiting area several times, and note the times in the medical record. If the patient does not respond, the medical record should include the time when hospital staff became aware of the departure and any other pertinent information related to the patient and his or her medical condition.

Some hospitals have initiated patient follow-up call programs where they telephone eloped patients within a few days after their emergency visits to inquire as to the reasons for leaving the hospital and their present medical status. This information has been used effectively by a hospital in responding to allegations of the quality improvement organization (QIO) that the hospital failed to provide medical screening examinations to a number of patients who allegedly may have had emergency medical conditions (based on triage data). Using the information derived from the follow-up calls, the hospital was able to demonstrate that the patients left the hospital for valid reasons (such as the patient felt better) and were in good health.

Patient Gives Reason for Leaving

If a patient advises the hospital that he or she is leaving prior to the medical screening, the hospital should make every effort to offer the patient the examination, encourage the patient to wait and, if unsuccessful, obtain from the patient the reasons for leaving the hospital. Some hospitals have developed forms for refusal of a medical screening examination. Regardless of whether the patient signs a form, the hospital should document the patient's reasons for leaving. The documentation should be sufficiently detailed to reply to a subsequent complaint from the patient or a licensing surveyor that the hospital refused or discouraged the patient from receiving a medical screening examination. The *Interpretive Guidelines* state that the medical record should reflect that the hospital offered to provide screening and treatment before the patient's refusal.

Patient Departs for Financial Reasons

One of the more difficult situations is handling the patient who leaves the hospital before the medical screening examination due to financial reasons. Often, a patient will ask hospital personnel how much his or her emergency services will cost or whether it accepts the patient's managed care plan, and then leave the hospital without receiving emergency services. CMS has repeatedly cautioned hospitals that discussing payment obligations when a patient is deciding on whether to accept or refuse treatment will be closely scrutinized to determine whether the hospital discouraged the patient from seeking further treatment. CMS has warned that hospitals "may not attempt to coerce individuals into making judgments against their interest by informing them that they will have to pay for their care if they remain but that their care will be free or at lower cost if they transfer to another hospital."

Compliance Tip: It is recommended that hospitals have clear guidelines for staff to handle these situations, and ensure, through in-service education and policies, that hospitals offer to provide emergency services, encourage the patient to stay and document the circumstances of and reasons for the patient's decision to decline further care.

Documentation of Risks and Benefits

Under the EMTALA regulations, a hospital must inform a patient of the risks and benefits of refusing further examination and treatment. The regulation applies this obligation to a refusal of the further examination and treatment rendered after a patient has received a medical screening examination.

If the patient withdraws his or her request for a medical screening before the examination has been performed, the hospital may not have sufficient medical information to describe the risks and benefits to the individual if he or she leaves the hospital. This is consistent with a statement by CMS and OIG in the Special Advisory Bulletin that prior to performing the medical screening examination, a hospital is "ill-informed" to advise a health plan of the patient's condition. The rationale for this position is that prior to receiving a medical screening, the patient has not been examined by a qualified professional who has obtained the requisite clinical knowledge to advise a health plan of the patient's medical status. If a hospital is "ill-informed" to advise a managed care plan of a patient's condition, then it should be equally "ill-informed" to advise the patient of the risks and benefits of withdrawing a request for a medical screening examination.

However, this interpretation of EMTALA is not necessarily held by CMS and the OIG. A number of hospitals have been cited by these agencies for their failure to inform a patient withdrawing a request for the medical screening of the risks and benefits of leaving the hospital prior to his or her examination. Regardless of what action a hospital takes with respect to a patient who withdraws his or her request for the medical screening prior to the performance of the examination, hospitals should take (and document) every step taken to offer and encourage the patient to remain for his or her medical screening examination.

☞ **References:**

42 C.F.R. Section 489.24(c)(2) and (4) (Appendix B)

Interpretive Guidelines, tag nos. A-2407/C-2407 and A-2409/C-2409 (Appendix C)

Health and Safety Code Section 1317.3(d) (Appendix D)

Special Advisory Bulletin (Appendix H)

C. Is a hospital liable for a potential EMTALA violation if a patient leaves the hospital after receiving a medical screening?

As discussed in this chapter, patients (and their representatives) have the right to refuse stabilizing treatment or other emergency services. If the patient has received a medical screening that reveals the presence of an emergency medical condition (EMC), the hospital is obligated to obtain an informed refusal if the patient refuses further examination and treatment that may stabilize the EMC.

In the *Interpretive Guidelines*, CMS specifies the circumstances that will not constitute an EMTALA violation when a patient leaves the hospital after the medical screening examination identifies the presence of an EMC without receiving further evaluation or stabilizing treatment:

If a screening examination reveals an EMC and the individual is told to wait for treatment, but the individual leaves the hospital, the hospital did not violate EMTALA unless one of the following situations applies to the departure:

1. The individual left the emergency department based on a "suggestion" by the hospital; or
2. The individual's condition was an emergency, but the hospital was operating beyond its capacity and did not attempt to transfer the individual to another facility.

However, if an individual leaves a hospital Against Medical Advice (AMA) or Left Without Being Seen (LWBS), on his or her own free will (no coercion or suggestion by the hospital), the hospital is not in violation of EMTALA.

☞ **References:**

42 C.F.R. Section 489.24(c)(2) and (4) (Appendix B)

Interpretive Guidelines, tag nos. A-2406/C-2406, A-2407/C-2407 and A-2409/C-2409 (Appendix C)

9 Maintenance of the Central Log

I. Overview 9.1

II. Questions 9.1

A. What information must be contained in the central log? 9.1

B. Can a hospital maintain separate logs? 9.2

C. Which patients must be recorded in the central log? 9.2

D. Are off-campus departments required to maintain a central log? 9.2

E. When must entries in the central log be completed? 9.3

9 Maintenance of the Central Log

I. OVERVIEW

Every hospital must maintain a central log as a condition of its Medicare provider agreement. The central log must record the names of all individuals who come to the dedicated emergency department. As described in chapter 2, "When and Where Does EMTALA Begin and End?" EMTALA applies to a person:

1. Who presents to a dedicated emergency department (on- or off-campus) seeking or needing examination or treatment for a medical condition;
2. Who presents to a location on hospital property outside of a dedicated emergency department seeking or needing examination or treatment for what may be an emergency medical condition;
3. In a hospital-owned ambulance under hospital direction; or
4. In a nonhospital-owned ambulance on hospital property.

Hospitals in California must also maintain an "emergency room log" in accordance with licensing requirements for a basic, comprehensive or standby emergency medical service.

The central log is the primary resource used by the licensing surveyors to verify the names of persons who have come to a hospital for emergency services, and to select patient medical records for review during EMTALA compliance surveys.

Compliance Tip: The failure to enter patient information or maintain the central log is grounds for an EMTALA violation and the termination of the hospital's Medicare provider agreement. Hospitals should have quality assurance/performance improvement measures in place to ensure that the required information is recorded in the central log, especially patient disposition for patients who presented to the emergency department but were admitted or treated and discharged from other areas of the hospital.

II. QUESTIONS

A. What information must be contained in the central log?

The central log must list the name of each person who comes to the dedicated emergency department (as described above). The log must also state whether a patient:

1. Refused treatment;
2. Was refused treatment by the hospital;

3. Was transferred;
4. Was admitted and treated;
5. Was stabilized and transferred; or
6. Was discharged.

The emergency room log required by California licensing regulations must include, at a minimum:

1. The name of the patient;
2. The date, time and means of arrival;
3. The age and sex of the patient;
4. The record number of the patient;
5. The nature of the presenting complaint;
6. The disposition of the patient; and
7. The time of departure.

The emergency room log must also include information on persons who are dead upon arrival to the emergency department.

A hospital may include additional information in the log as it deems appropriate.

B. Can a hospital maintain separate logs?

A hospital may maintain separate logs in each dedicated emergency department or other location that maintains a central log. Although there is no requirement that completed logs must be filed in a central location, hospitals should consider filing the completed logs in the medical records department for quick retrieval in the event of an EMTALA enforcement survey. The *Interpretive Guidelines* permit the central log to be maintained in an electronic format.

C. Which patients must be recorded in the central log?

The central log should be maintained for all patients who present to the hospital (including all on-campus or off-campus dedicated emergency departments) or other locations on the hospital property for services that are covered by EMTALA. Even if a patient leaves before triage or a medical screening examination, his or her name should be recorded in the central log. At a minimum, every dedicated emergency department of the hospital should maintain a central log. These departments include the emergency department, labor and delivery service, psychiatric service, urgent care center and other ambulatory departments that meet the definition of a dedicated emergency department *(see chapter 2, "When and Where Does EMTALA Begin and End?")*.

D. Are off-campus departments required to maintain a central log?

The 2003 revisions to the EMTALA regulations eliminated the need for an off-campus hospital department to maintain a central log unless the department is a dedicated emergency department. However, off-campus departments operated by a hospital, other than dedicated emergency departments, are required to provide appraisal and referral services to individuals with emergencies under the Medicare Conditions of Participation.

Compliance Tip: It is recommended that the policies and procedures for these off-site outpatient departments include documentation of the names and disposition of individuals in crisis who present to these departments seeking emergency assistance.

E. When must entries in the central log be completed?

The EMTALA regulations and the *Interpretive Guidelines* do not prescribe time limits for the completion of central log entries. However, some hospitals have been cited for not completing their central log entries in a timely fashion. Therefore, each hospital should establish policies for completion of log entries. CMS Region IX has recommended that all log entries be completed within approximately 48 hours of patient discharge from the department maintaining the log. Hospitals should establish procedures to verify the timely completion of log entries.

☞ **References:**

42 C.F.R. Section 489.20(r)(3) (Appendix B)

Interpretive Guidelines, tag no. A-2405/C-2405 (Appendix C)

Title 22, California Code of Regulations, Sections 70413(h), 70453(h) and 70651(h)

10 Required Signage

I. Overview 10.1

II. Requirements 10.1

III. Posters About Opioids and Pain Management 10.4

10 **Required Signage**

I. OVERVIEW

Hospitals must post conspicuous signs in the dedicated emergency department (on- and off-campus) and other places in which emergency patients may present (such as the entrance, waiting rooms, admitting area and treatment rooms). These signs must state the rights of individuals under EMTALA to examination and treatment for emergency medical conditions and women in labor, and whether the hospital participates in the Medicaid program. Posting of signs is not required in off-campus departments that are not dedicated emergency departments.

II. REQUIREMENTS

The Centers for Medicare & Medicaid Services (CMS) has listed the following requirements for EMTALA signage *(see extract from the preamble to the 1994 EMTALA regulations at the end of this chapter)*:

1. Signs must specify the rights of unstable individuals with emergency conditions and women in labor who come to the dedicated emergency department for health care services;
2. Signs must indicate whether the facility participates in the Medicaid program;
3. The wording of the signs must be clear and in simple terms understandable by the population served;
4. Signs must be printed in English and other major languages that are common to the population of the hospital service area;
5. The letters within the signs must be clearly readable at a distance of at least 20 feet, or from the expected vantage point of dedicated emergency department patrons; and
6. Signage must be posted in a place or places likely to be noticed by all individuals entering the dedicated emergency department, as well as those individuals waiting for examination and treatment (e.g., entrance, admitting area, waiting room, treatment area).

Some states have adopted additional requirements for signage relating to emergency care. For example, California law requires that signs list the name, address and telephone number of the district office of the California Department of Public Health, Licensing and Certification Division.

In the preamble to the final 1994 EMTALA regulations, CMS suggested the following model language for the EMTALA signage *(see extract from 1994 EMTALA regulations on page 10.3)*:

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;
- Necessary stabilizing treatment (including treatment for an unborn child);
- And, if necessary, an appropriate transfer to another facility even if you cannot pay, you do not have medical insurance or you are not entitled to Medicare or Medicaid.

This hospital [does/does not] participate in the Medicaid program.

[Add local address and telephone number for the district office of the Department of Public Health, Licensing and Certification.]

Hospitals are permitted to add other information to the signs. However, signs or other information that are viewed by CMS as discouraging patients from using the dedicated emergency department may result in an EMTALA violation.

California law also requires all hospitals providing licensed perinatal services to post a written notice in the obstetrical admitting area stating that the hospital does not maintain practices that result in different standards of obstetrical care based upon a patient's source of payment or ability to pay for medical services. The notice must be posted in the predominant language or languages spoken in the service area of the hospital. CHA has adopted model signage for complying with the law; the model signage is set forth in Appendix P under "Obstetrical Care Notice."

☞ **References:**

42 C.F.R. Section 489.20(q) (Appendix B)

59 Fed. Reg. 32086 (June 22, 1994)

Interpretive Guidelines, tag no. A-2402/C-2402 (Appendix C)

Health and Safety Code Sections 1256.2(a) and 1317.3(d) (Appendix D)

EXTRACT FROM PREAMBLE TO 1994 EMTALA REGULATIONS

Appendix II — Posting of Signs

Section 6018(a)(2) of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89), effective July 1, 1990, requires hospitals and rural primary care hospitals with emergency departments to post signs which specify the rights (under section 1867 of the Social Security Act) of women in labor and individuals with emergency medical conditions to examination and treatment.

To comply with these requirements:

- At a minimum, the sign must specify the rights of unstable individuals with emergency conditions and women in labor who come to the emergency department for health care services;
- It must indicate whether the facility participates in the Medicaid program;
- The wording of the sign must be clear and in simple terms understandable by the population serviced.
- Print the signs in English and other major languages that are common to the population of the area serviced;
- The letters within the signs must be clearly readable at a distance of at least 20 feet or the expected vantage point of the emergency department patrons; and
- Post signs in a place or places likely to be noticed by all individuals entering the emergency department, as well as those individuals waiting for examina- tion and treatment (e.g., entrance, admitting area, waiting room, treatment area).

The sample on the following page, which may be adapted for your use, contains sufficient information to satisfy these requirements. It does not, however, satisfy the visibility requirement.

Appendix III — 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.
- Necessary Stabilizing Treatment (including treatment for an unborn child) and if necessary.
- An appropriate Transfer to another facility even if you cannot pay or do not have medical insurance or you are not entitled to Medicare or Medicaid.

This hospital [does/does not] participate in the Medicaid program.

59 Fed. Reg. 32086 *et seq.* (June 22, 1994)

III. POSTERS ABOUT OPIOIDS AND PAIN MANAGEMENT

The Centers for Disease Control and Prevention (CDC) and the Centers for Medicare & Medicaid Services (CMS) have developed a poster about pain management and opioids called "Safer, More Effective Pain Management." In addition, CDC and the American Hospital Association (AHA) have developed a poster called "Prescription Opioids: What You Need to Know." Hospitals and other health care providers may post these signs in areas that patients are likely to see them, including emergency department waiting areas. CMS has confirmed that posting these signs will not be considered an EMTALA violation (even if some patients may read them and be discouraged from accessing services). The CDC/CMS poster may be found at https://www.cdc.gov/drugoverdose/pdf/Original-PatientPoster-Digital.pdf, and the CDC/AHA poster may be found at http://www.aha.org/content/16/opiodneedtoknow.pdf. Posting these notices is completely voluntary.[1]

1 Email from David R. Wright, Director, Survey and Certification Group, Center for Clinical Standards and Quality, Centers for Medicare & Medicaid Services to Karen Reeves, Vice President, Risk Management and Accreditation, South Carolina Hospital Association, Nov. 7, 2017.

11 Physician On-Call Responsibilities

I. Overview 11.1

II. General Questions Relating to On-Call Rosters 11.2

A. Do the on-call requirements apply to receiving hospitals? 11.2

B. What specialties must be on call to a hospital? 11.2

C. Must all specialties be on call at all times? 11.3

D. Are there special rules for critical access hospitals? 11.4

E. Can the medical staff exempt senior physicians from on-call coverage? .. 11.5

F. What are the requirements when there is no on-call coverage? 11.5

G. Who establishes the scope of on-call coverage? 11.5

H. Can a physician group be listed on the on-call roster? 11.6

III. Responding to Call 11.6

A. When is a physician on call? 11.6

B. If called by the emergency physician, when must an on-call physician respond? 11.7

C. Is a physician who is on call for his or her own patients also on call to a dedicated emergency department? 11.7

D. Can a physician schedule elective surgery while on call? 11.8

E. Can an on-call physician request a hospital to transfer a patient to another facility where the on-call physician will attend the patient? 11.8

IV. Shared Call or Community Call Plans 11.9

A. Can two hospitals share on-call coverage for a particular specialty? 11.9

B. Can a hospital satisfy its on-call obligations through participation in a community call plan? 11.9

C. Does CMS mandate a single way to organize a CCP? 11.10

D. What is the role of the local EMS agency in a CCP? 11.11

E. Does participation in a CCP require an on-call physician to travel to the hospital at which an individual presents? 11.11

F. Does a CCP affect the accepting hospital obligations? 11.11

G. What are the requirements for the annual assessment of the CCP? 11.12

H. Does participation in a CCP raise antitrust issues? 11.12

V. Other Questions 11.12

A. Can an on-call physician respond to a call by sending a qualified professional other than a physician to the emergency department? 11.12

B. Can an on-call physician respond to a call using telemedicine services? 11.13

C. What is the responsibility of an on-call physician to accept an emergency patient transfer? 11.14

VI. Response to an On-Call Failure or Refusal to Come to the Hospital 11.14

A. What if an on-call physician refuses to accept an emergency patient or fails to come to the hospital? 11.14

11 Physician On-Call Responsibilities

I. OVERVIEW

Under EMTALA, a hospital with a dedicated emergency department must maintain a list of physicians who are on call to come to the hospital and provide treatment necessary to stabilize an individual with an emergency medical condition (EMC). Some states, such as California, also have licensing regulations requiring emergency departments to have on-call rosters.

The on-call list must meet the needs of emergency patients in accordance with the resources available to the hospital, including the availability of on-call physicians. The on-call physicians are considered resources available to a dedicated emergency department that must be used to provide emergency services for an individual who has or may have an EMC. Under the *Interpretive Guidelines*, a hospital is expected to know "prospectively" the identity of its on-call physicians. CMS has also published separate guidance for on-call coverage of critical access hospitals *(see Appendix Y, discussed under D. "Are there special rules for critical access hospitals?," page 11.4)*.

The *Interpretive Guidelines* identify three "permitted on-call options" for meeting the coverage obligations:

1. Coverage physicians may perform elective surgery or other procedures during the period that they are on-call.
2. Simultaneous call, i.e., a physician may be on-call at the same time at two or more hospitals; and
3. Participation in a formal community call plan that meets certain regulatory criteria.

Some states have also adopted regulations that address the requirements for on-call coverage. For example, California law requires hospitals with licensed emergency departments to maintain on-call rosters and have full-time coverage of certain clinical specialties. Additional state requirements apply to hospitals with base-station and trauma designation status. Physicians who serve on call must provide emergency services without regard to a person's race, color, ethnicity, religion, national origin, ancestry, citizenship, age, sex, genetic information, marital status, sexual orientation, pre-existing medical condition, physical or mental disability, insurance status, economic status, ability to pay and other categories protected by state law, except where age, sex, pre-existing medical condition or physical or mental disability is medically significant to the provision of appropriate medical care to the patient.

There have been a number of studies and reports regarding on-call coverage and the changes in physician willingness to accept call obligations. One of the most comprehensive reports was published in 2003 by the California Senate Office of Research with the input of a large, multi-disciplinary task force of physicians, hospitals, health plans, government

agencies, consumers and others interested in emergency services. The report, "Stretched Thin: Growing Gaps in California's Emergency Room Backup System," is available at http://sor.senate.ca.gov/sites/sor.senate.ca.gov/files/Stretched%20Thin.pdf.

NOTE: This chapter does not address payment arrangements with physicians for on-call coverage. To date, the Office of Inspector General (OIG) has issued three Advisory Opinions addressing payment to physicians for on-call coverage. The first was issued on Sept. 20, 2007 (Advisory Opinion 07-10); the second was issued on May 14, 2009 (Advisory Opinion 09-05); and the third was issued on Oct. 30, 2012 (Advisory Opinion 12-15, Modification to Advisory Opinion 12-15). The opinions are posted on the OIG website (http://oig.hhs.gov). Hospitals should consult with their legal counsel to discuss the legal issues surrounding payment arrangements with physicians for on-call coverage.

II. GENERAL QUESTIONS RELATING TO ON-CALL ROSTERS

A. Do the on-call requirements apply to receiving hospitals?

The EMTALA regulations require an on-call list of physicians who are available to provide stabilizing treatment after the initial medical screening of an individual with an EMC. In the 2009 *Interpretive Guidelines*, the Centers for Medicare & Medicaid Services (CMS) states that the on-call obligations apply not only to hospitals with dedicated emergency departments, but also to hospitals that must accept appropriate transfers of individuals with EMCs. Effective in 2017, the EMTALA civil money penalties and exclusion regulations were revised to clarify that an on-call physician subject to sanctions includes not only a physician on-call to the treating hospital, but also a physician on-call to a receiving hospital that is requested to accept an appropriate transfer.

☞ **References:**

42 C.F.R. Sections 489.20(r)(2) and 489.24(j) (Appendix B)

Interpretive Guidelines, tag no. A-2404/C-2404 (Appendix C)

B. What specialties must be on call to a hospital?

Under EMTALA, if a hospital offers a service to the public, the service should be available to patients through on-call coverage of the hospital's dedicated emergency department(s). CMS has declined, however, to require that every medical and surgical specialty represented on the hospital medical staff have a call schedule. Under the EMTALA regulations, CMS requires that all hospital departments that are dedicated emergency departments, including labor and delivery, psychiatric services and urgent care centers, should have on-call coverage.

States may impose additional requirements for on-call coverage. For example, in California:

1. The hospital licensing regulations require hospitals providing basic 24-hour emergency services to provide on-call coverage for the basic services required for licensure (i.e., radiology, general surgery, pathology, anesthesia and general medicine) and for supplemental services listed on the hospital license (e.g., psychiatry, pediatrics and obstetrics).
2. There are additional on-call requirements for trauma facilities and for hospitals that have contractual arrangements to provide on-call coverage.
3. Hospitals operating standby emergency services are required to have a physician

on-call at all times to respond within a reasonable time relative to the patient's illness or injury.

4. Basic, comprehensive and standby emergency services are all required to maintain a roster of specialty physicians who are available for consultation at all times. The failure to maintain a roster of on-call physicians has, in least one instance, been held by the California Department of Public Health (CDPH) to constitute "immediate jeopardy," for which administrative sanctions may be imposed.

5. An acute psychiatric hospital is required to have a psychiatrist available at all times for psychiatric emergencies.

☞ **References:**

42 C.F.R. Sections 489.20(r)(2) and 489.24(j) (Appendix B)

Interpretive Guidelines, tag no. A-2404/C-2404 (Appendix C)

Title 22, California Code of Regulations, Sections 70225(b), 70235(c), 70245(b), 70255(c), 70455(a)(3), 70413(l)(3) and (4), 70415(a)(3), 70577(d)(3), 70653(a)(4) and 71203(a)(1)(B); trauma hospitals should also review the state trauma rules and designation agreements for the extent of required specialty coverage

C. Must all specialties be on call at all times?

The *Interpretive Guidelines* state that hospitals "should strive to provide adequate on-call coverage consistent with the services provided at the hospital and the resources the hospital has available, including the availability of specialists. There is no requirement under the EMTALA regulations that all of the hospital's clinical specialties be listed on the on-call roster at all times. CMS has explained that it has not set requirements on how frequently physicians are expected to provide on-call coverage. Therefore, except for more extensive requirements under state law (such as full-time on-call coverage for certain professional services that is discussed immediately above), coverage for other specialties that are represented on the hospital medical staff may be full-time or part-time.

There is no bright-line test under EMTALA for determining when coverage must be full-time for specialties that are not required to have full-time coverage under state law or other contractual obligations. CMS has explicitly rejected the long-standing misconception that call coverage must be full-time if there are three or more physicians in a particular specialty.

Under EMTALA, there are no fixed standards for part-time coverage, including the frequency of coverage by an individual physician (such as three to five days per month) or the periodicity of coverage (consecutive days, weekdays or weekends). These decisions are delegated to each hospital and its medical staff. However, the EMTALA regulations require a hospital to have written policies and procedures for handling emergency patients when a particular specialty is not available.

As noted above, the primary guidance for on-call coverage is that coverage should be consistent with the hospital's services and resources, including the availability of on-call physicians.

In the *Interpretive Guidelines*, CMS lists the following factors that hospitals may consider in establishing the frequency of on-call coverage:

1. The number of physicians on the medical staff in a specialty;
2. Other demands on staff physicians (such as patient care obligations, conferences, vacations, days off and similar factors);
3. The frequency with which the hospital's patients typically require the services of on-call physicians (for example, a hospital should consider the predictable demand for specialty services, such as orthopedic or cardiac emergencies, when scheduling its on-call specialists); and
4. The provisions that a hospital has made for situations when on-call coverage is unavailable or the physician on-call is unable to respond due to circumstances beyond his or her control.

Other factors that should be considered are the representations made by the hospital on its website and in its promotional and educational materials that describe the availability of services at the hospital (especially statements that a particular service is available at all times).

In addition, in at least one instance, CMS validated an EMTALA violation for failure to provide full-time coverage of a specific clinical specialty based on the review of the hospital's on-call coverage contracts with specialists on the medical staff. In the statement of deficiencies, CMS noted that the contract provided that the on-call physicians would accept call on a basis that was sufficient to ensure coverage for the specialty seven days a week, including holidays.

CMS provides another example in the *Interpretive Guidelines* for assessing the adequacy of on-call coverage:

> For instance, if the hospital under investigation performs a significant amount of interventional cardiac catheterizations and holds itself out to the public through various advertising methods as a center of excellence in providing this specialized procedure to the community, it would be reasonable to expect that there would be adequate on-call coverage by a physician who is able to perform an emergent interventional cardiac procedure on individuals who present to that hospital's DED in need of such an intervention or who are appropriately transferred to that hospital for such an intervention.

☞ **References:**

42 C.F.R. Sections 489.20)(r)(2) and 489.24(j) (Appendix B)

Interpretive Guidelines, tag no. A-2404/C-2404 (Appendix C)

D. Are there special rules for critical access hospitals?

Critical Access Hospitals (CAHs) have greater flexibility for maintaining on-call coverage. Under the Medicare Conditions of Participation (CoP) for a CAH, a physician, PA, NP or a clinical nurse specialist with training or experience in emergency care must be immediately available by telephone or radio, and available on-site within 30 minutes (60 minutes in a frontier area that meets certain conditions). While the CAH is required to have an on-call roster reasonably related to its services and medical staff members, this does not require that the staff physicians must be on-call and available to respond in person at all times, including every case involving an individual with an emergency medical condition.

The CAH CoPs require that a physician must be immediately available by telephone or radio contact on a continuous basis to receive emergency calls, provide information on the treatment of emergency patients, and refer patients. CMS guidance issued in 2013 (Appendix Y) indicates that this requirement may be met by a staff physician or a telemedicine physician. CMS does not require that a telemedicine physician must be listed on the on-call roster; in fact, CMS states that it is not advisable to do so.

However, state laws for emergency services, such as standby emergency services in California, may require that a physician be available at all times to come to the hospital.

☞ **References:**

CMS Survey and Certification Memorandum 13-38: Critical Access Hospital Emergency Services and Telemedicine (June 7, 2013) (Appendix Y)

E. Can the medical staff exempt senior physicians from on-call coverage?

The responsibility to maintain on-call coverage is vested in the hospital and its medical staff. In the *Interpretive Guidelines*, CMS states that exempting senior staff from on-call obligations would not be viewed as an automatic violation of EMTALA. However, CMS cautions that any exemptions of staff physicians should not adversely affect patient care.

☞ **Reference:**

Interpretive Guidelines, tag no. A-2404/C-2404 (Appendix C)

F. What are the requirements when there is no on-call coverage?

The EMTALA regulations require that a hospital must have policies and procedures for times when a specialty is not available or the on-call specialist cannot respond because of circumstances beyond his or her control (such as attending other emergency patients). CMS has stated that hospitals and their medical staffs should have flexibility to develop back-up plans, with the following guidance:

> The policies and procedures must also ensure that the hospital provides emergency services that meet the needs of an individual with an EMC if the hospital chooses to employ any of the on-call options permitted under the regulations…In other words, there must be a back-up plan to these optional arrangements. For instance, some hospitals may employ the use of "jeopardy" or back-up schedules to be used under extreme circumstances. The hospital must be able to demonstrate that hospital staff is aware of and able to execute the back-up procedures.

☞ **References:**

42 C.F.R. Sections 489.20(r)(2) and 489.24(j) (Appendix B)

Interpretive Guidelines, tag no. A-2404/C-2404 (Appendix C)

G. Who establishes the scope of on-call coverage?

Hospitals have the ultimate responsibility for ensuring adequate on-call coverage. Therefore, each hospital and its medical staff must determine how it will meet its on-call obligations. It is recommended that the medical staff bylaws or rules and regulations define the responsibility of on-call physicians to respond, examine and treat patients with EMCs.

There is no federal or state obligation requiring a physician to serve on-call as a Condition of Participation in the Medicare program or of state licensure. EMTALA requires hospitals to provide on-call coverage, but does not mandate that all physicians must serve on specialty call panels. Similarly, California law mandates hospital treatment of emergency patients, but expressly states "nothing in this [law] shall be construed as requiring that any physician serve on an 'on-call' basis."

☞ **References:**

Interpretive Guidelines, tag no. A-2404/C-2404 (Appendix B)

Health and Safety Code Section 1317.3(c) (Appendix D)

H. Can a physician group be listed on the on-call roster?

In the *Interpretive Guidelines*, CMS states that the names of individual physicians must be listed on the call roster with accurate contact information. As a result, listing the name of a medical group is considered an unacceptable practice for identifying the physician responsible for on-call coverage.

☞ **Reference:**

Interpretive Guidelines, tag no. A-2404/C-2404 (Appendix C)

III. RESPONDING TO CALL

A. When is a physician on call?

Under EMTALA, a physician is considered on call when he or she is listed on the on-call roster of the dedicated emergency department so the emergency department is prospectively aware of the physician's availability to come to the emergency department. The requirement that the dedicated emergency department must be prospectively aware of which physicians are on call means that a medical specialty or medical group cannot simply list all of its members and request that the emergency physician call the members in order to find an available physician when needed.

> In the past, CMS has indicated that it will look at how a hospital meets its on-call responsibilities not only by a review of the on-call roster, but also by the past practices of the physicians who are on call or "available" to the hospital. In the preamble to the 2003 regulations, CMS reiterated that the practice of refusing to be listed on the on-call roster, but taking calls selectively (for example, based on insurance status), "would clearly be a violation of EMTALA" [68 Fed. Reg. 53255]. This policy is reinforced in Interpretive Guidelines. However, if a hospital permits physicians to selectively take call only for their own established patients who present to the ED for evaluation, then the hospital must be careful to assure that it maintains adequate on-call services, and that the selective call policy is not a substitute for the on-call services required by the Medicare provider agreement.

If a physician has a de facto pattern of accepting on-call responsibilities, an enforcement agency may determine that his or her conduct is tantamount to being on call and hold the hospital responsible for permitting a coverage physician to refuse acceptance of an emergency patient or failing to come to the hospital when requested to do so by an emergency physician.

One of the continuing issues of on-call coverage is whether a physician must respond to the request of an emergency physician if he or she believes that the emergency patient requires services that are within the scope of his or her clinical privileges but beyond the scope of his or her actual practice (for example, various orthopedic subspecialty procedures). In the preamble to the 2003 regulations, CMS noted that a physician:

> who is in a narrow subspecialty may, in fact, be medically competent in his or her general specialty, and in particular may be able to promptly contribute to the individual's care by bringing skills and expertise that are not available to the emergency physician… [68 Fed. Reg. 53255].

In the event of a disagreement between the treating and on-call physicians regarding the need to come to the hospital, CMS indicated that the dispute:

> must be resolved by deferring to the medical judgment of the emergency physician or other practitioner who has personally examined the individual and is currently treating the individual [68 Fed. Reg. 53255].

☞ **References:**

42 C.F.R. Sections 489.20(r)(2) and 489.24(j) (Appendix B)

Interpretive Guidelines, tag no. A-2404/C-2404 (Appendix C)

B. If called by the emergency physician, when must an on-call physician respond?

In the *Interpretive Guidelines*, CMS states that physicians must "respond in person in a reasonable amount of time." The 2009 *Interpretive Guidelines* eliminated prior guidance that specifically required hospital policies to state response times in minutes. Instead, the *Interpretive Guidelines* now provide that "a hospital would be well-advised to establish in its on-call policies and procedures specific guidelines — e.g., the maximum number of minutes that may elapse between receipt of a request and the physician's appearance for what constitutes a reasonable response time…"

☞ **Reference:**

Interpretive Guidelines, tag no. A-2404/C-2404 (Appendix C)

C. Is a physician who is on call for his or her own patients also on call to a dedicated emergency department?

The fact that a physician is in the hospital does not automatically mean that the physician is on call to the emergency department. In the preamble to the 2003 regulations, CMS explained that a physician who comes to the hospital to see his or her own patients should not necessarily be interpreted as meaning that the physician is on call to the dedicated emergency department (assuming that the physician is not listed on the coverage roster for that time period). Similarly, a physician who is on call only for his or her own patients or for another physician's patients who are already admitted to a hospital should not be considered to be on call to the hospital for emergency patients.

☞ **Reference:**

68 Fed. Reg. 53255

D. Can a physician schedule elective surgery while on call?

The EMTALA regulations do not prohibit an on-call physician from maintaining office hours and performing other professional activities when the physician is on call. In the 2003 EMTALA regulations, CMS adopted the guidance from its 2002 Program Memorandum that a hospital may permit an on-call physician to perform elective surgery while on call; however, this guidance does not apply to critical access hospitals.[1] The regulations require a hospital to maintain policies and procedures to provide that emergency services are available to meet the needs of patients with emergency medical conditions if it elects to permit on-call physicians to schedule elective surgery when they are on call.

In the *Interpretive Guidelines*, CMS issues the following caution:

> When a physician has agreed to be on call at a particular hospital during a particular period of time, but also has scheduled elective surgery or an elective diagnostic or therapeutic procedure during the time as permitted by hospital policy, that physician and the hospital must have a planned back-up in the event that the physician is called while performing elective surgery and is unable to respond to an on-call request in a reasonable time.

While CMS permits hospitals to have the flexibility to establish their own policies for the availability of on-call physicians, state laws or hospital contractual commitments may require higher standards for call coverage. For example, hospitals with a trauma designation should also review the legal and contractual requirements for the availability of certain specialists when serving on call. The California trauma regulations require certain specialists (such as emergency physicians, general surgeons and anesthesiologists) to be "immediately available" to a trauma hospital. **"Immediately available"** is defined as unencumbered by conflicting duties or responsibilities; responding without delay when notified; and being physically available to the specified area of the trauma hospital when the patient is delivered in accordance with the local Emergency Medical Services (EMS) agency's policies and procedures. Other trauma call physicians must be "promptly available" or "available for consultation."

☞ **References:**

42 C.F.R. Sections 489.20(r) and 489.24(j) (Appendix B)

Interpretive Guidelines, tag no. A-2404/C-2404 (Appendix C)

Title 22, California Code of Regulations, Section 100237 (California trauma regulations)

E. Can an on-call physician request a hospital to transfer a patient to another facility where the on-call physician will attend the patient?

An on-call physician must be available to come to the hospital at which an emergency patient needs stabilizing treatment. However, it is not an automatic violation of EMTALA for an on-call physician to request an emergency physician to transfer a patient to another facility as long as the following conditions are documented:

1. There are legitimate medical reasons for making the transfer;
2. The transferring facility does not have back-up coverage available in the same specialty or the specialized services that are needed by the patient;

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1 Under 42 C.F.R. Section 413.70, a critical access hospital may be reimbursed for the cost of an emergency room physician who is on call and off-site, as long as the physician is not furnishing physician services while serving on call and not on call to any other hospital.

3. The emergency physician concurs (and documents) that the transfer is appropriate under the circumstances; and

4. The transfer is carried out in accordance with EMTALA standards.

Examples of an appropriate transfer are instances when an on-call physician is already at another area facility attending another critically ill patient, or the receiving facility offers services or equipment not available at the transferring hospital.

However, if an on-call physician has a pattern of directing patient transfers to other hospitals for convenience rather than coming to the hospital where the patient is located, the *Interpretive Guidelines* suggest that this pattern may indicate a violation of EMTALA. In general, hospitals should not discharge a patient to the on-call physician's private office unless the patient is stable for discharge. *(See chapter 5, "Transferring or Discharging an Emergency Patient.")*

☞ **Reference:**

Interpretive Guidelines, tag no. A-2404/C-2404 (Appendix C)

IV. SHARED CALL OR COMMUNITY CALL PLANS

A. Can two hospitals share on-call coverage for a particular specialty?

In the 2003 EMTALA regulations, CMS adopted the guidance from its 2002 Program Memoranda expressly authorizing hospitals to permit an on-call physician to provide simultaneous coverage at more than one hospital in order to maximize patient access to care. The regulations require that each hospital permitting simultaneous call must have written policies and procedures to provide that emergency services are available to meet the needs of patients with EMCs if the on-call physician has been called to another hospital.

In the *Interpretive Guidelines*, CMS states that when a specialist serves on call to two or more hospitals at the same time, all hospitals involved must be aware of the on-call schedule in order to meet their EMTALA obligations.

However, hospitals should review applicable state laws for required specialty coverage. For example, in California, certain specialists must be available at all times (such as general surgery). Hospitals should consult with their legal counsel or CDPH local district office to verify when coverage cannot be shared between two hospitals, or whether shared coverage is permitted if a back-up specialist is available at all times in case the primary coverage physician is unavailable due to an emergency situation at another hospital.

☞ **References:**

42 C.F.R. Section 489.24(j) (Appendix B)

Interpretive Guidelines, tag no. A-2404/C-2404 (Appendix C)

B. Can a hospital satisfy its on-call obligations through participation in a community call plan?

The 2008 EMTALA regulations established a third option for meeting on-call coverage obligations: a hospital may meet its on-call obligations by participating in a formal (i.e., written) community call plan (CCP).

A CCP must meet all of the following elements:

1. A clear delineation of on-call coverage responsibilities, that is, when each hospital participating in the plan is responsible for on-call coverage.
2. A description of the specific geographic area to which the plan applies (including what patient origin areas the plan will serve, e.g., certain communities, counties, regions or municipalities).
3. A signature by an appropriate representative of each hospital participating in the plan.
4. Assurances that any local and regional EMS system protocol formally includes the information on community-call arrangements.
5. A statement specifying that if an individual arrives at a hospital that is not designated as the on-call hospital at that time, the hospital at which the individual arrives still has an EMTALA obligation to provide a medical screening examination and stabilizing treatment within its capability, and that the hospital participating in the CCP must make an appropriate transfer.
6. An annual assessment of the CCP by the participating hospitals.

In the 2009 *Interpretive Guidelines*, CMS explains that hospital administrators and physicians who provide on-call services have some flexibility regarding how to configure an on-call coverage system that meets the federal requirements. The *Interpretive Guidelines* expressly provide that participation in a CCP is one way that a hospital can satisfy its on-call obligations. Participation in a CCP is strictly voluntary.

☞ **Reference:**

42 C.F.R. Section 489.24(j)(2)(iii) (Appendix B)

Interpretive Guidelines, tag no. A-2404/C-2404 (Appendix C)

C. Does CMS mandate a single way to organize a CCP?

CMS states in the *Interpretive Guidelines* that there are different ways that a CCP can be organized, but each plan must meet all of the criteria set forth above. For example, if two hospitals choose to participate in a CCP:

1. Hospital A could be designated as the on-call facility for the first 15 days of the month, and Hospital B could be designated as the on-call facility for the remainder of the month.
2. Hospital A could be designated as the on-call facility for cases requiring specialized interventional cardiac care, while Hospital B could be designated as the on-call facility for neurosurgical cases.

Regardless of the way in which the CCP is organized, the plan must clearly articulate which on-call services will be provided on which dates and times by each participating hospital. Further, each participating hospital's dedicated emergency department must have specific information about the allocation of on-call responsibilities in the plan readily available as part of the on-call list, so that personnel providing services to individuals covered by EMTALA will know the location of specialists who are available to provide the necessary specialty services at any given time.

☞ **References:**

Interpretive Guidelines, tag no. A-2404/C-2404 (Appendix C)

D. What is the role of the local EMS agency in a CCP?

In the *Interpretive Guidelines*, CMS states that if there are EMS protocols in effect in part or all of the geographic area covered by a CCP, the CCP-participating hospitals must attest that the arrangements in the plan have been communicated to the EMS agency (or agencies, if more than one). In addition, the EMS agency (or agencies) must receive periodic updates so that the agency (or agencies) may consider the plan in developing or modifying the EMS protocols. CMS also urges the hospitals in a CCP to include the EMS agency (or agencies) in the development of the CCP in order to facilitate implementation of the plan. In the absence of having an organized EMS agency, CMS advises that the hospitals should inform the local EMS providers of the plan.

E. Does participation in a CCP require an on-call physician to travel to the hospital at which an individual presents?

CMS states in the *Interpretive Guidelines* that participation in a CCP does not mean that an on-call physician must travel from the hospital at which he or she practices to the hospital needing his or her on-call services. Rather, a CCP arrangement permits appropriate transfers to the hospital providing the specialty on-call services under the CCP.

The hospital at which an individual initially presents still has an EMTALA obligation to screen the individual and, if necessary, stabilize within the hospital's capability and capacity. Thereafter, the hospital may transfer the individual for further stabilizing treatment to the CCP-participating hospital at which the specialty on-call physician is located on that particular date. For example, if an individual requiring neurology services presents at CCP-participating Hospital A on a day when the on-call neurologist under the CCP is based at Hospital B, then Hospital A may transfer the individual to Hospital B for treatment by the on-call neurologist, assuming all other transfer requirements have been met.

However, there is no regulatory prohibition against the on-call physician based at Hospital B from traveling to Hospital A to provide stabilizing specialty treatment, rather than transferring the individual to Hospital B, if that on-call physician is a member of Hospital A's medical staff and has neurology privileges.

☞ **Reference:**

Interpretive Guidelines, tag no. A-2404/C-2404 (Appendix C)

F. Does a CCP affect the accepting hospital obligations?

No. The *Interpretive Guidelines* explain that regardless of having a community call plan:

1. Hospitals that participate in the CCP are not relieved of accepting appropriate transfers from non-participating hospitals; and
2. Non-participating hospitals are not relieved from accepting appropriate transfers from participating hospitals.

☞ **Reference:**

Interpretive Guidelines, tag no. A-2404/C-2404 (Appendix C)

G. What are the requirements for the annual assessment of the CCP?

The conditions for having a CCP require an annual assessment of the plan. The *Interpretive Guidelines* require that the assessment include an analysis of the specialty call needs of the communities that are covered by the plan. Although the *Interpretive Guidelines* permit hospitals to have the flexibility to design and implement the assessment, the process is expected to follow a QAPI approach to the functioning of the CCP; the hospitals are expected to implement changes to the plan based on the annual assessment. The assessment report should be in writing, but each hospital is not required to sign the report.

☞ **Reference:**

Interpretive Guidelines, tag no. A-2404/C-2404 (Appendix C)

H. Does participation in a CCP raise antitrust issues?

Any collective action by two or more hospitals, as well as members of their medical staffs, to plan on-call coverage on a collective basis may implicate antitrust laws. Further, any collective decision making by hospitals as to payment rates for on-call coverage may raise concerns about price-fixing. In the preamble to the 2008 regulations establishing the CCP option, CMS expressly declined to respond to a comment about the antitrust implications of a CCP, indicating that antitrust issues were within the purview of the United States Department of Justice, and not CMS. Hospitals are therefore strongly encouraged to seek antitrust advice in developing a CCP for their community.

V. OTHER QUESTIONS

A. Can an on-call physician respond to a call by sending a qualified professional other than a physician to the emergency department?

CMS has issued guidance that the treating physician in the emergency department has the responsibility to determine whether the on-call physician must physically assess an emergency patient by coming to the hospital. However, the on-call physician may respond in some cases by directing a non-physician practitioner (such as a physician assistant or nurse practitioner) as his or her representative to provide the requested assessment or consultation for an emergency patient.

The decision as to whether a non-physician may respond for the on-call specialist will depend on the medical staff bylaws and rules and regulations, hospital policies, state scope of practice laws and the needs of the individual patient. If the on-call physician sends a non-physician in his or her stead, CMS will hold the on-call physician responsible for the care rendered to the individual patient by the responding professional.

However, if the emergency or other physician treating the patient disagrees with the on-call physician about sending a non-physician and requests that the on-call physician appear in person, the *Interpretive Guidelines* require the on-call physician to come to the hospital.

In 2011, the state legislature enacted amendments to the California emergency services laws to conform to the EMTALA rules. Under the change in law:

1. A physician or an appropriate licensed person acting under the supervision of a physician may provide consultation, further examination or stabilizing treatment necessary to relieve an emergency condition.

2. When determined to be medically necessary, jointly by the treating physician, the consulting physician and an appropriate licensed person acting within the scope of licensure, the consulting physician or the appropriate licensed person may provide emergency consultation services under the supervision of the consulting physician.
3. The treating physician (usually the ED physician) must approve the response by the appropriate licensed person instead of the consulting physician.
4. The consulting physician must continue to be available for consultation, including coming to the hospital to see the patient.
5. In all cases, the consulting physician remains "ultimately responsible" for providing the required consultation services for the patient, regardless of who comes to the hospital to see the patient.

To avoid possible confusion or disputes between on-call physicians and emergency physicians, it is recommended that a hospital and its medical staff review the rules and regulations and policies to determine whether an on-call physician is authorized to send a non-physician practitioner in response to an emergency call. If authorization is permitted, the hospital and the medical staff should include conditions for sending non-physician personnel, and reinforce that the emergency physician should make the final decision on who should respond in a particular circumstance.

☞ **Reference:**

Interpretive Guidelines, tag no. A-2404/C-2404 (Appendix C)

Health and Safety Code Section 1317.1 (Appendix D)

B. Can an on-call physician respond to a call using telemedicine services?

In a June 2007 memorandum (S&C 07-23), CMS sought to clarify its prior guidance regarding call by telemedicine since some hospitals had interpreted the 2004 *Interpretive Guidelines* as precluding emergency physicians from using telemedicine consultations with off-site specialists. In the memorandum, CMS states the following:

> There is no EMTALA prohibition against the treating physician consulting on a case with another physician, who may or may not be on the hospital's or CAH's on-call list, by telephone, video conferencing, transmission of test results, or any other means of communication.

The guidance, now part of the *Interpretive Guidelines*, reaffirms that in some cases an off-site physician providing specialty telemedicine consultation may not be available for personal assessment of the patient in the emergency department. However, if the physician is on call and requested by the treating physician to appear at the hospital, the on-call physician (and the hospital) may be subject to sanctions if the on-call physician fails or refuses to come to the hospital within a reasonable period of time.

Although the CMS guidance provides an alternative means of obtaining specialty consultation for an emergency patient, the use of telemedicine is subject to applicable state laws, hospital and medical staff policies.

As a reminder, the *Interpretive Guidelines* reaffirm that the guidance does not affect any telemedicine reimbursement policy of Medicare or other health plans or third-party payors.

In its 2013 guidance for critical access hospitals discussed under D. "Are there special rules for critical access hospitals?," page 11.4, CMS clarified that when a non-physician practitioner on-site at a CAH is assisted or directed by a qualified telemedicine physician in the diagnosis or treatment of a patient in a CAH ED, there is no requirement or expectation that the CAH must always require a local on-call physician to come to the ED. However, if hands-on treatment is required beyond the capability of the on-site practitioner, a request for local on-call physician could be required.

☞ **Reference:**

Interpretive Guidelines, tag no. A-2404/C-2404 (Appendix C)

CMS Survey and Certification Memorandum 07-23: EMTALA On-Call Requirements and Remote Consultation Utilizing Telemedicine Media (June 22, 2007)

CMS Survey and Certification Memorandum 13-38: Critical Access Hospital Emergency Services and Telemedicine (June 7, 2013) (Appendix Y)

C. What is the responsibility of an on-call physician to accept an emergency patient transfer?

As described in chapter 7, "Obligations of Receiving Hospitals," if a transferring hospital requests the transfer of an emergency patient with an unstabilized EMC in order to access a higher level of care than the transferring hospital provides, the receiving facility is obligated to accept the transfer unless it does not have the capacity to treat the patient. By extension, a physician on call to the receiving hospital has the same obligation as the hospital to accept a patient with an unstabilized EMC and to come to the hospital to treat the patient. If an on-call physician is available to accept the transfer of an unstabilized emergency patient, the receiving hospital has the capability and capacity to treat the patient, and the transfer is otherwise appropriate under the circumstances, a refusal by the on-call physician to accept the patient may be a violation by the hospital of EMTALA. As noted above, the EMTALA civil money penalties and exclusion regulations were extended in 2017 to apply to physicians on-call to a receiving hospital that are requested to accept an appropriate transfer.

VI. RESPONSE TO AN ON-CALL FAILURE OR REFUSAL TO COME TO THE HOSPITAL

A. What if an on-call physician refuses to accept an emergency patient or fails to come to the hospital?

A hospital should adopt policies and procedures for on-call coverage and provide guidance to dedicated emergency department personnel if an on-call physician refuses to accept a patient or refuses or fails to come to the hospital to consult or evaluate the patient when obligated to do so. For example, the hospital should adopt a chain of command policy specifying the personnel (such as department or section chair, or the administrator-on-call) to be contacted in the event of an on-call failure.

If an on-call physician fails to meet his or her obligations under EMTALA or state law, the hospital should consider the following actions:

1. Document in the patient medical record the time of notification of the requested transfer and the request made to the on-call physician, the response time of

the physician, and other pertinent information related to the failure of the on-call physician to meet his or her obligations;

2. Contact the chief of service or other designated person to enforce the call obligation;
3. Contact other staff physicians in the same specialty who may be available to see the patient in a timely manner;
4. Contact other area hospitals providing the specialty service to arrange for an appropriate transfer if other qualified physicians are not available to see the patient;
5. Transfer the patient in accordance with EMTALA guidelines;
6. Document in the medical record the name and address of the on-call physician who refused to consult and examine the patient (this documentation is expressly required by the EMTALA statute); and
7. Report the failure to the hospital's quality improvement and risk management programs, and initiate, where appropriate, a follow-up review of the actions of the on-call physician and the hospital by the medical staff and hospital administration.

In the *Interpretive Guidelines*, CMS notes that if an on-call physician does not fulfill his or her obligation to come to the hospital for an emergency patient, but the hospital arranges for another staff physician to assess the patient (and there are no other EMTALA violations), the hospital will not be cited for the on-call failure. However, the call physician who failed to respond may be in violation of EMTALA.

However, if the on-call failure results in a transfer of the patient to another facility, then the hospital will be subject to a CMS enforcement action and both the hospital and the on-call physician may be subject to civil money penalties imposed by the OIG. As discussed in chapter 5, "Transferring or Discharging an Emergency Patient," a hospital transferring a patient due to an on-call failure or refusal to respond must list the name and address of the on-call physician in the patient record that is sent to the receiving facility.

The oversight and enforcement of on-call coverage is a medical staff responsibility. Hospitals should expect that the enforcement agencies will inquire as to whether the medical staff has monitored the compliance of on-call physicians and taken appropriate disciplinary action against an on-call physician who refuses to accept an emergency patient or fails to come to the hospital in a timely manner to provide necessary consultation or other required services for a patient with an EMC.

☞ **References:**

42 C.F.R. Sections 489.20(r)(2) and 489.24(j) (Appendix B)

Interpretive Guidelines, tag nos. A-2404/C-2404, A-2406/C-2406, A-2407/C-2407, and A-2409/C-2409 (Appendix C)

Health and Safety Code Sections 1317 and 1317.3 (Appendix D)

California hospitals should also review Title 22 requirements for on-call coverage and emergency medical services

12 Reporting Patient-Dumping Violations

I. Overview 12.1

II. Questions 12.1

A. What is the deadline for reporting an EMTALA violation? 12.1

B. Where is the report filed? 12.1

C. What is the penalty for not filing a report? 12.1

D. Are there state reporting requirements? 12.1

E. Is a hospital required to self-report a violation of EMTALA or the state anti- dumping laws? 12.2

F. Is a violation of EMTALA or the state emergency services laws reportable to CDPH as an "adverse event?" 12.2

G. Can a hospital retaliate against a physician or staff member who reports an EMTALA or state anti-dumping law violation? 12.3

12 Reporting Patient-Dumping Violations

I. OVERVIEW

EMTALA requires a hospital to report to the Centers for Medicare & Medicaid Services (CMS) or the state survey agency (in California, this is the California Department of Public Health (CDPH), Licensing and Certification Division) "any time it has reason to believe that it may have received an individual who has been transferred in an unstable emergency medical condition from another hospital in violation of … EMTALA requirements."

II. QUESTIONS

A. What is the deadline for reporting an EMTALA violation?

The *Interpretive Guidelines* state that hospitals are required to promptly report a suspected violation within 72 hours of the occurrence.

B. Where is the report filed?

A report of a suspected EMTALA violation must be filed with CMS or the state survey agency. In general, the report should be made to the appropriate CMS regional office or the local field office of the state survey agency.

C. What is the penalty for not filing a report?

Under EMTALA, the failure of a receiving hospital to report a suspected EMTALA violation by a transferring hospital is grounds for termination of the receiving hospital's Medicare provider agreement. CMS has indicated that it will review the actions of all hospitals involved in an EMTALA complaint, and will take action against a receiving facility for failure to report an EMTALA violation. The *Interpretive Guidelines* require surveyors to "look for evidence" by reviewing medical records or interviewing patients, family members and staff that a receiving hospital knew or suspected that a patient had been transferred in violation of EMTALA standards.

D. Are there state reporting requirements?

Some states have adopted additional requirements for reporting patient-dumping violations. For example, California law requires a receiving hospital and its physicians and other licensed emergency care personnel to report apparent violations to CDPH within one week of the occurrence. A transferring hospital and its physicians and other licensed emergency care personnel may report apparent violations to CDPH within one week of the occurrence. The complaint must be forwarded to the transferring hospital and the local emergency medical services agency, unless CDPH concludes that the complaint does not require further investigation, is unmeritorious, or its investigation of the allegations would be impeded by disclosure.

E. Is a hospital required to self-report a violation of EMTALA or the state anti-dumping laws?

There is no requirement under the EMTALA regulations that a hospital must self-report an EMTALA violation that it has or may have committed. State licensing laws (Health and Safety Code Section 1317.4(c)) permit a transferring hospital or its personnel to report an apparent violation to CDPH. As discussed below, hospital personnel or physicians who report a suspected EMTALA or state law violation are protected under anti-retaliation laws.

If a hospital has identified a potential violation of EMTALA or state emergency laws, the hospital should consider the merits of self-reporting even if a report is not required. In some cases, if a hospital self-reports a violation before a complaint by another hospital or person is filed with CMS or the state survey agency, and the hospital has immediately addressed and appropriately corrected the circumstances that resulted in the violation, CMS may (but is not required to) limit the scope of the EMTALA investigation.

In a 2016 Final Rule, the OIG addressed self-reporting as a mitigating factor to reduce the potential amount of civil money penalties for an EMTALA violation. The OIG indicated that taking appropriate and timely corrective action in response to an EMTALA violation would be considered a potential mitigating factor. However, the OIG stated that:

1. Mitigating corrective actions must be completed before CMS initiates an investigation of the hospital and
2. The hospital must self-report the violation to CMS before CMS receives a complaint about the violation from another source.

As an example where self-reporting may be appropriate, a hospital self-reported an on-call violation where a specialist refused to come to the emergency department to treat a patient with an emergency medical condition. The hospital reported the circumstances to CMS and CDPH, along with a timeline of the event and a corrective action plan. CMS limited the survey to the incident and confirmed the violation. In a subsequent investigation, the OIG substantially reduced the civil penalty assessed against the hospital (which would have been much higher had the incident not been self-reported).

On the other hand, hospitals should thoroughly review the facts of a suspected violation, and consult with legal counsel as appropriate, before self-reporting a violation. As an example, a hospital self-reported an event as an EMTALA violation that did not even implicate the EMTALA obligations. The follow-up investigation led to a multi-day survey that, through the review of patient records unrelated to the self-reported case, identified not only serious violations in the emergency department, but also in labor and delivery.

F. Is a violation of EMTALA or the state emergency services laws reportable to CDPH as an "adverse event?"

Effective July 1, 2007, California hospitals must report "adverse events" to CDPH. A violation of EMTALA or the state emergency service laws is not itself a reportable event.

However, the circumstances surrounding the care provided to a patient who is covered by EMTALA or the state emergency services laws may fall into one of the categories of adverse events that must be reported to CDPH. Hospitals that identify an adverse event, or another circumstance involving an emergency patient, that may be reportable (such as elder or child abuse) should review CHA's *Consent Manual* or consult with legal counsel.

G. Can a hospital retaliate against a physician or staff member who reports an EMTALA or state anti-dumping law violation?

As discussed in chapter 13, "Regulatory Enforcement of EMTALA," EMTALA and some states have adopted laws that prohibit retaliation against personnel or physicians who report an EMTALA or state law violation.

Under EMTALA, a hospital may not penalize or take adverse action against a physician or another qualified professional because that person refused to authorize the transfer of an individual with an emergency medical condition that had not been stabilized.

Some states also have anti-retaliation laws. Under California law, retaliation is prohibited against a physician or emergency personnel for reporting in good faith an apparent violation of the statute, or for refusing to transfer a patient if the physician determined, based on reasonable medical probability, that a transfer would have created a medical hazard. A hospital, government agency or person who violates the state anti-retaliation law for emergency services is subject to a civil money penalty of no more than $10,000 per violation.

In addition, the California hospital licensing laws (Health and Safety Code Section 1278.5) prohibit a hospital from discriminating or retaliating against any patient, employee, medical staff member, or other health care worker for presenting a grievance or complaint, or initiating or cooperating in any governmental investigation or proceeding relating to the care, services, or conditions of that facility. Violations by hospitals are subject to a civil penalty of up to $25,000, and willful violations by an individual are a misdemeanor subject to a fine of up to $75,000, in addition to the civil penalty.

☞ **References:**

42 C.F.R. Sections 489.20(m); 489.24(e)(3) (Appendix B)

Interpretive Guidelines, tag nos. A-2401/C-2401 and A-2410/C-2410 (Appendix C)

Health and Safety Code Section 1317.4 (Appendix D)

13 Regulatory Enforcement of EMTALA

I. Overview of the Administrative Review Process 13.1

II. Questions 13.2

A. What is the difference between EMTALA enforcement and other Medicare certification reviews? 13.2

B. How is an EMTALA investigation started? 13.3

C. What is the frequency of EMTALA investigations? 13.3

D. Does EMTALA provide for whistleblower protection? 13.4

E. What is the scope of an EMTALA complaint survey? 13.4

Entrance Conference 13.4

Document Request 13.4

Patient Record Request 13.4

Further Review 13.5

Expanded Scope of Survey 13.5

Interviews 13.5

Exit Survey 13.5

F. What are CMS's enforcement options if it confirms an EMTALA violation? 13.6

No Termination 13.6

90-Day Termination 13.6

23-Day Termination 13.6

G. How should a hospital respond to a notice of termination? 13.7

The Transmittal Letter 13.7

The Statement of Deficiencies 13.7

EMTALA Compliance Team 13.7

Plan of Correction 13.7

Review of Hospital Compliance with EMTALA 13.8

Review of Cases 13.8

H. Does submitting a plan of correction imply that a hospital admits it violated EMTALA? 13.9

I. What can the hospital do if it disagrees with the survey findings? 13.9

J. What is the role of the QIO in the EMTALA enforcement process? 13.10
Notice 13.10
Reply to the Notice 13.11
The QIO Meeting 13.12
Additional Information 13.14
Final Report 13.14
Failure to Receive a QIO Review 13.14

III. Civil Sanctions 13.15

A. How are civil sanctions imposed by OIG? 13.15
B. Are settlement agreements with the OIG available to the public? 13.15
C. Are EMTALA violations referred to other governmental agencies? 13.15
D. What are the sanctions under state laws for patient-dumping? 13.15
E. Can a violation of state law also constitute "immediate jeopardy" and be grounds for licensing sanctions? 13.16

13 Regulatory Enforcement of EMTALA

I. OVERVIEW OF THE ADMINISTRATIVE REVIEW PROCESS

Regulatory enforcement of EMTALA involves three agencies: the Centers for Medicare & Medicaid Services (CMS) (with the support of state licensing surveyors), the Quality Improvement Organization (QIO) and the Office of Inspector General (OIG). In addition, the Office for Civil Rights (OCR) of the U.S. Department of Health and Human Services (HHS) may follow up on a violation of EMTALA with a request for documents and information from Hill-Burton hospitals that have community service obligations.

The enforcement of EMTALA is a complaint-driven process. Upon a confirmed EMTALA violation, CMS may suspend or terminate a hospital's provider agreement. The notice of suspension or termination can be 23 days (if the violations constitute immediate jeopardy) or 90 days (if the violations do not constitute immediate jeopardy).

All confirmed EMTALA violations must be forwarded to the OIG to determine whether civil money penalties should be imposed for the violations. In considering sanctions, OIG must request that the QIO assess the appropriateness of the medical screening examination, the presence of an emergency medical condition, patient stabilization and other clinical issues related to a possible EMTALA violation.

The QIO assessment, referred to as the 60-day review, is an important part of the enforcement process and a potential opportunity to reduce or eliminate possible civil money sanctions if the assessment is favorable to the hospital. Hospitals should be aware that, in at least one instance, an OIG enforcement attorney has advised that failure to respond to or participate in a QIO 60-day review may increase the likelihood or amount of civil money penalties.

Under the EMTALA statute (Appendix A), the OIG has the authority to impose civil money penalties up to $50,000 against hospitals and physicians ($25,000 for hospitals with less than 100 beds), and/or to exclude a hospital or physician from the Medicare and Medicaid programs for violations of EMTALA that are "gross and flagrant or repeated." In December, 2016, the OIG issued final regulations updating the amount of civil money penalties, including EMTALA fines. Effective in 2017, the OIG may now impose civil penalties up to $104,826 against hospitals and physicians ($52,414 for hospitals with less than 100 beds) for an EMTALA violation. The maximum amounts of the fines are subject to annual adjustment for inflation.

Physicians may be penalized for:

1. Signing a certification for transfer if a physician knew or should have known that the benefits of the transfer did not outweigh the risks, or misrepresenting a patient's condition or other information; or

2. Failing or refusing to respond within a reasonable period of time (while serving as an on-call physician) after being requested to come to the hospital to examine, treat, or transfer a patient. This applies to on-call physicians at the hospital where the individual presents initially, as well as on-call physicians at a hospital with specialized capabilities or facilities which may receive a transferred patient; or
3. Refusing to accept an appropriate transfer, including on-call physicians.

In the 2016 regulations increasing civil money penalties for an EMTALA violation, the definition of a "responsible physician" was expanded to apply to on-call physicians. Fines may now imposed on on-call physicians who fail or refuse to respond to a hospital that receives a request to accept an appropriate transfer.

In the same regulations, the OIG added as a mitigating factor situations in which a hospital takes appropriate and timely corrective action in response to a violation. However, the corrective actions must be completed prior to CMS initiating an investigation of the hospital and must include disclosing the violation to CMS prior to CMS receiving a complaint regarding the violation from another source. Early corrective action and reporting to CMS does not eliminate potential liability for fines, but it may reduce the amount of fines if the OIG decides to impose penalties for the violation.

In addition, the OIG may seek to exclude a physician or a hospital from the Medicare program for a violation of EMTALA. Physicians are subject to exclusion from the Medicare program for gross and flagrant, or repeated, violations. Hospitals are subject to termination of their Medicare provider agreement if they fail substantially to meet EMTALA requirements.

In 2003, CMS adopted a regulation that sanctions under EMTALA for inappropriate transfers during a national emergency (such as a bioterrorist attack) do not apply to a hospital with a dedicated emergency department located in an emergency area if certain conditions are present *(see chapter 16, "Application of EMTALA to Disasters and Public Health Emergencies")*.

A diagram of the EMTALA enforcement process is included in Appendix I.

II. QUESTIONS

NOTE: CHA has published the *California Hospital Survey Manual* that describes the scope of, and response to, CMS and California Department of Public Health (CDPH) surveys, and includes guidance for responding to CMS investigations of EMTALA compliance. The discussion in this chapter only addresses the scope and response to EMTALA surveys, as well as reviews of EMTALA compliance by the QIOs and the OIG. Hospitals should review the *California Hospital Survey Manual* for additional information on responding to surveys and preparing plans of correction.

A. What is the difference between EMTALA enforcement and other Medicare certification reviews?

The obligation to comply with EMTALA is a term of a hospital's Medicare provider agreement. The obligations are therefore in addition to compliance with the Conditions of Participation in the Medicare program.

All of the EMTALA obligations are considered equal (medical screening examinations, stabilizing treatment and appropriate transfers, signage, central log, on-call roster and patient transfer records, on-call response, and reporting EMTALA violations); the failure to meet any EMTALA obligation constitutes a breach of the Medicare provider agreement, for which CMS may terminate the agreement. The notice of termination does not require a hearing prior to the termination action; instead, CMS may give a hospital notice of termination of its Medicare provider status on 23- or 90-day notice based on a survey report confirming a violation of EMTALA.

B. How is an EMTALA investigation started?

The enforcement of EMTALA is a complaint-driven process. An EMTALA investigation is usually started when a complaint is filed with CMS or the state survey agency (in California, this is CDPH's Licensing and Certification Division). The sources of complaints include patients and families, hospitals, physicians and other health care professionals, and ambulance and emergency services agencies. An EMTALA investigation may also originate from a licensing, certification or Joint Commission survey that identifies possible EMTALA violations during the course of the survey.

Regardless of the source of an EMTALA complaint, CMS must first determine whether the complaint identifies a possible EMTALA violation and warrants an investigation. If it does, CMS will direct the state survey agency to conduct a complaint survey (CMS can also conduct the survey). The results of the survey are forwarded to CMS, which then makes the final decision as to whether an EMTALA violation has occurred. If CMS determines that an EMTALA violation has occurred, CMS may then give notice of termination of a hospital's Medicare provider agreement.

C. What is the frequency of EMTALA investigations?

There is limited research or reporting of the frequency of EMTALA investigations. In a February 2017 article in the Annals of Emergency Medicine, a research team consisting of physicians and other health care professionals published findings on the incidence of CMS enforcement of EMTALA between 2005 and 2014. The team reported that there were 4,772 investigations, of which 2,118 (44%) resulted in citations of EMTALA deficiencies at 1,498 hospitals. The team also reported a declining trend in enforcement.

The team also looked at the allegations by tag number in the EMTALA *Interpretive Guidelines*. Most of the citations issued by CMS involve failure to follow hospital policies and procedures (73%). As to substantive requirement, failure to conduct an appropriate medical screening examinations was cited in 55% of the cases; other common citations were failure to provide stabilizing treatment (25%), transfers (28%), on-call performance (14%), and accepting hospital obligations (16%). As to administrative requirements, citations for the central log were cited in 25% of the cases.

☞ **Reference:**

Terp et al., "Enforcement of the Emergency Medical Treatment and Labor Act, 2005 to 2014," 69 Annals of Emergency Medicine, No. 2, February 2017 (pp. 155-162).

D. Does EMTALA provide for whistleblower protection?

EMTALA and California whistleblower protection laws are discussed in chapter 12, "Reporting Patient-Dumping Violations," under G. "Can a hospital retaliate against a physician or staff member who reports an EMTALA or state anti-dumping law violation?," page 12.3.

E. What is the scope of an EMTALA complaint survey?

A complaint survey must be conducted within five working days after receiving CMS authorization. All surveys are unannounced. The focus of the survey is on the initial allegation of a violation and the discovery of additional violations. The purposes of the survey are to:

1. Ascertain whether a violation occurred, and if so, whether it constituted an immediate and serious threat to patient health and safety;
2. Identify any patterns of violations at the hospital; and
3. Assess whether the hospital has policies and procedures to address the EMTALA obligations.

If the survey confirms that a violation occurred, the surveyors are directed to continue their investigation, with an emphasis on EMTALA compliance within the six-month period preceding the survey. If the survey confirms that a violation did not occur, the surveyors are directed to seek assurance that the hospital's policies and procedures, physician certifications for transfer, and other actions are in compliance with the EMTALA obligations. The survey consists of the following tasks.

Entrance Conference

A brief entrance conference is conducted with the hospital chief executive officer (or his or her designee) and any other invited hospital staff to explain the nature of the allegation, the purpose of the investigation and the standards for the survey. The identities of the complainant and the patient are not to be disclosed in the absence of written consent.

Document Request

The hospital is requested to provide the documents and information set forth in Appendix J, "Hospital Records Subject to EMTALA Enforcement Survey." These include central logs, policies and procedures, medical staff records, on-call rosters, personnel files, in-service records, quality improvement minutes, etc.

Patient Record Request

Although a single occurrence may trigger an EMTALA survey, a sample of patient medical records must be reviewed in order to identify the presence of additional violations or a pattern of violations. Therefore, the surveyors are directed to select 20 to 50 patient records to review in detail; the sample size may be expanded as necessary to adequately investigate possible violations or patterns of violations.

The type of records reviewed will vary based on the nature of the complaint and the types of patients seeking emergency services. For example, an inappropriate transfer complaint will require the review of patients who were transferred by the hospital. If the review identifies multiple violations, the surveyors are directed to determine, if possible, whether the pattern of violations is related to diagnosis, race, color, insurance status, nationality or disability.

Further Review

If one or more violations are identified from a review of the medical records, the surveyors are directed to obtain copies of the records for the cases of suspected violations. In addition, the surveyors will review documents pertaining to quality assurance/performance improvement for the dedicated emergency department(s) and remedial actions taken in response to the violations. Corrective action taken before the survey will be documented by the surveyor and considered in the recommendations submitted to the CMS regional office. Additional information on the record review and documentation is discussed in chapter 3, "Medical Screening Examinations," and pages 9-11 of Appendix K, "Investigative Procedures for EMTALA Surveyors" (part of the *State Operations Manual*).

Expanded Scope of Survey

If, during the survey of an accredited hospital, the surveyors identify a possible violation of the Medicare Conditions of Participation, the surveyors will seek authorization from the CMS regional office to expand the investigation. If the hospital is not accredited, the surveyors may expand the survey without prior contact with the CMS regional office.

Interviews

A key part of the survey is the interview of hospital staff and physicians. The guidance for surveyors states that the surveyor "may be able to gather a great deal of information from the admitting clerk in the emergency department, the nurses on shift at the time the individual sought treatment, and the Director of Quality Improvement in the hospital to name a few." The surveyors may also interview witnesses, ambulance personnel, the patient or his or her family members, or the personnel at a hospital that accepted or received the patient.

Exit Survey

At the end of the survey, the survey team will schedule an exit conference to review the scope of the investigation, the survey tasks, the requirements investigated and whether any Conditions of Participation were violated. The surveyors are directed not to advise the hospital whether a violation was confirmed because that determination is reserved for the CMS regional office. However, the surveyors are directed to inform the hospital staff of the consequences of a violation and the time frames to correct any violation that may be confirmed by the regional office.

The results of the survey are documented on the Statement of Deficiencies and Plan of Correction (Form CMS 2567), the same form used for validation surveys. The paperwork must be forwarded to the CMS regional office within prescribed time frames. A discussion of how the survey report should be prepared is discussed on pages 13-16 of Appendix K.

In addition to the survey team report, the CMS regional office is directed to request a QIO review before terminating a hospital's provider agreement for violations. The purpose of the QIO review is to determine:

1. If a medical screening was appropriate (i.e., suitable for the presenting symptoms and conducted in a non-disparate fashion);
2. If an individual had an emergency medical condition;
3. In the case of a pregnant woman, whether there was inadequate time to effect a safe transfer prior to the delivery, or the transfer posed a threat to the health and safety of the woman or the unborn child;

4. If stabilizing treatment was appropriate within the capability of the hospital;
5. If a transfer was made with qualified personnel and transportation equipment;
6. If applicable, the on-call physician's response time was reasonable; and
7. If a transfer was appropriate for the individual, including a determination that the medical benefits of the transfer outweighed the risks or the patient made an informed request for the transfer.

The QIO must be provided five days to conduct the review (this is often referred to as "The Five-Day Review"). The review by the QIO is not required if the delay would jeopardize the health and safety of patients.

There is no time frame for the CMS regional office to accept, modify or reject the draft survey report. The "Investigative Procedures for EMTALA Surveyors" (part of the *State Operations Manual*) strongly encourages the regional office to share information with the hospital (subject to applicable privacy laws).

F. What are CMS's enforcement options if it confirms an EMTALA violation?

If CMS determines that a hospital has violated EMTALA, it has three options.

No Termination

CMS may advise the hospital of the violation, but take no further enforcement action if there have been no further violations. This course of action may be taken if the hospital and its medical staff identified the violation and implemented appropriate corrective action before the EMTALA enforcement survey.

90-Day Termination

CMS may terminate the hospital's provider agreement on a 90-day notice if it determines that the violation is a threat to patient health and safety. In the "Investigative Procedures for EMTALA Surveyors" (part of the *State Operations Manual*), the following examples are provided as guidance to the CMS regional offices of the types of administrative errors for which a 90-day termination notice may be indicated:

1. A transfer was appropriate, but the physician certification form was not signed or dated by the physician;
2. An appropriate, functioning central log was not fully completed on a particular day; or
3. A hospital policy was missing at the time of the survey, but had been implemented by the hospital.

23-Day Termination

CMS may terminate the hospital's provider agreement on a 23-day notice if it determines that the violation constitutes imminent jeopardy to patient health and safety. The following examples are provided as guidance to the CMS regional offices as to the types of cases for which a 23-day termination notice may be indicated:

1. Failing to provide necessary stabilizing treatment;
2. Failing to respond appropriately while acting as an on-call physician;

3. Making an improper transfer; or
4. Denying a medical screening examination or necessary stabilizing treatment as a direct result of requesting payment information before performing a medical screening examination.

G. How should a hospital respond to a notice of termination?

If CMS determines that a hospital has violated EMTALA, the hospital will receive a transmittal letter and a Statement of Deficiencies (Form CMS 2567) from the CMS regional office.

The Transmittal Letter

The transmittal letter advises the hospital whether CMS intends to seek termination of the hospital's Medicare provider agreement on a 23- or 90-day notice. The notice also states when the plan of correction must be submitted to CMS and the date on which CMS will publish the notice of termination in the local newspaper if an acceptable plan of correction has not been submitted to CMS in a timely manner.

The Statement of Deficiencies

The Statement of Deficiencies will cite the EMTALA tag numbers (e.g., A-2409/C-2409 for an inappropriate transfer) identified in the *Interpretive Guidelines* for each EMTALA regulation for which the hospital is not in compliance. The Statement of Deficiencies will include the text of the cited regulation, the general nature of the noncompliance (such as "the hospital failed to conduct an appropriate medical screening examination") and recite the facts for each violation, including specific patient medical records, hospital practices or information obtained from staff interviews as evidence of alleged violations of EMTALA.

EMTALA Compliance Team

Upon receipt of the transmittal letter containing the notice of termination and the Statement of Deficiencies, the hospital should immediately assemble an EMTALA compliance team and establish a timetable for preparing the plan of correction. The compliance team should include, at a minimum, one or more members of the executive staff, department heads, medical directors, the compliance officer, risk management and the quality improvement director. As appropriate, the hospital should add other staff members and legal counsel to provide the necessary expertise for developing and implementing an effective plan of correction. The EMTALA compliance team should be responsible for developing, implementing and overseeing the plan of correction, reviewing EMTALA compliance in other hospital departments and evaluating cases cited in the Statement of Deficiencies for possible civil money penalties or potential litigation.

Plan of Correction

A hospital must submit a credible and effective plan of correction in order for CMS to withdraw the termination action. The hospital team should review the Statement of Deficiencies, the *Interpretive Guidelines*, applicable department and quality management policies, existing hospital practices and in-service education programs. Hospital staff should be interviewed if there are gaps in the patient medical record or other facts that are pertinent to the alleged violation. The hospital should consider describing in a transmittal letter to CMS or the plan of correction the process followed to bring the hospital into compliance with EMTALA (especially if responding to a 23-day notice of termination).

The plan of correction should include the following three elements.

Corrective Action

For each deficiency cited by CMS, the plan should identify the corrective action implemented to remedy the deficiency. The action may require the development of new policies and procedures, the revision of existing policies and procedures or other changes in hospital practices that are necessary to bring the hospital into compliance.

For each corrective action taken by the hospital, the plan of correction must state the specific actions to correct the deficiency, the timetable for implementing the action, the performance measures to ensure compliance and the staff person responsible for overseeing compliance. To the extent feasible, the corrective action should be implemented prior to the submission of the plan of correction.

In-Service Education

As discussed in chapter 15, "Quality Improvement and Risk Management," in-service education is the key to effective EMTALA compliance. It is essential that all affected hospital staff are aware of the changes in policies and practices adopted by the hospital in response to the statement of deficiencies. During the re-survey of the hospital to verify compliance with the plan of correction, the surveyors are likely to question staff as to their understanding of the new policies and practices. The hospital should maintain documentation of the in-service education programs, including copies of the sign-in sheets and the education materials distributed to staff as part of the in-service education plan.

Quality Improvement

The hospital must adopt effective quality management practices and survey tools in order to ensure that the hospital complies with the plan of correction and that the deficiencies will not be repeated. Recommendations for monitoring EMTALA compliance are provided in chapter 15, "Quality Improvement and Risk Management." The quality improvement program adopted in response to the statement of deficiencies should be described in the plan of correction. The program should be implemented concurrent with the submission of the plan of correction, and the results should be available for review during the re-survey.

Review of Hospital Compliance with EMTALA

In addition to preparing the plan of correction, the team should review EMTALA compliance in areas that were not the focus of the original survey (for example, patient transfers, if the survey focus was on medical screening) or in other locations of the hospital that were not visited by the surveyors at the time of the original survey.

Because the scope of the re-survey is not limited to the issues cited in the Statement of Deficiencies, the surveyors may visit other departments providing emergency services. For example, if the original survey was limited to the emergency department, the surveyors may visit labor and delivery or other departments during the re-survey to verify compliance with EMTALA. The team should review policies and practices in other departments, implement changes in the policies and practices as necessary, initiate in-service education and implement quality improvement activities.

Review of Cases

The team should also oversee the review of the medical records copied by the surveyors (a list will usually be provided to the hospital) to determine potential liability for civil money penalties or litigation. In accordance with the "Investigative Procedures for EMTALA

Surveyors" (part of the *State Operations Manual*), some or all of the medical records will be forwarded by CMS to the QIO for analysis of potential EMTALA violations and quality of care issues. As discussed later in this chapter, the preliminary QIO findings are forwarded to the hospital for review and comment. The final QIO report is forwarded by CMS to the OIG for consideration of the imposition of civil money penalties.

The review of the medical records should be performed to determine whether the description of each case in the Statement of Deficiencies is accurate and whether the entire medical record was copied for the surveyors. In some cases, the surveyors receive only a portion of a record, which may result in only a partial understanding of the case. If a medical record reflects poor documentation, the team should attempt to fill in the gaps with supplementary documentation. If the medical record itself requires revision, this should be done in an appropriate manner in accordance with hospital policy. If the team identifies medical records that may pose liability for civil money penalties or potential litigation, the cases should be reported to risk management. The hospital, under the direction of legal counsel, should continue to compile any information and documentation that is available to defend the hospital's actions in the event that it later becomes necessary.

H. Does submitting a plan of correction imply that a hospital admits it violated EMTALA?

No. The submission of a plan of correction by a hospital to address allegations of noncompliance with EMTALA is not interpreted as an admission by the hospital of an EMTALA violation. Many hospitals include a sentence at the beginning of the plan of correction that the submission of the plan of correction does not constitute an admission or agreement of the facts or conclusions contained in the Statement of Deficiencies.

I. What can the hospital do if it disagrees with the survey findings?

In some cases, the hospital may disagree that its actions constitute a violation of EMTALA, or believe that the survey team misinterpreted the EMTALA obligations or accepted industry guidelines and practices. Although submitting a plan of correction is not admission of a violation, the hospital may feel that it should not have been cited at all.

The "Investigative Procedures for EMTALA Surveyors" (Appendix K) provide that the "hospital has the opportunity to present evidence to CMS that it believes demonstrates its compliance and the opportunity to comment on evidence CMS believes demonstrates the hospital's noncompliance." For example, the hospital may be able to present its case to CMS between the exit conference and the issuance of a Statement of Deficiencies. In a very rare case, the hospital may be able to convince CMS to withdraw a Statement of Deficiencies after it is issued.

However, CMS may reject a plan of correction that attacks the findings in the Statement of Deficiencies, without a stated plan for correcting the alleged deficiencies cited in the survey. Even if the plan of correction includes compliance actions, CMS may still request that the hospital rewrite the plan of correction to delete the parts of the plan that attack the findings.

If a hospital desires to dispute the findings of the survey, it needs to move quickly to compile its evidence of compliance and then present its case to CMS. The hospital should consult with physicians, legal counsel and others who may assist in confirming whether its actions were appropriate or inappropriate under EMTALA. A request should be made to CMS for copies of the five-day reviews conducted by the QIO to evaluate the analysis presented to CMS.

Despite convictions that the hospital met its obligations, the hospital should expect that it will have an uphill battle to reverse one or more alleged deficiencies in the absence of obvious mistakes by the survey team.

J. What is the role of the QIO in the EMTALA enforcement process?

Following the completion of the EMTALA survey process, including one or more re-surveys, CMS will usually refer one or more cases from the EMTALA surveys to the QIO for review. The QIO review, typically referred to as the "60-day review," is an opportunity for the hospital and physicians to discuss the cases selected by CMS for QIO review. The QIO is required to review the facts of each case, as well as comment on quality concerns. However, the QIO does not determine whether a hospital or physician violated the EMTALA obligations; that determination is the responsibility of CMS and the OIG.

The QIO 60-day review is performed as part of the EMTALA sanctions process. In considering sanctions, the OIG must request that the QIO assess whether a patient had an emergency medical condition (EMC) that was not stabilized, in addition to other medical issues. Except where delay would jeopardize health or safety or there is no medical issue to review, OIG must request a QIO review before terminating or suspending a provider, or imposing civil money penalties.

Compliance Tip: One QIO organization has commented that a number of hospitals have not responded to the QIO review. Hospitals should consider the QIO review an essential part of the OIG process. From the viewpoint of the OIG, ignoring the QIO notice indicates a failure to take seriously the review process and the EMTALA obligations. Therefore, the failure to respond to the QIO review may result in higher than anticipated demands from the OIG for civil penalties or settlement amounts.

The QIO process described below follows chapter 9 of the *Quality Improvement Organization Manual*, which was revised by CMS in 2016.

Notice

The QIO begins the process by providing written notice of the 60-day review to the responsible physician and hospital. The notice includes:

1. The names of the patient or patients;
2. The date(s) of the alleged violation;
3. An invitation to meet by telephone or in person and to submit additional information within 30 days; and
4. A copy of the regulations.

The notice of the 60-day review that is typically mailed by the QIO does not include copies of the completed five-day reviews that were performed by the QIO prior to the issuance by CMS of the Statement of Deficiencies. If the hospital has not requested the five-day reviews before receiving the QIO notice, it should immediately contact CMS for copies of the reviews.

The QIO physician reviewer uses an EMTALA Physician Review Worksheet *(see Appendix W)* to evaluate each case that is referred to the QIO (the worksheet for the 60-day review is the

same form that is used for the five-day review). This worksheet includes each element of the EMTALA obligations. The worksheet is in the form of questions, with a checkbox (usually with "yes," "no" and "not applicable") for each element and space for comments by the reviewing physician. Items 14 and 15 address whether there were inappropriate delays in the medical screening or stabilizing treatment and whether there were any quality of care issues. At the end of the worksheet (Item 16), the physician reviewer will summarize the overall findings. The worksheet includes an admonition that the reviewer should not state whether the actions of the hospital or the physician violated EMTALA.

The QIO evaluation is usually written by a physician in the same specialty as the responsible physician (for example, an emergency physician will review alleged violations of EMTALA for failure to provide an adequate medical screening in the emergency department). In some cases, the QIO may assign the case to a physician in a different specialty, such as a psychiatrist to review a psychiatric assessment performed by an emergency physician. If this occurs, the hospital or responsible physician should request the QIO to assign a physician in the same specialty as the treating physician.

Reply to the Notice

The hospital or physician must reply to the QIO notice for the 60-day review in a timely manner in order to schedule a meeting or submit a written response for each case evaluated by the reviewing physician. The meeting or written response usually must be completed within 30 days from receipt of the QIO notice.

In preparing for a meeting or drafting the response, the hospital should consider that the QIO review is part of the OIG process. The hospital should include both clinical analysis and any applicable legal arguments that respond to the reviewer's concerns and findings. As appropriate, the response should address each of the EMTALA elements considered by the reviewer to be applicable to the patient's case.

The hospital or physician should also consider the limited information that may have been given to the QIO. In most cases, the QIO reviewer has received a copy of the patient medical records for the cases, and some information or notes compiled by the surveyors; the QIO does not in all cases have a copy of the survey report (i.e., Statement of Deficiencies) or the plan of correction.

The 60-day review affords the hospital or physician an opportunity to submit additional information and documents (including, as appropriate, declarations from physicians and nurses, tapes or films, or other information that may have not been available or requested at the time of the on-site survey) that provide a more complete picture to the reviewer of the cases.

Compliance Tip: If the cases reviewed by the QIO involve emergency department saturation or capacity constraints, the hospital should submit documentation of the emergency department census (hour-by-hour if available), acuity of patients held in the emergency department (especially trauma cases and patients waiting for an inpatient bed), waiting times and other information that provide greater context to circumstances existing at the time of the incidents that were cited by CMS in the Statement of Deficiencies.

The QIO Meeting

The QIO must provide written notice to an affected hospital or physician of the opportunity to schedule a telephonic or face-to-face meeting. The QIO is directed to inform the OIG through the appropriate CMS Regional Office of the time and date of the meeting, and whether the hospital or physician declines the opportunity to meet with the QIO. The meeting is an informal forum for discussion of the EMTALA case(s); it is not an adversarial hearing governed by rules of evidence, cross-examination of witnesses or other legal rules.

The primary purpose of the meeting is for the physician and/or hospital to present their views on the case. Past experience with QIO meetings indicates that the QIO personnel prefer that one or more physicians present the hospital's view of the cases(s). While the hospital and physicians may have legal counsel present, it is optional for the QIO to have legal counsel at the meeting. The QIO may limit the scope, extent and manner of any questioning by legal counsel. The physician or hospital may present expert testimony in written or oral form, although the QIO may reasonably limit the number of witnesses and the length of irrelevant or repetitive testimony. The presenting hospital or physician should not expect the QIO or a physician reviewer to provide a clinical opinion about the case during the meeting.

The QIO must arrange for a recording of the meeting, but it is not required to produce a transcript of the recording unless requested by the CMS Regional Office or the OIG.

After the completion of the meeting, the QIO is not required to consider additional information from the hospital or physician that was not submitted at the meeting, unless the QIO requests the information before the end of the meeting. Under CMS Guidelines, the time frame to submit any additional information after the meeting is five days.

Hospitals should not consider the 60-day review as an unnecessary burden. It may be an opportunity to limit the likelihood or amount of civil money penalties. Some pointers for preparing for the meeting include the following:

1. Ensure that the QIO notice is immediately referred to the hospital representative designated as the point person for managing the EMTALA review process. The notice should also be forwarded to legal counsel as appropriate. The QIO notice is typically sent to the hospital chief executive officer. If the importance or timeliness of the QIO notice is not immediately apparent, it may result in either scrambling to arrange and prepare for the meeting or to submit a written response within the 30-day period from the receipt of the QIO notice.
2. After reviewing the QIO notice and identifying the cases selected for review, the hospital should identify the key persons who should participate in the meeting and their availability. While participation of legal counsel is not required for the meeting, hospitals should consult their in-house or outside legal counsel with respect to the QIO notice and the meeting since the 60-day review may be preparatory to a decision by CMS to refer one or more cases to the OIG for consideration of civil money penalties.
3. As soon as possible, the hospital should contact the QIO representative identified in the QIO notice to arrange a date for the meeting.
4. As noted above, the hospital should contact CMS to obtain the five-day reviews of the cases selected for the meeting in order to determine the issues identified by the QIO in its prior review of the cases.

5. The hospital's team should review the facts of the cases, including any internal reviews of the cases, or interviews with physicians or hospital staff regarding the facts or circumstances of the cases. If the medical record is incomplete, an effort should be made to identify the missing information that may be pertinent to the presentation of the case at the QIO meeting.
6. The hospital's team should identify any additional information that the reviewer may not have received in conducting the five-day review (for example, missing parts of the medical record).

At the time the hospital is scheduling the meeting for the 60-day review, a representative of the hospital should request a QIO representative to identify the documents relating to each case, including the contents of the patient medical record. Even if the QIO cannot release copies of the documents, it may be possible to determine whether the records are complete.

If the timing of the medical screening exam or other emergency services is an issue, the hospital should review the emergency department census and other relevant information for the date of service.

The hospital should also review whether there are documents or information that the surveyors may not have reviewed or taken in connection with the survey. For example, in a case involving a patient who died in the emergency waiting room while waiting to be seen, a hospital submitted to the QIO a videotape of the waiting room that included the patient up to the point of death.

1. After compiling all available information, the hospital's team should consider its approach to each case, including discussion of unusual facts or circumstances related to the case, the clinical analysis of the care and treatment provided to each patient, and any legal arguments.
2. The hospital should identify a member of the management team to introduce the physicians and staff who will participate in the meeting. It may be helpful for the member of the management team to make a brief (5-10 minute) presentation at the meeting to provide an overview of the hospital and its services, the characteristics of its service area, the demographics of the patient population (especially emergency patients), emergency department volume and other relevant data, and any other information that may be helpful to provide a picture of the hospital and its role in the community.
3. Each case selected for QIO review should be presented by a physician, such as the chief medical officer, director of quality, director of the emergency department, etc. While not required, it is usually helpful to script each case presentation in relevant time sequence, beginning with the patient's arrival and continuing to the patient's departure or other disposition. The case presentation should be complete to make sure that all relevant facts and circumstances of the cases are presented "on the record." As may be applicable, this includes pre-arrival information, presenting condition and complaint, triage, the medical screening, the continuing course of care, diagnostic and other testing, the clinical decision making about the case and the patient's disposition.
4. There is no requirement that the physician or staff who were involved with the cases must participate in the QIO meeting.

Practice Tip: The hospital should not assume that the QIO has a complete copy of the patient medical records, even if the hospital has provided the entire medical record to the EMTALA survey team.

Case Example: In a QIO 60-day review regarding the appropriateness of a medical screening examination, QIO reported at the meeting that it did not have a copy of the emergency department physician's dictated patient report, even though the report had been provided to the survey team and quoted in the Statement of Deficiencies issued by CMS.

Additional Information

If the meeting with the QIO reveals additional information that was not reviewed by the QIO or is helpful to the hospital's case, the hospital should request the opportunity to submit the additional information after the meeting. The additional information must usually be submitted within five days of the meeting.

Final Report

The final QIO report must be submitted to CMS within 60 days of the QIO notice, and include expert medical opinion as to whether:

1. The patient had an emergency medical condition;
2. The condition was stabilized;
3. The patient was transferred appropriately; and
4. There were other medical utilization or quality-of-care issues involved in the case.

Compliance Tip: In the transmittal letter from the QIO, the physician or the hospital is usually offered an opportunity to request that CMS release the final QIO report to the physician or hospital. Hospitals should calendar the time to submit a request for the final report from the CMS regional office. The final report should be reviewed by the hospital and legal counsel to assess the strengths or weaknesses of the cases that may be considered by the OIG for imposition of sanctions for one or more EMTALA violations.

Failure to Receive a QIO Review

In the *St. Anthony Hospital* case (discussed in chapter 7, "Obligations of Receiving Hospitals"), the receiving hospital raised a procedural objection to the imposition of monetary penalties based on the failure by the OIG to obtain a QIO review before the OIG initiated the sanctions process. The court found that the QIO review was a mandatory obligation of the OIG, and that the failure to provide the review has the potential to prejudice the hospital under investigation. However, the court upheld the Departmental Appeals Board decision, stating that it excluded the QIO's analysis of the case in its consideration of the hospital's appeal.

☞ **References:**

QIO Manual, Chapter 9 – Sanction, EMTALA, Fraud and Abuse (Feb. 12, 2016)

III. CIVIL SANCTIONS

A. How are civil sanctions imposed by OIG?

Upon confirmation of an EMTALA violation, OIG may exercise its discretion to impose civil money penalties against a hospital or physician found to have violated EMTALA. In the typical case, OIG will notify the hospital or physician of the alleged violations, request the submission of additional information to respond to the allegations and invite settlement discussions.

If the hospital or physician disputes the allegations, or is unable to settle the matter with the OIG, the case may be submitted for a hearing before an administrative law judge of the U.S. Department of Health and Human Services, and ultimately appealed to the federal courts. In the *St. Anthony Hospital* case (discussed in chapter 7, "Obligations of Receiving Hospitals"), the appeals court stated that a hospital must "negligently" violate EMTALA in order to support the imposition of civil money penalties.

B. Are settlement agreements with the OIG available to the public?

Once executed, a settlement agreement is subject to public disclosure under the Freedom of Information Act. Some settlements are reported in hospital or health care publications or legal newsletters.

C. Are EMTALA violations referred to other governmental agencies?

If CMS determines that an EMTALA violation involves possible patient discrimination, the case will be referred to OCR. The IRS has also requested information on tax-exempt hospitals that have been sanctioned under EMTALA.

Within the past few years, OCR has requested information and documents from Hill-Burton hospitals that receive a Statement of Deficiencies from CMS. The typical OCR letter requests policies and procedures for emergency services, patient transfers, hospital admissions, ambulatory clinics and patient payment practices (such as deposits and alternative arrangements). The letter also requests the hospital to describe its service area, state whether the hospital participates in Medicare, Medicaid and other third-party payer programs, report whether the hospital places limits on its services to patients and confirm the locations where the hospital has posted the Hill-Burton community service notices. OCR usually gives the hospital 30 days to respond to the request for documents and information.

D. What are the sanctions under state laws for patient-dumping?

Some states have adopted penalties for violation of state anti-dumping laws. For example, under California law, hospitals are subject to a civil money penalty of up to $25,000 per violation, and possible suspension or loss of an emergency medical services permit. Hospitals are regulated by CDPH, but any violation by a hospital that is owned and operated by a licensed health care service plan (such as Kaiser) with respect to a plan member must be referred to the Department of Managed Health Care for enforcement.

Physicians are subject to a civil money penalty of up to $5,000 per violation, with credit for fines paid to the federal government under EMTALA. Enforcement actions against physicians

are the responsibility of the Medical Board of California. The Board may impose a fine if it finds that:

1. The violation was knowing or willful;
2. The violation was reasonably likely to result in a medical hazard; or
3. There were repeated violations.

Personnel who knowingly or intentionally violate California law are also subject to misdemeanor penalties brought by the district attorney.

The state fines may not duplicate federal fines. The state is required to credit a hospital or a physician for amounts paid as federal fines. The imposition of civil money fines may be appealed administratively (including an informal conference). If contested, the attorney general may bring action to enforce fines, with the burden of proof on the state to prove the violation and the appropriateness of the fine. If fines are dismissed or reduced, the administrative records must reflect the dismissal or reduction. In lieu of judicial review, the dispute may be submitted to arbitration.

E. Can a violation of state law also constitute "immediate jeopardy" and be grounds for licensing sanctions?

Yes. If in the course of an EMTALA or state survey, the surveyors identify practices, actions or errors that constitute "immediate jeopardy" under California law, CDPH may initiate penalties that are permitted under the California Health and Safety Code. Under California law, "immediate jeopardy" is defined as "a situation in which the licensee's noncompliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to the patient."

Examples of immediate jeopardy sanctions that have been issued for emergency service obligations include the failure to maintain an appropriate roster of on-call physicians, the failure to ensure an appropriate and readily accessible supply of emergency drugs, and medication errors that may constitute an "adverse event."

Further information on administrative penalties for incidents constituting "immediate jeopardy" can be found in CHA's *California Hospital Survey Manual*. In addition to explaining the potential penalties under California law, the guide explains who the surveyors are, which laws they assess compliance with and how they conduct a survey. For more information about the manual or to order, visit www.calhospital.org/survey-manual.

☞ **References:**

42 U.S.C. Section 1395dd(i) (Appendix A)

42 C.F.R. Sections 489.20(l) and 489.24(f)-(h) (Appendix B)

42 C.F.R. Sections 489.53 and 1003 et seq.

Health and Safety Code Sections 1317.3(e); 1317.4(d), (e), (f) and (h); 1317.5; 1317.6 (Appendix D)

Health and Safety Code Sections 1280.1 and 1280.3

EMTALA Enforcement Chart (Appendix I)

Hospital Records Subject to EMTALA Enforcement Survey (Appendix J)

Investigative Procedures for EMTALA Surveyors, Provider Certification, paragraph 3400 et seq. (Appendix K)

EMTALA Physician Review Worksheet (Appendix W)

14 Private Actions to Enforce EMTALA

I. Overview 14.1

II. Private Actions 14.1

A. A Patient May Bring an EMTALA Action Against a Hospital, Not Against Physicians 14.1

B. Private Actions Against Public Hospitals 14.1

C. Third-Party Right of Action Against a Hospital 14.2

D. Procedural Rules and Damages 14.2

Limitations on Damages 14.2

Discovery of Peer Review Records 14.2

Injunctive Relief 14.3

Termination of Medicare Provider Status 14.3

Punitive Damages 14.3

Preemption 14.3

E. Standard of Proof 14.3

F. Application to Hospital Inpatients 14.4

G. Decisions Refusing to Apply EMTALA to Inpatients 14.4

James v. Sunrise Hosp., 86 F.3d 885 (9th Cir. 1996) 14.4

Bryant v. Adventist Health System West, 289 F.3d 1162 (9th Cir. 2002) 14.5

Bryan v. Rectors & Visitors of the Univ. of Virginia, 95 F.3d 349 (4th Cir. 1996) 14.5

Baxter v. Holy Cross Hosp. et al., 155 F.3d 557 (4th Cir. 1998) (unpublished opinion) 14.6

H. Decisions Applying EMTALA to Inpatients 14.6

Thornton v. Southwest Detroit Hosp., 895 F.2d 1131 (6th Cir. 1990) 14.6

Roberts v. Galen of Virginia, Inc., 525 U.S. 249 (1999) 14.7

Lopez-Soto v. Hawayek, 175 F.3d 170 (1st Cir. 1999) 14.7

Postscript 14.8

Moses v. Providence Hospital and Medical Ctrs., 561 F.3d 573 (6th Cir. 2009) 14.8

Liles v. TH Healthcare, LTD, et al., No. 2:11-cv-528-JRG (E.D. Tex. Sept. 10, 2012) 14.8

Application to Ambulance Patients 14.9

I. Application to Urgent Care Centers 14.10

Friedrich et al. v South County Hospital Healthcare System, et al., 221 F. Supp. 3d 240 (D. Rhode Island 2016) 14.10

J. Duty to Treat — Inadequate Examination or Refusal or Failure to Treat ... 14.10
Inadequate Examination or Stabilization ... 14.10
Standard for Medical Screening and Stabilization ... 14.11
K. Duty to Treat — Extent of Treatment ... 14.13
L. Failure to Provide Appropriate Transfer ... 14.13

14 Private Actions to Enforce EMTALA

I. OVERVIEW

Any individual who suffers personal harm as a direct result of a hospital's violation of EMTALA may bring a civil lawsuit against the hospital, with damages limited to those available under the personal injury law of the state in which the hospital is located. Additionally, any facility that suffers a financial loss as a direct result of another hospital's violation of EMTALA can obtain damages and equitable relief under applicable state law. No private enforcement action may be brought under EMTALA more than two years after the date of the violation.

Under California law, persons suffering personal harm and facilities suffering financial loss from violations of state statutes/regulations may seek civil action, including damages, reasonable attorney fees and other appropriate relief. The attorney general or district attorney may also bring an action to enforce state emergency service laws.

NOTE: Since the enactment of EMTALA, there have been hundreds of reported decisions in EMTALA actions brought by patients against hospitals. The following is an overview of the types of judicial decisions interpreting EMTALA in these civil actions. This summary is intended to provide a sampling of EMTALA cases; it is not a comprehensive review or listing of EMTALA decisions.

II. PRIVATE ACTIONS

A. A Patient May Bring an EMTALA Action Against a Hospital, Not Against Physicians

The language and legislative history of EMTALA show that the statute was not intended to provide a private cause of action against physicians. However, many federal EMTALA claims also include state malpractice claims against the physicians involved. The federal courts have shown a willingness to retain jurisdiction of such claims, even when the EMTALA claim has been dismissed.

B. Private Actions Against Public Hospitals

EMTALA allows any individual who suffers personal harm as a direct result of a violation to initiate a civil action against the hospital for damages (to the degree available under the laws of the state) and/or equitable relief. However, several district court cases and a Sixth Circuit case dismissed EMTALA claims brought by patients against public hospitals. These courts have concluded that in EMTALA, Congress did not convey a clear intent to eliminate a state's ability to determine which types of cases can be brought against it (or against political subdivisions of the state, such as counties or districts that operate hospitals) in its courts. If a state voluntarily waives its immunity from EMTALA lawsuits, or does not raise immunity claims in response to a private action against it, an individual can maintain an EMTALA action for money damages against a public hospital.

C. Third-Party Right of Action Against a Hospital

The EMTALA statute provides that "any individual" who suffers personal harm as a direct result of a violation may initiate a civil action against the hospital. In a groundbreaking decision, the Sixth Circuit recently interpreted "any individual" expansively, to include not just patients or their representatives, but also third parties who suffer personal harm as a direct result of a hospital's failure to screen or stabilize a patient as required under EMTALA.

In *Moses v. Providence Hospital and Medical Ctrs.*, 561 F.3d 573 (6th Cir. 2009), the estate of Marie Moses-Irons brought an action for damages alleging that the hospital had violated EMTALA in discharging Moses-Irons' husband ten days before he murdered her. On Dec. 13, 2002, Moses-Irons took her estranged husband to the emergency room due to physical and psychiatric symptoms including hallucinations, delusions and threatening behavior that she reported to emergency room staff had made her fear for her safety. Her husband was admitted as an inpatient, but was not transferred to the hospital's psychiatric unit despite physician documentation requesting such transfer. Howard was discharged on Dec. 19, 2002 and murdered Moses-Irons ten days later.

The district court dismissed the action in 2007 without addressing the issue of whether Moses-Irons had standing to sue. However, the Sixth Circuit squarely addressed the issue, holding that the plain language of EMTALA allows any individual, not just a patient, to sue after sustaining personal harm as a direct result of a hospital's EMTALA violation.

The Moses decision marks the first time a federal court has addressed whether non-patients have standing to sue for personal harm under EMTALA. It remains to be seen whether other federal courts will find the decision in the Moses case persuasive. As noted later in this chapter, the court rejected the hospital's argument that EMTALA did not apply since the husband was admitted as an inpatient; the Sixth Circuit has held in several cases that EMTALA applies to the discharge of inpatients who first presented to the emergency department.

D. Procedural Rules and Damages

Limitations on Damages

A number of federal and state courts have held that state limits on damage recovery for personal injury or malpractice actions apply to EMTALA damages. In *Barris v. County of Los Angeles* (20 Cal.4th 101 (1999)), the California Supreme Court held that the limitations on recovery for noneconomic damages prescribed by the Medical Injury Compensation Reform Act (MICRA) of 1975 apply to certain EMTALA claims. The court stated in a footnote to the case that it was limiting its conclusion to claims under EMTALA for failure to provide necessary stabilizing treatment. The court noted that it did not consider whether the MICRA limits apply to failure to provide an appropriate medical screening examination since the plaintiff's EMTALA screening claim was dismissed and not an issue before the court.

Discovery of Peer Review Records

California Evidence Code Section 1157 protects from discovery in civil litigation (such as malpractices cases) the records and proceedings of peer review bodies (including hospital medical staff). As a state rule of evidence, Section 1157 is not always given full effect in federal court. In *Burrows v. Redbud Community Hospital* (187 F.R.D. 606 (1998)), the plaintiff sought to obtain access to peer review records. The California district court declined to apply Section 1157 to the discovery request, based on a prior ruling permitting discovery in

a California antitrust case, and a finding that the absolute protection of Section 1157 was inconsistent with the flexibility of federal privilege law.

Injunctive Relief

A patient may bring an action under EMTALA for injunctive relief against a hospital.

Termination of Medicare Provider Status

EMTALA does not authorize private plaintiffs to initiate a civil action to terminate a hospital's Medicare provider agreement.

Punitive Damages

Recovery of damages may include punitive damages if permitted under state law.

Preemption

State and local laws are not preempted, except to the extent that a requirement directly conflicts with EMTALA.

E. Standard of Proof

In January 1999, the U.S. Supreme Court (524 U.S. 249) reversed a Kentucky case in which the Court of Appeals for the Sixth Circuit held that EMTALA requires showing an improper motive in order for damages to be recovered for an EMTALA violation.

In *Roberts v. Galen of Virginia, Inc.*, the patient was admitted to the then Humana Hospital — University of Louisville for injuries resulting from being hit by a truck. Following a two-month stay, the patient was discharged to a nursing facility, where her condition significantly deteriorated. Although the hospital social worker who placed the patient knew that the patient was uninsured, the resident who discharged the patient was unaware of the patient's financial condition. The patient's guardian brought an action alleging that the hospital failed to comply with EMTALA by discharging the patient in an unstabilized condition, among other grounds.

The district court ruled in favor of the hospital, finding that the plaintiff had not proven that the patient was medically unstable or that the transfer order was caused by an improper motive. The Sixth Circuit, in affirming the district court decision, held that a patient must demonstrate an improper motive beyond financial considerations in order to maintain a cause of action under EMTALA. As examples of an "improper motive," the court cited race, sex, politics, occupation, education, personal prejudice, drunkenness and spite.

The *Roberts* case was the first and only EMTALA case to be considered by the U.S. Supreme Court. In a unanimous opinion, the court held that a plaintiff does not have to demonstrate an improper motive by a provider in order to recover damages under EMTALA for failure to provide further examination and treatment to stabilize an emergency medical condition prior to discharge or transfer.

This decision generally follows the view of the Centers for Medicare & Medicaid Services (CMS) and the Office of Inspector General (OIG) that motive is not a relevant consideration in determining whether a physician or hospital violated EMTALA. However, an improper motive may increase the amount of civil money penalties assessed against a provider and, in particularly egregious or repeated cases, the possibility of an action to seek exclusion of the provider from the Medicare program.

F. Application to Hospital Inpatients

In *Roberts*, the Sixth Circuit (187 F.3d 637) noted in a footnote a prior decision of the same circuit (*Thornton v. Southwest Detroit Hosp.*, discussed on page 14.6) holding that EMTALA applies to the transfer or discharge of an inpatient. Although the inpatient issue was argued before the court, the decision did not address the issue. At the time that the Supreme Court considered the *Roberts* case, the Sixth Circuit Court of Appeals had applied EMTALA to inpatients in both *Roberts* and *Thornton*; however, the Fourth and Ninth Circuit Courts of Appeals had declined to apply EMTALA to other cases involving inpatients. The Supreme Court declined to address the inpatient question since it was able to decide the case on narrower grounds.

Although EMTALA clearly applies to patients presenting to a dedicated emergency department, the statute's applicability to inpatients is not as obvious. The courts that have addressed the inpatient issue have reached different interpretations of the following two relevant subsections in the statute:

1. Subsection (a) of EMTALA specifies that any individual who comes to the emergency department is entitled to a medical screening exam to determine whether an emergency medical condition (EMC) exists.
2. Subsection (b) of EMTALA requires the provision of further examination and stabilizing treatment to any emergent patient who comes to a hospital.

The difference between the references to "emergency department" in subsection (a), and to "hospital" in subsection (b), has been explored by the courts in determining whether they are interdependent or independent.

By construing each subsection of the statute in conjunction with the other, the Fourth and Ninth Circuits limited the scope of EMTALA to patients who received initial stabilizing care by the hospital. According to these circuits, the statute's stabilization requirements in subsection (b) apply to patients who have been determined under subsection (a) to have an EMC; therefore, applying the law to hospital inpatients would erroneously extend EMTALA's scope.

The First and Sixth Circuits, however, have read these two subsections independently. These circuits have applied the EMTALA obligations to inpatients with an EMC. According to these circuits, EMTALA should apply to all patients suffering from an EMC because the problem of patient dumping is not limited to the emergency room.

G. Decisions Refusing to Apply EMTALA to Inpatients

James v. Sunrise Hosp., 86 F.3d 885 (9th Cir. 1996)

In James, the plaintiff entered the hospital with acute renal failure. A week later, the hospital discharged her despite her complaints about pain and numbness, a weak pulse and discoloration that had developed since receiving a synthetic graft in her arm when she came to the hospital. The plaintiff's hand subsequently had to be amputated. The plaintiff sued the hospital under subsection (c) of EMTALA, claiming that she was at the hospital with an EMC and was not stabilized before discharge.

The Ninth Circuit held that the case should be dismissed for failure to state a claim under EMTALA, determining that each subsection of EMTALA must be read in conjunction with the

others. The court concluded that the transfer/discharge obligations in subsection (c) of the EMTALA statute apply only to individuals who first presented to the emergency department (i.e., subsection (a)). Since subsection (c)(iii) of EMTALA requires a qualified professional to certify a transfer when a physician is not present in the emergency department, the court reasoned that the transfer obligations in subsection (c) must apply only to emergency room transfers. "It is impossible to think of a good reason why Congress would condition some subsection (c) transfer provisions on whether a physician 'is not physically present in the emergency department' unless it meant to be speaking in subsection (c) about decisions to be made in the emergency room." Since the plaintiff was not in the emergency room when she was discharged from the hospital, the court refused to apply EMTALA's transfer obligations to her discharge.

Bryant v. Adventist Health System West, 289 F.3d 1162 (9th Cir. 2002)

In *Bryant*, the patient presented to the emergency department with a fever and chest pain. The emergency physician examined the patient, ordered tests, and discharged the patient with instructions to return the following day for further diagnosis and treatment. The following day, the hospital called the patient's family and requested that the patient return to the hospital immediately because of a lung abscess. The patient was seen in the emergency department, admitted as an inpatient, and transferred three days later to a hospital with a higher level of care. Following the death of the patient, the family sued the hospital, claiming a failure by the hospital to detect an EMC and to stabilize that condition as both an emergency patient and an inpatient.

Based on the medical screening and stabilization standard discussed on page 14.11 in connection with the *Jackson* decision, the court upheld the district court's determination that the hospital did not violate EMTALA on the initial visit to the emergency department. With respect to the alleged failure to provide stabilizing treatment during the inpatient stay, the court, after reviewing the *Thornton* and *Bryan* cases (discussed below), determined that EMTALA does not apply to inpatients unless the patient is admitted as a subterfuge to avoid the EMTALA requirements.

Bryan v. Rectors & Visitors of the Univ. of Virginia, 95 F.3d 349 (4th Cir. 1996)

In *Bryan*, the patient was admitted to the hospital in emergency respiratory distress. After 12 days of treating the patient, the hospital determined it would not make further efforts to prevent her death, despite the family's wishes to the contrary. Eight days later, when the patient faced a life-threatening heart attack, the hospital took no action and the patient died. The plaintiff sued the University of Virginia, claiming that the university's hospital failed to stabilize the patient as required under EMTALA.

The Fourth Circuit upheld the district court's dismissal of the plaintiff's complaint for failure to state a claim under EMTALA. The court explained that "[t]he stabilization requirement was intended to regulate the hospital's care of the patient only in the immediate aftermath of the act of admitting her for emergency treatment." The court pointed out that professional standards of care and state medical malpractice laws govern the adequacy of care for a patient once EMTALA's limited purpose is served, and the patient is beyond initial emergency admission and stabilization. The court added, "everyone agrees EMTALA was not intended to preempt [malpractice law]." Therefore, although it did not address the issue specifically, the court's reasoning suggests that EMTALA does not impose a continuing obligation to provide stabilizing care to inpatients during the entirety of their stay in the hospital.

Baxter v. Holy Cross Hosp. et al., 155 F.3d 557 (4th Cir. 1998) (unpublished opinion)[1]

In *Baxter*, the patient was admitted for kidney and cardiac problems. Approximately two weeks after admission, the patient's wife, after consultation with the treating physician, agreed to the termination of the patient's dialysis due to difficulties in the procedure. The patient remained in the hospital for another week, at which time his wife was advised that the hospital would no longer assume payment for her husband's care. Although the hospital did not require the patient to leave, his wife consented to his transfer to a nursing facility within a few days of being informed of the hospital's financial decision. The patient died the day after the transfer. The wife then sued, basing a claim under EMTALA for the hospital's failure to comply with the statute's stabilization and transfer requirements.

The Fourth Circuit upheld the dismissal of the plaintiff's EMTALA claim. The court stated that because the dialysis was discontinued because of the wife's informed decision, it was impossible for her to claim that the hospital did not meet its duty of stabilization under EMTALA. The court found the case hardly distinguishable from *Bryan* and, accordingly, determined that EMTALA only applied to the initial emergency stabilization. In addition, the court reaffirmed that recovery for allegedly inadequate care beyond the initial emergency treatment should be sought through existing state malpractice laws.

H. Decisions Applying EMTALA to Inpatients

Rather than limit EMTALA's application to the initial treatment and stabilization of emergency patients, the First and Sixth Circuits have applied EMTALA's stabilization and transfer requirements to hospital inpatients. These courts have interpreted the subsections of the statute independently. Thus, the stabilization and transfer requirements in subsections (b) and (c) apply to all patients who have come to the hospital.

Thornton v. Southwest Detroit Hosp., 895 F.2d 1131 (6th Cir. 1990)

In *Thornton*, the patient was transferred to the hospital following a stroke. She entered the hospital through its emergency room, and was admitted to the intensive care unit. After a three-week stay, including 11 days in regular inpatient care, the attending physician recommended that the patient be discharged to a rehabilitation facility. However, the rehabilitation facility refused to accept her because she could not afford the treatment, and the patient instead was released to her sister's home until she could eventually gain admission to the rehabilitation facility. The patient sued under EMTALA, claiming that the hospital failed to stabilize the EMC that brought her to the hospital. The district court granted summary judgment to the hospital, finding that the hospital had in fact stabilized the patient within the meaning of the law.

The Sixth Circuit upheld the dismissal of the patient's EMTALA claim since she failed to make a showing that she was not stabilized at the time of discharge. The court specifically noted that its decision was not based on the length of the patient's stay and treatment in the hospital. At the same time, the court rejected the hospital's defense that EMTALA did not apply to the patient because she was not discharged from the emergency department.

Instead, the court examined the different wording in subsections (a) and (b) of EMTALA to mean "that once a patient is found to suffer from an emergency medical condition in the

1 As an unpublished opinion, *Baxter* does not have the force of law. However, it is instructive in its reasoning and its demonstration of the Fourth Circuit's continuing position on EMTALA.

emergency room, she cannot be discharged until the condition is stabilized, regardless of whether the patient stays in the emergency room." As further stated by the court:

> Although emergency care often occurs, and almost invariably begins, in the emergency room, emergency care does not always stop when a patient is wheeled from the emergency room into the main hospital … Emergency care must be given until the patient's emergency medical condition is stabilized.

Although the *Thornton* opinion is noteworthy in its implication that EMTALA applies to inpatients, the court appears to limit the reach of EMTALA only to those patients who first present in the emergency room.

Roberts v. Galen of Virginia, Inc., 525 U.S. 249 (1999)

In *Roberts*, a car accident victim was hospitalized for several weeks before the hospital could find a skilled nursing care facility that would agree to take her for long-term care. The patient's guardian (her aunt) sued the hospital for failure to stabilize her niece prior to transfer. As discussed above, the Sixth Circuit rejected the plaintiff's EMTALA claim since she failed to show that the transfer was based on an improper motive. It is noteworthy that the appellate court did not address whether EMTALA applied to this case; rather, the court merely cited its *Thornton* decision (discussed above) in a footnote for the proposition that EMTALA applied to an inpatient discharge.

During oral argument of this case before the U.S. Supreme Court, the federal government advised the court that it would adopt regulations clarifying whether EMTALA applied to inpatients. Accordingly, the court did not provide insight in *Roberts* as to whether EMTALA applies to inpatients, despite the existing conflict over this issue among the lower courts.

Lopez-Soto v. Hawayek, 175 F.3d 170 (1st Cir. 1999)

In *Lopez-Soto*, the plaintiff was admitted to the maternity ward and gave birth by cesarean section in the operating room to a baby boy who suffered from severe respiratory distress and a pulmonary pneumothorax. The pediatrician determined that the infant required neonatal intensive care available at another hospital; however, the court observed that the pediatrician did not attempt to stabilize the infant or treat him before transfer that evening. The child died the next day.

In reinstating the plaintiff's claim, the First Circuit explored the relationship of the subsections of EMTALA, and found that they established independent obligations. According to the court, although the screening requirement in subsection (a) refers only to the emergency department, the further treatment and stabilizing treatment requirement in subsection (b) refers to all patients who come to a hospital with an emergency condition. The court stated that the language in subsection (b) "unambiguously imposes certain duties on covered hospitals vis-à-vis any victim of a detected medical emergency, regardless of how that person enters the institution or where within the walls he may be when the hospital identifies the problem." Therefore, although the infant entered the hospital through the operating room, his emergency condition entitled him to necessary stabilizing treatment under EMTALA.

After reviewing the split among the circuit courts (discussed above), the court decided that Congress would not have used particularly different language in subsections (a) and (b) of the statute if it had intended to protect only the emergency department patients identified in subsection (a) from patient dumping. According to the court, "Congress' decision to change the 'emergency department' language rather than repeat it in subsection (b) is potent evidence that Congress preferred to cast a wider net in respect to stabilization."

The court concluded that the hospital's detection of the infant's emergency condition triggered the stabilization and transfer requirements under EMTALA. However, the court declined to express a view on the application of EMTALA to patients with continuing unstable conditions (as was the issue in the Fourth Circuit cases above), because the *Lopez-Soto* situation did not call for it. But the court did suggest in a footnote that the issue was a "conundrum" to be dealt with at a later day.

Postscript

All of the foregoing court decisions were rendered prior to the revision of the EMTALA regulations by CMS in 2003. CMS has interpreted the EMTALA statute as not applying to inpatients. The application of EMTALA by CMS to inpatients is discussed further in chapter 2, "When and Where Does EMTALA Begin and End?" Although CMS developed the 2003 regulations based on its view of prevailing judicial trends on the application of EMTALA to inpatients, courts that have previously extended EMTALA to inpatients may not follow the CMS interpretation. As discussed below, the Sixth Circuit decision in *Moses v. Providence* (discussed earlier in this chapter) reaffirmed the view of the Sixth Circuit that the EMTALA obligations apply to inpatients regardless of the contrary CMS regulation. In addition, a District Court in Texas more recently made a distinction in *Liles v. TH Healthcare LTD* (discussed below) between a patient's "administrative status (i.e., admitted as a bona fide patient)" and a patient's medical status and whether it was "stabilized," to apply EMTALA to an inpatient.

Moses v. Providence Hospital and Medical Ctrs., 561 F.3d 573 (6th Cir. 2009)

As discussed earlier in this chapter, plaintiff Moses-Irons took her estranged husband Howard to the emergency room due to physical and acute psychiatric distress. Howard was admitted as an inpatient, discharged six days later, and murdered Moses-Irons ten days later. Relying on the 2003 CMS regulation providing that a hospital satisfies its EMTALA obligations by screening and admitting an individual, the hospital argued that it had discharged its EMTALA obligations by providing a screening examination and then admitting her husband to an inpatient care unit for further testing and care. The Sixth Circuit disagreed, stating that the CMS regulation is inconsistent with EMTALA's language prohibiting a hospital from releasing a patient without first determining that the patient is actually stabilized. In other words, merely admitting her husband as an inpatient and subjecting him to further testing did not discharge the hospital's EMTALA obligations — the hospital was obligated to actually treat and stabilize her husband before discharge.

Liles v. TH Healthcare, LTD, et al., No. 2:11-cv-528-JRG (E.D. Tex. Sept. 10, 2012)

The *Liles* case addressed two separate ED visits by an uninsured patient for EMTALA claims. Plaintiff Liles first came to the emergency room complaining of fever, cough, and shortness of breath and was admitted to the hospital. Over the next few days, Liles contended that while his condition was unstable, various physicians and nurses attempted to transfer him out of the hospital on 18 separate occasions. At one point, he was certified stable for transfer, but at or near the time he was placed in the ambulance he went into cardiac arrest. He was brought back into the hospital's ICU for approximately one month before being discharged home. The second visit occurred two days after the discharge when Liles was transported to the hospital by ambulance. The hospital refused to admit him for treatment on the grounds that there was no pulmonologist available to evaluate and treat him at the hospital. Liles was eventually transferred to another facility and was diagnosed with a collapsed lung.

Regarding the first visit, the hospital argued that the plaintiff's EMTALA claims were barred because he had been admitted to a hospital as a bona fide inpatient. The court rejected this argument, citing the statutory language of EMTALA without reference to the regulations and case law from the Fifth Circuit. More specifically, the court held that the plain language of the EMTALA statute indicates that a hospital may not transfer an individual with an emergency medical condition that has not been "stabilized." The court acknowledged the Fifth Circuit's holding that a hospital's responsibility under EMTALA ends when it has stabilized the individual's medical condition. Therefore, the court found that the application of EMTALA does not depend on the patient's administrative status (i.e., admitted as an inpatient), but on his or her medical status and whether it was "stabilized." The court determined that Liles had pled sufficient facts to state a plausible EMTALA claim that his medical condition was not "stabilized" prior to his discharge from his first visit to the hospital, even though he was an inpatient at the time.

It is important to note that the court did not address the 2003 EMTALA regulations in its decision.

Application to Ambulance Patients

As discussed in chapter 2, "When and Where Does EMTALA Begin and End?" the EMTALA regulations provide that a patient in a nonhospital-owned ambulance off hospital property is not considered to have come to the hospital's emergency department, even if a member of the ambulance staff contacts the hospital and requests transport to the hospital for a patient. In *Arrington vs. Wong*, 237 F.3d 1066 (9th Cir. 2001), ambulance personnel contacted a hospital to which they were transporting a patient in severe respiratory distress. The emergency physician asked the ambulance attendant the name of the patient's physician, and then told the attendant that it "would be okay" to take the patient to a military hospital. Following the death of the patient, the family brought an action against the hospital (among others) alleging an EMTALA violation for refusing the ambulance. The district court dismissed the action on the grounds that the patient never came to the hospital.

On appeal, the court interpreted the phrase "comes to the emergency department" to include both the physical arrival on the hospital grounds, as well as the act of traveling to the hospital. The court then reviewed the regulation on ambulances, and noted that a hospital may deny access when it is on diversion. The court interpreted the diversion language as prohibiting a hospital from denying individual access unless it is on diversion. Therefore, the court held that a hospital not on diversion must have a valid treatment-related reason to refuse to accept a patient in a nonhospital-owned ambulance.

In 2008, the First Circuit came to the same conclusion on similar facts. In *Morales v. Sociedad Espanola De Auxilio Mutuo Y Beneficencia et al.*, 524 F.3d 54 (1st Cir. 2008), ambulance personnel contacted the hospital to which they were transporting a patient in pregnancy-related distress. The emergency physician told the ambulance attendant that he was worried that the plaintiff might voluntarily have induced an abortion, that he was very busy and to call back. When the paramedics called again, the emergency physician asked whether the patient had insurance and when he did not receive an affirmative response, hung up the phone. The paramedics took this as a refusal to treat the patient and took her to an alternate facility. The patient and her family brought an action against the hospital alleging an EMTALA violation for refusing the ambulance. The district court granted the hospital summary judgment, but the First Circuit reversed, holding that an individual can "come to"

the emergency department for EMTALA purposes without physically arriving on the hospital's grounds as long as the individual is en route to the hospital and the emergency department has been notified of the individual's imminent arrival.

Many commentators have been critical of the *Arrington* and *Morales* decisions since the regulation specifically states that a nonhospital-owned ambulance must be on hospital property in order to trigger the EMTALA obligations. Although some CMS personnel have suggested that *Arrington* does not reflect CMS policy, it declined to revise its definition of "comes to the emergency department" in the revised EMTALA regulations. Although it is uncertain whether CMS would confirm an EMTALA violation for a similar case, *Arrington* and *Morales* remain the interpretation of EMTALA in the Ninth Circuit (which includes California) and First Circuit, respectively, for private EMTALA lawsuits against hospitals.

I. Application to Urgent Care Centers

Friedrich et al. v South County Hospital Healthcare System, et al., 221 F. Supp. 3d 240 (D. Rhode Island 2016)

In *Friedrich*, the patient presented to the hospital's Urgent/Walk-In Care complaining of severe pain and burning in chest and right arm. She was diagnosed with gastroesophageal reflux disease, given a "GI cocktail," and discharged with no follow-up ordered. The next day she was found unresponsive at home, transported to the hospital, and pronounced dead. The cause of death was confirmed as atherosclerotic and hypertensive cardiovascular disease.

The issue the court explored was whether the Urgent/Walk-In Care was subject to EMTALA, and therefore required to provide an appropriate medical screening and stabilizing treatment. The decision focused on whether the Urgent/Walk-In Care met the definition of a "dedicated emergency department" of the hospital. Under CMS' definition (including a department of the hospital that is "held out to the public by name, posted signs, advertising or other means as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment"), the court noted that the most important criterion is whether the clinic would be perceived by an individual as an appropriate place to go for emergency care. In that case, even though the hospital's website stated that the clinic was for "non-emergency needs," and that it did not provide "emergency room level care," the court found that a person driving by and seeking emergency care would not first check the website; the court also indicated that the signage did not distinguish "urgent" care from "emergency" care. Since patients would believe that the urgent/walk-in care clinic was held out as an appropriate place to go for emergency care, it was a "dedicated emergency department" under EMTALA.

J. Duty to Treat — Inadequate Examination or Refusal or Failure to Treat

Inadequate Examination or Stabilization

The courts have held that a patient may establish a cause of action under EMTALA if a hospital fails to provide an appropriate medical screening examination or stabilize an EMC before transferring a patient to another hospital. A refusal to treat, regardless of whether a transfer has occurred, has been found to constitute an EMTALA violation.

Standard for Medical Screening and Stabilization

As discussed in chapter 3, "Medical Screening Examinations," the *Interpretive Guidelines* define an appropriate medical screening examination as an examination sufficient to determine, within reasonable clinical confidence, whether an individual has an EMC. From the beginning of EMTALA, there have been numerous lawsuits against hospitals seeking damages under EMTALA for an inadequate medical screening.

In *Jackson v. East Bay Hospital* (246 F.3d 1248, 1257 (9th Cir. 2001)) the Ninth Circuit Court of Appeal addressed the standards for providing the medical screening examination and stabilizing treatment. In *Jackson*, the patient presented to the hospital emergency department three times in a four-day period. The initial visit resulted from the referral of the patient who had a psychotic disorder by county mental health for medical clearance; the emergency physician obtained a history, performed a physical examination, ordered tests and determined that there was no medical emergency. Two days later, the patient presented again with a complaint of sore throat, chest pain and dry heaves. The emergency physician saw the patient, ordered EKG and lab tests, diagnosed chest contusions, hypertension and psychosis, prescribed medication and discharged the patient with instructions to return to county mental health the following day. On the following day, the patient was taken to the emergency department after he was found wandering in the road; the emergency physician prescribed additional medication. On request of county mental health, the emergency physician arranged the transfer of the patient to an inpatient psychiatric hospital. Shortly after arrival at the receiving hospital, the patient went into cardiac arrest, and subsequently died following transfer to a third hospital.

In reviewing the three screening examinations performed by the hospital, the court adopted the "comparative test" that had been followed by seven other judicial circuits. A medical screening must be comparable to the screening provided to patients presenting with similar signs and symptoms, unless the examination is so cursory that it is not designed to identify acute or severe symptoms alerting the physician to a possible emergency condition. The court therefore upheld the finding of the district court that the patient received a medical screening on each visit, and that expert witnesses did not believe that this patient was treated differently from other patients presenting with similar signs and symptoms.

The court also adopted the "actual detection" standard that had been followed by five other judicial circuits, and affirmed that a hospital is required to stabilize only those medical conditions that it has detected. The court reaffirmed that EMTALA is not a medical malpractice statute by finding that if the medical screening meets the comparative test, there is no EMTALA liability for failure to identify the patient's condition or to transfer and discharge the patient based on that assessment.

In an unpublished 2007 decision,[2] a federal district court considered when a medical screening examination is so cursory that it is not designed to identify acute or severe symptoms alerting the physician to a possible EMC. In *Lewellen v. Schneck Medical Center a/k/a Schneck Memorial Hospital et al.*, an intoxicated driver was injured when he drove off an interstate highway into a ditch 50 to 100 yards from the road. The paramedics transported the driver to a hospital emergency department due to the driver's complaint of lower back pain. The patient records indicated that the emergency physician examined

2 As noted in footnote 1, an unpublished opinion does not have the force of law, although its reasoning and application of EMTALA may be instructive for compliance purposes.

the patient, noting a complaint of lower back pain and tenderness of his lumbar spine. The emergency physician also ordered X-rays of the patient's lumbar and cervical spine.

A little over an hour after arrival, the emergency physician discharged the patient, despite the patient's pleading with an emergency department nurse that he was in tremendous pain and wanted to see the physician. The court noted that the last of the X-rays had not been printed at the time of the discharge order.

According to the court, the emergency physician at some point noted in the medical record that the X-rays did not reveal a fracture and the patient's lack of cooperation caused the films to be of poor quality. In a quality control process, a hospital radiologist reviewed the films two hours after discharge and noted an ossific density that could be a bone spur, and could not completely exclude a fracture due to the poor quality of the X-rays. The court noted that the radiologist did not notify the emergency physician of his findings, despite hospital protocol.

Lewellen subsequently sued the medical center alleging that the emergency physician failed to provide an appropriate medical screening examination and stabilizing treatment for what turned out to be a burst fracture in his lower back. The court cited the Jackson decision, noting two prongs to the screening test — differential screening and cursory screening. The court then sided with the medical center that Lewellen had not presented evidence that the screening of his medical condition differed from the screening provided to any other patient.

However, the court then determined that a reasonable jury could conclude that the screening was so cursory that it was not designed to identify acute and severe symptoms. The medical center argued that the emergency physician had performed a neurological examination that appeared normal, and exercised medical judgment in concluding the patient could be safely discharged. The court rejected the medical center's argument and its request for summary judgment on Lewellen's EMTALA claim, stating the following:

> But according to the evidence presented by the Plaintiffs, the X-rays ordered by Dr. Resiert were being printed off as Lewellen was being discharged. A jury could conclude that either Dr. Reisert did not even bother to look at them or looked at them so casually that he missed what two other physicians said was obvious: that the X-rays demonstrate that Lewellen had a burst fracture in his spine. If Reisert did not study the X-rays how could his screen be designed to identify acute and severe symptoms? Lewellen's stay at the hospital was alarmingly brief considering he was in a motor vehicle accident and complaining of severe back pain so bad that he could not stand or sit in a chair correctly. Lewellen still had a bleeding gash in his arm with grass and dirt when he arrived at prison. The court is mindful that EMTALA's screening requirement means more than an inadvertent failure to follow the regular screening process in a particular case…But this scenario is so grave that a jury could conclude that rather than a negligent deviation from normal practice, the screening requirement was simply not met." [citations omitted]

In general, the courts have held that EMTALA is not intended to ensure each emergency room patient a correct diagnosis, but rather to ensure that each patient is accorded the same level of treatment regularly provided to patients in similar medical circumstances. A misdiagnosis alone does not create a cause of action under EMTALA. As stated by one court, "what constitutes an 'appropriate' screening is properly determined not by reference to particular outcomes but instead by reference to a hospital's standard screening procedures." This has resulted in most courts looking for evidence as to whether a hospital followed its

policies and procedures, provided a medical screening examination to determine whether a patient had an EMC, and treated a patient in the same manner as other patients presenting with similar symptoms and conditions. However, the analysis and application of EMTALA in the *Lewellen* decision (even if not a published decision) is a reminder the examination must also meet the "cursory screening" test described in the *Jackson* decision.

K. Duty to Treat — Extent of Treatment

In the *Matter of Baby "K,"* 16 F.3d 590 (4th Cir. 1994), the court held that EMTALA "does not provide an exception for stabilizing treatment physicians may deem medically or ethically inappropriate." In this case, the hospital sought a declaration from the court that EMTALA does not require continuation of emergency medical treatment (other than warmth, hydration and nutrition) for an anencephalic infant when the physicians and hospital, in accordance with hospital and community standards, determine that treatment would be futile. The court rejected the hospital's arguments, finding that the hospital was required to provide treatment necessary to prevent the material deterioration of the patient's EMC (in this case, to provide respiratory support). The court also rejected the hospital's argument that EMTALA did not require a hospital to provide treatment exceeding the prevailing standard of care, stating that the hospital was obligated to provide stabilizing care for anencephalic infants in the same manner as comatose, cancer or muscular dystrophy patients who may repeatedly present in respiratory distress.

L. Failure to Provide Appropriate Transfer

As described in chapter 5, "Transferring or Discharging an Emergency Patient," if an individual has an EMC that a hospital does not have the capability to treat, or upon the informed request by the patient, EMTALA obligates a hospital to make an appropriate transfer of an individual to another hospital. There have been several lawsuits against hospitals seeking damages under EMTALA challenging the sufficiency of an informed request for transfer and the physician certification.

As discussed more fully in chapter 5, a 2009 federal district court in *Guzman v. Memorial Hermann Hospital System* (S.D.Tex., No. H-07-3973, June 16, 2009), addressed a patient's informed request for transfer. The court stated that a hospital cannot meet its EMTALA obligation to obtain patient consent to transfer (as opposed to physician certification) by merely having a patient or proxy sign a form. Rather, EMTALA requires that the hospital inform the patient about the hospital's obligations to provide examination and stabilizing treatment as well as the risks and benefits of transfer before initiating the request and having the patient or proxy sign the form.

In a separate 2009 decision, a District Court in Iowa reviewed the sufficiency of the physician certification, finding a lack of evidence that the physician adequately deliberated and weighed the medical risks and benefits of a transfer. The court also found that the physician gave improper consideration to significant factors in certifying the transfer (*Heimlicher v. Steele* (615 F.Supp.2d 884, 2009)). The analysis of the *Heimlicher* court is discussed in chapter 3, "Medical Screening Examinations."

15 Quality Improvement and Risk Management

I. Overview 15.1

II. Policies and Procedures 15.1

III. Internal Monitoring 15.1

IV. In-Service Education 15.2

15 Quality Improvement and Risk Management

I. OVERVIEW

EMTALA compliance is a responsibility of the hospital and its medical staff. Each hospital should have a board-approved policy mandating compliance with EMTALA, and making compliance a substantial part of its in-service education, quality improvement and risk management programs. A model hospital policy on compliance with EMTALA is attached as Appendix O of the manual.

EMTALA should also be part of a hospital's compliance program. Failure to comply with EMTALA should be viewed as potentially exposing the hospital to the Centers for Medicare & Medicaid Services (CMS) enforcement action, possible monetary sanctions, patient litigation and adverse publicity. Responding to a CMS enforcement survey is time-consuming, costly and highly disruptive, and often places a high degree of stress on emergency personnel, as well as other departments responsible for ensuring EMTALA compliance.

CMS and the Office of Inspector General (OIG) are interested in the quality improvement processes used by hospitals to evaluate EMTALA compliance, train personnel and implement corrective action. CMS routinely advises its surveyors to review the quality management process as part of an EMTALA survey. In more than one sanction case, the OIG inquired as to the actions taken by a hospital medical staff to evaluate the failure of an on-call physician to accept a patient. An attorney representing the OIG suggested that action by the medical staff or the hospital to discipline an on-call physician for refusal to accept a call when required to do so would be viewed favorably by the OIG in deciding whether to seek sanctions against the hospital for transferring a patient due to the on-call failure.

II. POLICIES AND PROCEDURES

Quality improvement, risk management and EMTALA compliance start with policies and procedures. Included as Appendix N is a checklist of the types of policies and procedures recommended for EMTALA compliance. Included as Appendix O is a model hospital policy on compliance with EMTALA.

III. INTERNAL MONITORING

Monitoring EMTALA compliance is a responsibility of hospital administration, department heads, the medical staff, quality improvement and risk management. At a minimum, hospitals and their medical staffs should adopt a quality assurance/performance improvement program for monitoring EMTALA compliance, including the conduct of medical screening examinations and sending and receiving patient transfers.

The Quality Assurance and Performance Improvement (QAPI) program should include:

1. Responsibilities for monitoring;
2. A schedule for monitoring activities;
3. Monitoring tools and surveys used to measure EMTALA compliance;
4. Thresholds for focused reviews;
5. Action steps to resolve or correct problems identified by the program; and
6. Communication of monitoring results to hospital medical staff, administration and other affected department heads and facility personnel.

Although there is no mandated sample size for reviewing screening and transfer cases, many hospitals review 100 percent of their emergency, labor and psychiatric patient transfers. Sample sizes vary for medical screening due to the volume of emergency visits. A hospital should determine a statistically valid sample size, and re-evaluate the sample size periodically based on the degree of compliance evidenced by the reviews. If certain patterns of noncompliance are discovered, focused reviews in those areas should be added to the screening review. Sample tools for review of patient transfers and medical screening examinations are included as Appendix L.

A number of hospitals have expanded the scope of their quality assessments. Additional reviews include:

1. Transfers received by the hospital;
2. All requested transfers to the facility that were denied by the hospital;
3. Patient intake and financial screening processes;
4. All patients who elope or leave the hospital prior to receiving a medical screening examination;
5. All patients who refuse necessary stabilizing treatment or leave against medical advice;
6. Patient disposition for patients referred from the emergency department to other departments for their medical screening examination;
7. On-call physician compliance;
8. Response to individuals seeking or in need of emergency services on hospital property outside of the main facility building; and
9. Timely and accurate completion of central logs.

IV. IN-SERVICE EDUCATION

The key to effective EMTALA compliance is ongoing in-service education for all personnel and physicians involved in emergency patient intake and acceptance, screening, treatment and transfer. For emergency personnel, EMTALA education should be continuous, using formal in-service education programs; periodic meetings to identify, discuss and resolve EMTALA questions and issues or reach consensus on best practices for handling difficult cases or

circumstances; and memoranda and other communications to reinforce staff compliance with the EMTALA requirements.

In-service programs should focus on documentation, including such areas as:

1. Findings of the triage examination;
2. Findings of the medical screening examination;
3. The offer by the hospital to provide a medical screening examination or further examination or treatment to a patient who refuses the services;
4. Reasons and circumstances relating to a patient leaving the hospital prior to receiving a medical screening examination;
5. Reasons and circumstances relating to a patient's refusal to accept further emergency care;
6. Assessment of, and response to, individuals seeking or in need of emergency services outside of the main facility building;
7. Any unusual occurrences relating to access to, or receipt of, emergency services;
8. Findings from continuous monitoring of an unstabilized patient;
9. Conversations with on-call physicians;
10. Actions taken if an on-call physician fails or refuses to respond to call;
11. Conversations with off-site physicians and managed care plans;
12. The patient's vital signs and health status immediately prior to transfer or discharge (especially for a patient who has, had or was suspected of having, an emergency medical condition);
13. Patient's discharge instructions;
14. Conversations (including times of calls and names of persons spoken to) relating to transferring a patient to another facility;
15. Conversations (including times of calls and names of persons spoken to) relating to accepting a patient transfer from another hospital;
16. Full and accurate completion of patient transfer forms;
17. The hospital's capacity and capability to accept a transfer and, as applicable, the reasons for refusing an appropriate transfer; and
18. Completion of the central log (especially if the patient received care outside of the emergency department and was discharged by another hospital department).

16 Application of EMTALA to Disasters and Public Health Emergencies

I. Overview 16.1

A. Federal Provisions to Waive EMTALA Sanctions 16.1

B. Revised Federal Regulation 16.2

C. California Authority 16.3

II. When an Emtala Waiver Goes Into Effect 16.3

III. How Long is the Duration of an Emtala Emergency Waiver? 16.4

IV. Effect of an EMTALA Waiver 16.4

A. Medical Screening 16.4

B. Transfers 16.5

C. Other Obligations 16.5

D. Hospitals Outside the Designated Emergency Area 16.5

V. Options for Managing Extraordinary Ed Surges Without a Waiver 16.5

A. Ebola Specific Guidance 16.6

Pre-Hospital Arrangements 16.6

EMTALA Obligations 16.6

16 Application of EMTALA to Disasters and Public Health Emergencies

I. OVERVIEW

The EMTALA regulations define the obligations of hospitals to provide services to individuals seeking emergency care and treatment. California has enacted similar requirements that apply to hospitals with licensed emergency departments. Congress has adopted legislation that authorizes the federal government to reduce or waive compliance with certain EMTALA requirements during a national emergency for hospitals covered by the waiver that meet certain requirements.

A. Federal Provisions to Waive EMTALA Sanctions

In 2002, Congress enacted the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 that authorized the Secretary of the U.S. Department of Health and Human Services (HHS) to waive EMTALA sanctions for an inappropriate transfer of an individual with an unstabilized emergency medical condition (EMC) during a public health emergency (as defined in a Presidential declaration). In response to the Congressional authorization, HHS adopted amendments to the EMTALA regulations in 2003 that precluded the imposition of sanctions for an inappropriate transfer during a national emergency by a hospital located in an emergency area.

☞ **References:**

Pub. L. 107-188

42 C.F.R. Section 489.24(a)(2) (Appendix B)

In 2004, Congress enacted the Project Bioshield Act of 2004, which permitted HHS to waive some of the EMTALA requirements during emergency periods in a designated emergency area. The expanded authority permitted the Secretary of HHS to temporarily waive or modify the application of EMTALA standards pertaining to the transfer of an individual who has not been stabilized to receive medical screening in an alternate location if the transfer is required by the circumstances of a declared emergency in the emergency area during the emergency period in accordance with an appropriate state emergency preparedness plan.

☞ **Reference:**

Pub. L. 108-276; Section 9

On Sept. 4, 2005, HHS implemented this authority for the first time, issuing an emergency waiver in the wake of Hurricane Katrina. The waiver suspended sanctions under EMTALA "for the redirection of an individual to another location to receive a medical screening examination pursuant to a state emergency preparedness plan or transfer of an individual who has not been stabilized if the redirection or transfer arises out of hurricane related emergency circumstances."

Since 2005, HHS has implemented this authority on several occasions, most recently during Hurricanes Harvey, Irma and Maria in 2017. These waivers similarly suspended sanctions under EMTALA for "direction or relocation of an individual to another location to receive medical screening pursuant to an appropriate state emergency preparedness plan or for the transfer of an individual who has not been stabilized if the transfer is necessitated by the circumstances of the declared Federal public health emergency for Hurricane [Harvey, Irma, and Maria]."

☞ **Reference:**

U.S. Department of Health and Human Services, Waiver under Section 1135 of the Social Security Act, Sept. 4, 2005, paragraph 3

B. Revised Federal Regulation

On Aug. 22, 2007, CMS adopted a final regulation that amended the EMTALA regulations to provide that the EMTALA sanctions would not be imposed against certain hospitals in the event of inappropriate transfers or relocations of individuals for medical screening exams during a national emergency. Effective Oct. 1, 2009, CMS revised 42 C.F.R. Section 489.24(a)(2) to provide the following guidance:

1. EMTALA sanctions may be waived for an inappropriate transfer only if the transfer arises out of the circumstances of the emergency;
2. EMTALA sanctions may be waived for an inappropriate transfer or for the relocation or redirection of an individual to receive a medical screening exam at an alternate location only if the hospital covered by the waiver does not discriminate based on the source of the individual's payment or ability to pay;
3. HHS has the authority to apply the waiver of EMTALA sanctions to one or more hospitals in a portion of an emergency area or a portion of an emergency period.

☞ **Reference:**

42 C.F.R. Section 489.24(a)(2) (Appendix B)

74 Fed. Reg. 24194 at pages 24194-5 (May 22, 2009)

Thus, effective Oct. 1, 2009, EMTALA sanctions for an inappropriate transfer or for the direction or relocation of an individual to receive medical screening at an alternate location during the period of a waiver issued by HHS will not apply to a hospital if all the following conditions are met:

1. The transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period;
2. The direction or relocation of an individual to receive medical screening at an alternate location is pursuant to an appropriate state emergency preparedness plan or, in the case of a public health emergency that involves a pandemic infectious disease, pursuant to a state pandemic preparedness plan;
3. The hospital does not discriminate on the basis of an individual's source of payment or ability to pay;

4. The hospital is located in an emergency area during an emergency period, as those terms are defined in Section 1135(g)(1) of the Act; and

5. There has been a determination that a waiver of sanctions is necessary.

The waiver of sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect until the termination of the applicable declaration of a public health emergency.

☞ **Reference:**

42 C.F.R. Section 489.24(a)(2) (Appendix B)

C. California Authority

Under California law, the Governor is empowered to suspend statutes and regulations during an emergency. California Government Code Section 8571 states:

> During a state of war emergency or a state of emergency the Governor may suspend any regulatory statute, or statue prescribing the procedure for conduct of state business, or the orders, rules, or regulations of any state agency ... where the Governor determines and declares that strict compliance with any statute, order, rule, or regulation would in any way prevent, hinder, or delay the mitigation of the effects of the emergency.

☞ **Reference:**

California Government Code Section 8571

II. WHEN AN EMTALA WAIVER GOES INTO EFFECT

The *Interpretive Guidelines* explain that during a national emergency, each hospital's EMTALA obligations continue in full force and effect until the following three conditions are met:

1. The federal government declares a national emergency;

2. HHS has declared a public health emergency; and

3. HHS has issued a waiver that excuses or suspends one or more requirements of EMTALA.

In addition to all of the above conditions, the waiver applies only to a hospital in an emergency area if all of the following three conditions are met:

1. The hospital must be located in the emergency area covered by the declaration of an emergency;

2. The hospital must activate its disaster protocol; and

3. The state must activate an emergency preparedness plan or pandemic preparedness plan in the emergency area, and the redirection of individuals to other hospitals for medical screening must be consistent with the state plan.

The emergency waiver may be obtained by either CMS notice of the waiver to hospitals in the emergency area or by hospitals requesting a waiver from CMS. The process for obtaining a waiver is described in the *Interpretive Guidelines*.

☞ **Reference:**

Interpretive Guidelines, tag no. A-2406/C-2406 (Appendix C)

III. HOW LONG IS THE DURATION OF AN EMTALA EMERGENCY WAIVER?

Except for pandemic emergencies, the EMTALA emergency waiver is limited to 72 hours beginning with the activation of a hospital's disaster protocol. However, the waiver may be terminated earlier if the state emergency preparedness plan is deactivated before the expiration of the hospital waiver.

In the event of a pandemic emergency, the EMTALA emergency waiver will continue until the termination of the public health emergency. Similar to the emergency waiver, the pandemic waiver may be terminated earlier if the state emergency pandemic preparedness plan is deactivated before the expiration of the hospital pandemic waiver. In addition, CMS may terminate the pandemic waiver for a specific hospital or group of hospitals before the termination of the public health emergency if there is a determination that the pandemic waiver is no longer necessary for the affected hospitals.

IV. EFFECT OF AN EMTALA WAIVER

If a waiver is issued by HHS, hospitals in the emergency area must continue to meet all EMTALA requirements except for the obligations that are excused or suspended under the terms of the waiver. As discussed below, the language of the waiver authority is critically important in determining the specific requirements that are suspended during the period of the emergency, and in determining which hospitals within an emergency area are covered by the waiver.

A. Medical Screening

Hospitals should review very carefully the scope of the waiver and their state emergency preparedness plan, and consult with legal counsel as necessary. Within the capacity of the hospital, the review should consider:

1. Whether the waiver covers the hospital;
2. If the waiver covers the hospital, does it permit the hospital to redirect or relocate all patients (such as in an earthquake or other natural disaster) who present for emergency services to other facilities that are designated by state or local health officers for medical screening and examination; or
3. Does the waiver permit the hospital to redirect or relocate only those patients whose presenting complaints relate to the national emergency (e.g., patients presenting with pandemic flu symptoms or victims of bioterrorism) to other designated facilities while still providing medical screening to patients whose presenting complaints are unrelated to the emergency (such as women in labor or patients with psychiatric emergencies)?

As explained in the *Interpretive Guidelines*, CMS expects that in all cases, persons who are protected under EMTALA will receive appropriate medical screening examinations somewhere, even if not at the hospital to which they present.

B. Transfers

The wording of the waiver with respect to transfers should also be reviewed very closely. For example, the Katrina waiver lifted the obligation to make an appropriate transfer if the transfer was required by the circumstances of the declared emergency. However, even if the transfer falls within the scope of the waiver and the hospital is excused from meeting the technical requirements of EMTALA, the hospital should make reasonable efforts to explain the need for the transfer to the patient and provide, under the circumstances, any available assistance to facilitate the transfer. Similar to the expectations for medical screening, the *Interpretive Guidelines* indicate the expectation of CMS that all persons with EMCs who are transferred will be routed to facilities that are capable of providing stabilizing services.

C. Other Obligations

The scope of the statutory authorization to waive EMTALA requirements is limited to medical screening (which, as noted above, may be limited or broad in scope) and transfers required by the emergent situation. Therefore, other obligations (such as on-call, central log, etc.) may be in force during an emergency. In this regard, the *Interpretive Guidelines* reinforce that the obligation to accept the transfer of individuals with EMCs is not waived during the declaration of an emergency. Importantly, even if a hospital is covered by a waiver, the hospital is prohibited from discriminating in the provision of all emergency services and care on the basis of an individual's source of payment or ability to pay. Further, the waiver authority does not eliminate the private right of individuals to bring actions for EMTALA violations (although the effect of the waiver may substantially diminish or even eliminate the likelihood of success of any subsequent litigation alleging an EMTALA violation during a disaster or public health emergency).

D. Hospitals Outside the Designated Emergency Area

As discussed above, HHS may waive EMTALA requirements for some or all hospitals that are located within an emergency area. However, under the statutory waiver authority and the EMTALA regulations, HHS does not have the authority to reduce or eliminate compliance with the EMTALA obligations for hospitals that are outside of the designated emergency area, even if they serve as catchment facilities for transfers outside of the emergency area. Hospitals outside of the designated emergency area will continue to be subject to EMTALA within their capacity and capability.

V. OPTIONS FOR MANAGING EXTRAORDINARY ED SURGES WITHOUT A WAIVER

On Aug. 14, 2009, CMS issued a Fact Sheet that provides guidance to hospitals with regard to managing extraordinary emergency department surges under existing EMTALA requirements, in the absence of a waiver that covers the hospital. While the Fact Sheet aims to provide guidance to hospitals that are worried about an influenza outbreak, the guidance is also applicable to other public health and emergency situations. CMS suggests three options for hospitals to consider in such situations that meet EMTALA requirements and that do not require a waiver:

1. A hospital may set up alternative screening sites on the hospital's campus. The medical screening examination does not need to take place in the emergency

department, and a hospital can set up alternative sites on its campus to perform the screening.

2. A hospital may set up screening at off-campus, hospital-controlled sites. Hospitals and community officials can encourage the public to go to these alternate sites instead of the emergency department for screening of certain symptoms (such as flu-like symptoms). However, a hospital cannot tell individuals who have already arrived at the emergency department to go to the off-site location for screening.
3. Communities can set up screening clinics at sites that are not under the control of a hospital. These sites are not subject to EMTALA requirements. Hospitals and communities may encourage people to go to these sites instead of the hospital for screening, but a hospital cannot tell individuals who have already arrived at the emergency department to go to the off-site location for screening.

Compliance Tip: Implementation of the above options may require compliance with hospital disaster and overflow plans established under state licensing requirements, including prior approval of the Licensing and Certification Division of the California Department of Public Health (CDPH). Hospitals should check with their local licensing office before establishing special screening sites.

☞ **Reference:**

Interpretive Guidelines, tag no. A-2406/C-2406 (Appendix C)

S&C 09-52, Emergency Medical Treatment and Labor Act (EMTALA) Requirements and Options for Hospitals in a Disaster (Aug. 14, 2009) (Appendix R)

A. Ebola Specific Guidance

In 2014, due to increasing public concerns about Ebola, CMS issued guidance concerning Ebola's implications for hospital compliance with EMTALA.

Pre-Hospital Arrangements

CMS clarified that pre-hospital arrangements (to bring individuals who meet criteria for a suspected case of Ebola only to hospitals that have been designated to handle potential or confirmed cases) do not present any conflict with EMTALA. This is the case even with hospital-owned ambulances, so long as they are operating in accordance with a community-wide EMS protocol.

EMTALA Obligations

CMS reiterated in its guidance that if an individual comes to the ED, the hospital must provide the individual with an appropriate MSE, notwithstanding any concern that the patient may have Ebola. A refusal to provide an appropriate MSE to anyone who comes to the ED for examination or treatment of a medical condition is a violation of EMTALA. CMS also noted that it violates EMTALA when a hospital uses signage that creates a barrier or prevents individuals who may have been exposed to Ebola from coming to the ED.[1] CMS did note, however, that if violations are reported in this context, it will take into consideration the public

1 Signs may be used to direct individuals around the hospital property.

health direction/designation of hospitals as Ebola treatment centers at the time of alleged noncompliance, as well as clinical considerations specific to individual cases.

CMS also noted that it expects all hospitals and CAHs to provide MSEs and initiate stabilizing treatment, while meeting Ebola isolation requirements and other CDC requirements.

In 2015, CMS published Questions and Answers about EMTALA obligations and Ebola, appropriate transfers under Ebola, state public health agency response frameworks and screening examinations and stabilizing treatment requirements. A copy of this guidance is attached at Appendix AA.

☞ **Reference:**

CMS Survey & Certification Memoranda 15-10 and 15-24: EMTALA and Ebola (Nov. 21, 2014 and Feb. 13, 2015) (Appendix AA)

Index

SYMBOLS

9-1-1, 2.10, 3.15, 3.16
24-hour hold, 6.29 to 6.32
250-yard rule, 1.4, 2.9
5150, 6.1 to 6.32—*See also Lanterman-Petris-Short (LPS) Act*

A

Active labor—*See Labor and delivery*
Advance Beneficiary Notice (ABN), 4.6
Aerosol transmissible disease, 5.9 to 5.10
Ambulance, 1.7, 2.2, 2.16 to 2.18, 14.9
Ancillary services, 3.1, 3.8
Arrington v. Wong, 2.16
Authorization, 4.7, 4.9

B

Bioterrorism—*See Disasters*
Blood pressure checks, 2.14

C

California Department of Public Health (CDPH), 6.8, 6.14, 12.1
Campus, 1.6
Capability, 1.10, 5.13 to 5.15
Capacity, 1.6, 5.13 to 5.15
CDPH—*See California Department of Public Health (CDPH)*
Centers for Medicare & Medicaid Services (CMS), 1.1, 6.9, 6.11, 6.13, 6.15, 6.16, 12.1, 13.1 to 13.18
Central log, 9.1 to 9.4
Clinics, 2.4
CMS—*See Centers for Medicare & Medicaid Services (CMS)*
Comes to the hospital, 2.1, 2.11 to 2.16
Community call plan, 11.9 to 11.12
Complaint, 13.1, 13.3
Complaint survey, 13.4 to 13.6
Consultation, 1.7
Contractions—*See Labor and delivery*
Crisis stabilization unit, 6.5, 6.20 to 6.21
Critical access hospitals (CAH), 1.2, 3.7

D

Dedicated emergency department, 1.7, 2.2, 2.3, 2.5 to 2.8, 2.11, 2.19, 3.10, 3.11, 3.12, 3.14, 6.9 to 6.10
Definitions, 1.6
Department of Health Care Services (DHCS), 6.1, 6.5, 6.8, 6.9
Designated hospitals/facilities, 6.5
DHCS—*See Department of Health Care Services (DHCS)*
Disasters, 16.1 to 16.8
Discrimination, 1.1, 1.5, 3.3, 3.10, 4.1
Diversionary status, 2.16
Documentation, 3.4, 3.10, 3.17, 5.1, 6.13, 7.10, 8.1, 8.4, 11.14

E

Emergency medical condition, 1.7—*See also Psychiatric emergency medical condition*
EMTALA waiver—*See Waiver*
EMTs—*See Paramedics*

F

Financial considerations, 4.1 to 4.14, 5.11, 7.12—*See also Discrimination*

G

General Accountability Office, 1.4

H

Helipad, 2.17
Hill-Burton Act, 1.2
Holding out test, 2.5, 6.9
Homeless patient, 5.18 to 5.22
Hospital property, 1.8, 2.8

I

Infant—*See Labor and delivery, See Newborn*
Inpatient, 2.3, 2.18 to 2.19, 14.4 to 14.14
Interpretive Guidelines, 1.1 to 1.2
Involuntary detention, 6.1 to 6.32

J

Joint Commission, The, 6.15

L

Labor and delivery, 1.8, 2.6, 3.8, 3.12, 3.15, 3.17, 3.17 to 3.20
Lanterman-Petris-Short (LPS) Act, 6.1 to 6.32
Lawsuits, 14.1 to 14.14
License test, 2.5
LPS—*See Lanterman-Petris-Short (LPS) Act*

M

Managed care patients, 3.10, 3.12, 4.1, 4.7 to 4.13
  Post-stabilization services, 4.7 to 4.13
  Prior authorization, 4.7—*See also Prior authorization*
Medi-Cal, 6.9, 6.14, 6.22
Medical clearance, 2.15
Medical screening examination, 3.1 to 3.22
  Labor patient, 3.17
  Psychiatric patient, 3.20, 6.12
  Triage—*See Triage*
Medicare Advantage, 4.13
Mental health patient—*See Psychiatric patient*
Midlevel practitioner, 3.6 to 3.7, 3.18, 11.12
Midwife—*See Midlevel practitioner*
Minors, 3.11, 6.8

N

Newborn, 3.19
Non-designated hospitals, 6.24, 6.29 to 6.32
Notice to patient, 2.8, 4.6, 4.10
Nurse—*See Midlevel practitioner*
Nurse-staffing ratios, 5.14 to 5.15, 7.8

O

Observation status, 2.19
Occupational medicine, 2.7
Off-campus facilities, 2.1, 2.3, 2.5, 2.10, 3.16
Office for Civil Rights (OCR), 1.2, 13.1
Office of Inspector General (OIG), 1.2, 1.3, 13.1, 13.15
On-call, 7.7, 11.1 to 11.16
One-third test, 2.5, 6.9
Outpatient department, 2.6

P

Pandemic—*See Disasters*
Paramedics, 3.9
Peer review records, 14.2
Penalties, 12.3, 13.1, 13.15
Physician, 13.1
Physician assistant—*See Midlevel practitioner*
Physician certification, 5.5
Plan of correction, 13.7
Policies and procedures, 2.7, 3.10, 3.13, 3.14, 3.16, 3.20, 15.1
Post-stabilization services, 4.9
Preventive care services, 2.14
Prior authorization, 4.1, 4.3, 4.11, 5.15, 7.9
Provider number, 2.4, 3.14
Prudent layperson, 1.6, 2.15
Psychiatric emergency medical condition, 6.13 to 6.19
Psychiatric health facility, 6.5, 6.9, 6.11, 6.20 to 6.21
Psychiatric hospitals/facilities, 2.5, 3.20, 6.9
Psychiatric patient, 3.20
  Stabilized, 5.4, 5.18
Psychiatric services, 2.6

Q

QAPI—*See Quality improvement*
Quality improvement, 15.1 to 15.4
Quality improvement organization (QIO), 1.2, 13.1, 13.5, 13.10

R

Receiving hospital obligation, 7.1 to 7.14
Records retention, 3.5, 5.1
Refusal of examination, 8.1 to 8.6
Refusal of treatment, 8.1 to 8.6
Refusal to accept transfer, 8.1 to 8.6
Registered nurse—*See Midlevel practitioner*
Reporting violations, 12.1 to 12.16
Request for transfer—*See Transfer request*
Required signage, 10.1 to 10.4
Retaliation—*See Whistleblower*
Risk management, 15.1 to 15.4

S

Special Advisory Bulletins, 1.2
Specialized capabilities or facilities, 7.1
Stabilization, 5.4
Stabilized, 1.10, 5.4, 5.17 to 5.18
    Psychiatric patient, 6.15 to 6.17
St. Anthony Hospital, 13.14
State laws, 1.5
Statement of Deficiencies, 13.7
Stewart v. Parkview Hospital, Inc., 6.10
Surge, 16.5
Survey process, 2.5

T

Tags, 1.1
Technical advisory group, 1.4
Telemedicine, 11.13
Termination of provider agreement, 13.1, 13.6 to 13.7, 14.3
TJC—*See Joint Commission, The*
Transfer, 1.10
    Agreement, 5.11, 7.12
    Appropriate, 5.1, 5.5 to 5.10
    Request, 5.5
    Transportation, 5.12
    Unstabilized patient, 5.1
Treating physician, 3.11, 4.4, 5.11, 5.12
Triage, 3.2

U

Unstabilized patient, 5.1, 5.2
Urgent care center, 2.5, 2.6 to 2.7

V

Violations, 12.1 to 12.16, 13.6

W

Waiver, 16.1 to 16.8
Whistleblower, 12.3, 13.4

Appendices

A. EMTALA Statute

B. EMTALA and Emergency-Related Federal Regulations

C. EMTALA *Interpretive Guidelines* (Part II: Responsibilities of Medicare Participating Hospitals in Emergency Cases)

D. California Hospital Licensing Laws on Emergency Services and Care

E. CoP for Emergency Services: Hospital *Interpretive Guidelines*

F. Knox-Keene Act Provisions

G. Medicare Advantage Regulations

H. Special Advisory Bulletin

I. EMTALA Enforcement Chart

J. Hospital Records Subject to EMTALA Enforcement Survey

K. Investigative Procedures for EMTALA Surveyors (Part I of EMTALA *Interpretive Guidelines*)

L. Sample Survey Tools for Patient Transfers and Medical Screening Examinations

M. An Explanation of the Scope of RN Practice Including Standardized Procedures

N. Policies Recommended for EMTALA Compliance

O. Model Hospital Policy on Compliance with EMTALA

P. CHA Transfer Forms and Model Signage

Q. CMS Survey and Certification Memorandum 08-08: Requirements for Off-Campus Emergency Departments *(Jan. 11, 2008)*

R. CMS Survey and Certification Memorandum 09-52: EMTALA Options in a Disaster *(Aug. 14, 2009)*

S. Sample Transfer Agreement

T. Sample Transfer Checklist and Script for Accepting Emergency Patients

U. CDPH All-Facility Letter 12-17 *(May 17, 2012)*

V. CMS Letter Regarding Transfer of Patients to Crisis Stabilization Units

W. EMTALA Physician Review Worksheet

X. CMS Survey and Certification Memorandum 14-06: EMTALA Requirements & Conflicting Payor Requirements or Collection Practices *(Dec. 13, 2013)*

Y. CMS Survey and Certification Memorandum 13-38: Critical Access Hospital Emergency Services and Telemedicine *(June 7, 2013)*

Z. CMS Survey and Certification Memoranda 06-21 and 07-20: Detaining EMS Personnel and Equipment *(July 13, 2006 and April 27, 2007)*

AA. CMS Survey and Certification Memoranda 15-10 and 15-24: EMTALA and Ebola *(Nov. 21, 2014 and Feb. 13, 2015)*

APPENDIX A

EMTALA Statute

Source: United States Code, Title 42, Section 1395dd (42 U.S.C. Section 1395dd)
www.gpo.gov/fdsys

Section 1395dd. Examination and treatment for emergency medical conditions and women in labor

(a) Medical screening requirement

In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists.

(b) Necessary stabilizing treatment for emergency medical conditions and labor

(1) In general

If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—

(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or

(B) for transfer of the individual to another medical facility in accordance with subsection (c) of this section.

(2) Refusal to consent to treatment

A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and treatment. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.

(3) Refusal to consent to transfer

A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) of this section and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer, but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.

(c) Restricting transfers until individual stabilized

(1) Rule

If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B) of this section), the hospital may not transfer the individual unless—

(A) (i) the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility,

(ii) a physician (within the meaning of section 1395x(r)(1) of this title) has signed a certification that[1] based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or

(iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1395x(r)(1) of this title), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and

(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.

(2) Appropriate transfer

An appropriate transfer to a medical facility is a transfer—

(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(B) in which the receiving facility—

(i) has available space and qualified personnel for the treatment of the individual, and

(ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(C) in which the transferring hospital sends to the receiving facility all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(1)(C) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

[1] So in original. Probably should be followed by a comma.

(D) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(E) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.

(d) Enforcement

(1) Civil money penalties

(A) A participating hospital that negligently violates a requirement of this 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 provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1320a-7a(a) of this title.

(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section, including a physician who—

(i) signs a certification under subsection (c)(1)(A) of this section that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or

(ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section,

is subject to a civil money penalty of not more than $50,000 for each such violation and, if the violation is gross and flagrant or is repeated, to exclusion from participation in this subchapter and State health care programs. The provisions of section 1320a-7a of this title (other than the first and second sentences of subsection (a) and subsection (b)) shall apply to a civil money penalty and exclusion under this subparagraph in the same manner as such provisions apply with respect to a penalty, exclusion, or proceeding under section 1320a-7a(a) of this title.

(C) If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians (required to be maintained under Section 1395cc(a)(1)(I) of this title) and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B). However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.

(2) Civil enforcement

(A) Personal harm

Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(B) Financial loss to other medical facility

Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(C) Limitations on actions

No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

(3) Consultation with peer review organizations

In considering allegations of violations of the requirements of this section in imposing sanctions under paragraph (1) or in terminating a hospital's participation under this subchapter, the Secretary shall request the appropriate utilization and quality control peer review organization (with a contract under part B of subchapter XI of this chapter) to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall request such a review before effecting a sanction under paragraph (1) and shall provide a period of at least 60 days for such review. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this subchapter for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the organization's report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B.

(4) Notice upon closing an investigation

The Secretary shall establish a procedure to notify hospitals and physicians when an investigation under this section is closed.

(e) Definitions

In this section:

(1) 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.

(2) The term "participating hospital" means hospital that has entered into a provider agreement under section 1395cc of this title.

(3) (A) The term "to stabilize" means, with respect to an emergency medical condition described in paragraph (1)(A), to provide such medical treatment of the condition as may be 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 from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).

(B) The term "stabilized" means, with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).

(4) The term "transfer" means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

(5) The term "hospital" includes a critical access hospital (as defined in section 1395x(mm)(1) of this title).

(f) Preemption

The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

(g) Nondiscrimination

A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

(h) No delay in examination or treatment

A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) of this section or further medical examination and treatment required under subsection (b) of this section in order to inquire about the individual's method of payment or insurance status.

(i) Whistleblower protections

A participating hospital may not penalize or take adverse action against a qualified medical person described in subsection (c)(1)(A)(iii) of this section or a physician because the person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section.

APPENDIX B

EMTALA and Emergency-Related Federal Regulations

Source: Title 42, Code of Federal Regulations, Sections 413.65, 482.12, 485.618(d), 489.20 and 489.24 www.ecfr.gov

NOTE: Ellipses (…) indicate omitted text.

§ 413.65 Requirements for a determination that a facility or an organization has provider-based status.

(a) *Scope and definitions*.

…

(2) *Definitions*. In this subpart E, unless the contect indicates otherwise —

Campus means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider's campus.

…

(g) *Obligations of hospital outpatient departments and hospital-based entities.* To qualify for provider-based status in relation to a hospital, a facility or organization must comply with the following requirements:

(1) The following departments must comply with the antidumping rules of Sections 489.20(l), (m), (q), and (r) and 489.24 of this chapter:

(i) Any facility or organization that is located on the main hospital campus and is treated by Medicare under this section as a department of the hospital; and

(ii) Any facility or organization that is located off the main hospital campus that is treated by Medicare under this section as a department of the hospital and is a dedicated emergency department, as defined in Section 489.24(b) of this chapter.

…

Part 482—Conditions of Participation for Hospitals

§ 482.12 Conditions of participation: Governing body.

…

(f) *Standard: Emergency Services*.

…

(2) If emergency services are not provided at the hospital, the governing body must assure that the medical staff has written policies and procedures for appraisal of emergencies, initial treatment, and referral when appropriate.

(3) If emergency services are provided at the hospital but are not provided at one or more off-campus departments of the hospital, the governing body of the hospital must assure that the medical staff has written policies and procedures in effect with respect to the off-

Part 485—Conditions of Participation for Community Access Hospitals

§ 485.618 Conditions of participation: Emergency services.

…

(d) *Standard: Personnel*.

(1) Except as specified in paragraph (d)(3) of this section, there must be a doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist, with training or experience in emergency care, on call and immediately available by telephone or radio contact, and available on site within the following timeframes:

(i) Within 30 minutes, on a 24-hour a day basis, if the CAH is located in an area other than an area described in paragraph (d)(1)(ii) of this section; or

(ii) Within 60 minutes, on a 24-hour a day basis, if all of the following requirements are met:

(A) The CAH is located in an area designated as a frontier area (that is, an area with fewer than six residents per square mile based on the latest population data published by the Bureau of the Census) or in an area that meets the criteria for a remote location adopted by the State in its rural health care plan, and approved by CMS, under section 1820(b) of the Act.

(B) The State has determined, under criteria in its rural health care plan, that allowing an emergency response time longer than 30 minutes is the only feasible method of providing emergency care to residents of the area served by the CAH.

(C) The State maintains documentation showing that the response time of up to 60 minutes at a particular CAH it designates is justified because other available alternatives would increase the time needed to stabilize a patient in an emergency.

(2) A registered nurse with training and experience in emergency care can be utilized to conduct specific medical screening examinations only if —

(i) The registered nurse is on site and immediately available at the CAH when a patient requests medical care; and

(ii) The nature of the patient's request for medical care is within the scope of practice of a registered nurse and consistent with applicable state laws and the CAH's bylaws or rules and regulations.

(3) A registered nurse satisfies the personnel requirement specified in paragraph (d)(1) of this section for a temporary period if—

(i) The CAH has no greater than 10 beds;

(ii) The CAH is located in an area designated as a frontier area or remote location as described in paragraph (d)(1)(ii)(A) of this section;

(iii) The State in which the CAH is located submits a letter to CMS signed by the Governor, following consultation on the issue of using RNs on a temporary basis as part of their State rural healthcare plan with the State Boards of Medicine and Nursing, and in accordance with State law, requesting that a registered nurse with training and experience in emergency care be included in the list of personnel specified in paragraph (d)(1) of this section. The letter from the Governor must attest that he or she has consulted with State

Boards of Medicine and Nursing about issues related to access to and the quality of emergency services in the States. The letter from the Governor must also describe the circumstances and duration of the temporary request to include the registered nurses on the list of personnel specified in paragraph (d)(1) of this section;

(iv) Once a Governor submits a letter, as specified in paragraph (d)(3)(iii) of this section, a CAH must submit documentation to the State survey agency demonstrating that it has been unable, due to the shortage of such personnel in the area, to provide adequate coverage as specified in this paragraph (d).

(4) The request, as specified in paragraph (d)(3)(iii) of this section, and the withdrawal of the request, may be submitted to us at any time, and are effective upon submission.

…

Subpart B—Essentials of Medicare Provider Agreements

§ 489.20 Basic commitments.

The provider agrees to the following:

…

(l) In the case of a hospital as defined in Section 489.24(b) to comply with Section 489.24.

(m) In the case of a hospital as defined in Section 489.24(b), to report to CMS or the State survey agency any time it has reason to believe it may have received an individual who has been transferred in an unstable emergency medical condition from another hospital in violation of the requirements of Section 489.24(e).

…

(q) In the case of a hospital as defined in Section 489.24(b)—

(1) To post conspicuously in any emergency department or in a place or places likely to be noticed by all individuals entering the emergency department, as well as those individuals waiting for examination and treatment in areas other than traditional emergency departments (that is, entrance, admitting area, waiting room, treatment area), a sign (in a form specified by the Secretary) specifying rights of individuals under Section 1867 of the Act with respect to examination and treatment for emergency medical conditions and women in labor; and

(2) To post conspicuously (in a form specified by the Secretary) information indicating whether or not the hospital or rural primary care hospital participates in the Medicaid program under a State plan approved under title XIX.

(r) In the case of a hospital as defined in Section 489.24(b) (including both the transferring and receiving hospitals), to maintain —

(1) Medical and other records related to individuals transferred to or from the hospital for a period of 5 years from the date of the transfer;

(2) An on-call list of physicians who are on the hospital's medical staff or who have privileges at the hospital, or who are on the staff or have privileges at another hospital

participating in a formal community call plan, in accordance with Section 489.24(j)(2)(iii), available to provide treatment necessary after the initial examination to stabilize individuals with emergency medical conditions who are receiving services required under Section 489.24 in accordance with the resources available to the hospital; and

(3) A central log on each individual who comes to the emergency department, as defined in Section 489.24(b), seeking assistance and whether he or she refused treatment, was refused treatment, or whether he or she was transferred, admitted and treated, stabilized and transferred, or discharged.

…

(w) In the case of a hospital as defined in Section 489.24(b), to furnish written notice to all patients at the beginning of their hospital stay or outpatient visit if a doctor of medicine or a doctor of osteopathy is not present in the hospital 24 hours per day, 7 days per week, in order to assist the patients in making informed decisions regarding their care, in accordance with Section 482.13(b)(2) of this subchapter. The notice must indicate how the hospital will meet the medical needs of any patient who develops an emergency medical condition, as defined in Section 489.24(b), at a time when there is no physician present in the hospital. For purposes of this paragraph, the hospital stay or outpatient visit begins with the provision of a package of information regarding scheduled preadmission testing and registration for a planned hospital admission for inpatient care or outpatient service.

…

§ 489.24 Special responsibilities of Medicare hospitals in emergency cases.

(a) *Applicability of provisions of this section.* (1) In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) "comes to the emergency department," as defined in paragraph (b) of this section, the hospital must —

(i) Provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations and who meets the requirements of Section 482.55 of this chapter concerning emergency services personnel and direction;[1] and

(ii) If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment, as defined in paragraph (d) of this section, or an appropriate transfer as defined in paragraph (e) of this section. If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under this section ends, as specified in paragraph (d)(2) of this section.

(2)(i) When a waiver has been issued in accordance with Section 1135 of the Act that includes a waiver under Section 1135(b)(3) of the Act, sanctions under this section for an inappropriate transfer or for the direction or relocation of an individual to receive medical

[1] Section 482.55 is the Medicare Condition of Participation for emergency services.

screening at an alternate location do not apply to a hospital with a dedicated emergency department if the following conditions are met:

(A) The transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period.

(B) The direction or relocation of an individual to receive medical screening at an alternate location is pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan.

(C) The hospital does not discriminate on the basis of an individual's source of payment or ability to pay.

(D) The hospital is located in an emergency area during an emergency period, as those terms are defined in Section 1135(g)(1) of the Act.

(E) There has been a determination that a waiver of sanctions is necessary.

(ii) A waiver of these sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect until the termination of the applicable declaration of a public health emergency, as provided under Section 1135(e)(1)(B) of the Act.

(b) *Definitions*. As used in this subpart —

Capacity means the ability of the hospital to accommodate the individual requesting examination or treatment of the transferred individual. Capacity encompasses such things as numbers and availability of qualified staff, beds and equipment and the hospital's past practices of accommodating additional patients in excess of its occupancy limits.

Comes to the emergency department means, with respect to an individual who is not a patient (as defined in this section), the individual—

(1) Has presented at a hospital's dedicated emergency department, as defined in this section, and requests examination or treatment for a medical condition, or has such a request made on his or her behalf. In the absence of such a request by or on behalf of the individual, a request on behalf of the individual will be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs examination or treatment for a medical condition;

(2) Has presented on hospital property, as defined in this section, other than the dedicated emergency department, and requests examination or treatment for what may be an emergency medical condition, or has such a request made on his or her behalf. In the absence of such a request by or on behalf of the individual, a request on behalf of the individual will be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs emergency examination or treatment:

(3) Is in a ground or air ambulance owned and operated by the hospital for purposes of examination and treatment for a medical condition at a hospital's dedicated emergency department, even if the ambulance is not on hospital grounds. However, an individual in an ambulance owned and operated by the hospital is not considered to have "come to the hospital's emergency department" if —

(i) The ambulance is operated under communitywide emergency medical service (EMS) protocols that direct it to transport the individual to a hospital other than the hospital that

owns the ambulance; for example, to the closest appropriate facility. In this case, the individual is considered to have come to the emergency department of the hospital to which the individual is transported, at the time the individual is brought onto hospital property;

(ii) The ambulance is operated at the direction of a physician who is not employed or otherwise affiliated with the hospital that owns the ambulance; or

(4) Is in a ground or air nonhospital-owned ambulance on hospital property for presentation for examination and treatment for a medical condition at a hospital's dedicated emergency department. However, an individual in a nonhospital-owned ambulance off hospital property is not considered to have come to the hospital's emergency department, even if a member of the ambulance staff contacts the hospital by telephone or telemetry communications and informs the hospital that they want to transport the individual to the hospital for examination and treatment. The hospital may direct the ambulance to another facility if it is in "diversionary status," that is, it does not have the staff or facilities to accept any additional emergency patients. If, however, the ambulance staff disregards the hospital's diversion instructions and transports the individual onto hospital property, the individual is considered to have come to the emergency department.

Dedicated emergency department means any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements:

(1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department;

(2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or

(3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during the calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

Emergency medical condition means—

(1) A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) 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

(2) 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.

Hospital includes a critical access hospital as defined in Section 1861(mm)(1) of the Act

Hospital property means the entire main hospital campus as defined in Section 413.65(b) of this chapter,[2] including the parking lot, sidewalk, and driveway, but excluding other areas or structures of the hospital's main building that are not part of the hospital, such as physician offices, rural health centers, skilled nursing facilities, or other entities that participate separately under Medicare, or restaurants, shops, or other nonmedical facilities.

Hospital with an emergency department means a hospital with a dedicated emergency department as defined in this paragraph (b).

Inpatient means an individual who is admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services as described in Section 409.10(a) of this chapter[3] with the expectation that he or she will remain at least overnight and occupy a bed even though the situation later develops that the individual can be discharged or transferred to another hospital and does not actually use a hospital bed overnight.

*Labo*r means the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman experiencing contractions is in true labor unless a physician, certified nurse-midwife, or other qualified medical person acting within his or her scope of practice as defined in hospital medical staff bylaws and State law, certifies that, after a reasonable time of observation, the woman is in false labor.

Participating hospital means (1) a hospital or (2) a critical access hospital as defined in Section 1861(mm)(1) of the Act that has entered into a Medicare provider agreement under Section 1866 of the Act.

Patient means —

(1) An individual who has begun to receive outpatient services as part of an encounter, as defined in Section 410.2 of this chapter,[4] other than an encounter that the hospital is obligated by this section to provide;

(2) An individual who has been admitted as an inpatient, as defined in this section.

Stabilized means, with respect to an "emergency medical condition" as defined in this section under paragraph (1) of that definition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility or, with respect to an "emergency medical condition" as defined in this section under paragraph (2) of that definition, that the woman has delivered the child and the placenta.

To stabilize means, with respect to an "emergency medical condition" as defined in this section under paragraph (1) of that definition, to provide such medical treatment of the condition 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

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[2] The definition of "campus" in Section 413.65 is set forth on page B.1.

[3] Section 409.10(a) defines "inpatient hospital or inpatient CAH services" as including bed and board; nursing and related services; use of hospital and CAH facilities; medical social services; drugs, biologicals, supplies, appliances and equipment; certain other diagnostic and therapeutic services; medical and surgical services provided by interns and residents; and transportation services.

[4] Section 410.2 defines "encounter" as a "direct personal contact between a patient and a physician, or other person who is authorized by State licensure law and, if applicable, by hospital or CAH staf bylaws, to order or furnish hospital services for diagnosis or treatment of the patient."

individual from a facility or that, with respect to an "emergency medical condition" as defined in this section under paragraph (2) of that definition, the woman has delivered the child and the placenta.

Transfer means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (i) has been declared dead, or (ii) leaves the facility without the permission of any such person.

(c) *Use of dedicated emergency department for nonemergency services.* If an individual comes to a hospital's dedicated emergency department and a request is made on his or her behalf for examination or treatment for a medical condition, but the nature of the request makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition.

(d) *Necessary stabilizing treatment for emergency medical conditions —*

(1) *General*. Subject to the provisions of paragraph (d)(2) of this section, if any individual (whether or not eligible for Medicare benefits) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—

(i) Within the capabilities of the staff and facilities available at the hospital, for further medical examination and treatment as required to stabilize the medical condition.

(ii) For transfer of the individual to another medical facility in accordance with paragraph (e) of this section.

(2) *Exception: Application to inpatients*.

(i) If a hospital has screened an individual under paragraph (a) of this section 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.

(ii) This section is not applicable to an inpatient who was admitted for elective (nonemergency) diagnosis or treatment.

(iii) A hospital is required by the conditions of participation for hospitals under Part 482 of this chapter to provide care to its inpatients in accordance with those conditions of participation.

(3) *Refusal to consent to treatment.* A hospital meets the requirements of paragraph (d)(1)(i) of this section with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of the examination and treatment, but the individual (or a person acting on the individual's behalf) does not consent to the examination or treatment. The medical record must contain a description of the examination, treatment, or both if applicable, that was refused by or on behalf of the individual. The hospital must take all reasonable steps to secure the individual's written informed refusal (or that of the person acting on his or her behalf). The written document should indicate that the person has been informed of the risks and benefits of the examination or treatment, or both.

(4) *Delay in examination or treatment.*

(i) A participating hospital may not delay providing an appropriate medical screening examination required under paragraph (a) of this section or further medical examination and treatment required under paragraph (d)(1) of this section in order to inquire about the individual's method of payment or insurance status.

(ii) A participating hospital may not seek, or direct an individual to seek, authorization from the individual's insurance company for screening or stabilization services to be furnished by a hospital, physician, or nonphysician practitioner to an individual until after the hospital has provided the appropriate medical screening examination required under paragraph (a) of this section, and initiated any further medical examination and treatment that may be required to stabilize the emergency medical condition under paragraph (d)(1) of this section.

(iii) An emergency physician or nonphysician practitioner is not precluded from contacting the individual's physician at any time to seek advice regarding the individual's medical history and needs that may be relevant to the medical treatment and screening of the patient, as long as this consultation does not inappropriately delay services required under paragraph (a) or paragraphs (d)(1) and (d)(2) of this section.

(iv) Hospitals may follow reasonable registration processes for individuals for whom examination or treatment is required by this section, including asking whether an individual is insured and, if so, what that insurance is, as long as that inquiry does not delay screening or treatment.[5] Reasonable registration processes may not unduly discourage individuals from remaining for further evaluation.

(5) *Refusal to consent to transfer.* A hospital meets the requirements of paragraph (d)(1)(ii) of this section with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with paragraph (e) of this section and informs the individual (or a person acting on his or her behalf) of the risks and benefits to the individual of the transfer, but the individual (or a person acting on the individual's behalf) does not consent to the transfer. The hospital must take all reasonable steps to secure the individual's written informed refusal (or that of a person acting on his or her behalf). The written document must indicate the person has been informed of the risks and benefits of the transfer and state the reasons for the individual's refusal. The medical record must contain a description of the proposed transfer that was refused by or on behalf of the individual.

(e) *Restricting transfer until the individual is stabilized*—(1) *General.* If an individual at a hospital has an emergency medical condition that has not been stabilized (as defined in paragraph (b) of this section), the hospital may not transfer the individual unless—

(i) The transfer is an appropriate transfer (within the meaning of paragraph (e)(2) of this section); and

(ii)(A) The individual (or a legally responsible person acting on the individual's behalf) requests the transfer, after being informed of the hospital's obligations under this section and of the risk of transfer. The request must be in writing and indicate the reasons for the request as well as indicate that he or she is aware of the risks and benefits of the transfer;

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[5] However, California law is stricter. See "State Requirements," page 4.3.

(B) A physician (within the meaning of section 1861(r)(1) of the Act) has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman or the unborn child, from being transferred. The certification must contain a summary of the risks and benefits upon which it is based; or

(C) If a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as determined by the hospital in its bylaws or rules and regulations) has signed a certification described in paragraph (e)(1)(ii)(B) of this section after a physician (as defined in section 1861(r)(1) of the Act) in consultation with the qualified medical person, agrees with the certification and subsequently countersigns the certification. The certification must contain a summary of the risks and benefits upon which it is based.

(2) A transfer to another medical facility will be appropriate only in those cases in which—

(i) The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(ii) The receiving facility—

(A) Has available space and qualified personnel for the treatment of the individual; and

(B) Has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(iii) The transferring hospital sends to the receiving facility all medical records (or copies thereof) related to the emergency condition which the individual has presented that are available at the time of the transfer, including available history, records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) required under paragraph (e)(1)(ii) of this section, and the name and address of any on-call physician (described in paragraph (g) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment. Other records (e.g., test results not yet available or historical records not readily available from the hospital's files) must be sent as soon as practicable after transfer; and

(iv) The transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.

(3) A participating hospital may not penalize or take adverse action against a physician or a qualified medical person described in paragraph (e)(1)(ii)(C) of this section because the physician or qualified medical person refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized, or against any hospital employee because the employee reports a violation of a requirement of this section.

(f) *Recipient hospital responsibilities.* A participating hospital that has specialized capabilities or facilities (including, but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive care units, or, with respect to rural areas, regional referral centers (which, for purposes of this subpart, mean hospitals meeting the requirements of referral centers found at Section 412.96 of this chapter)) may not refuse to accept from a

referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual.

(1) The provisions of this paragraph (f) apply to any participating hospital with specialized capabilities, regardless of whether the hospital has a dedicated emergency department.

(2) The provisions of this paragraph (f) do not apply to an individual who has been admitted to a referring hospital under the provisions of paragraph (d)(2)(i) of this section.

(g) *Termination of provider agreement.* If a hospital fails to meet the requirements of paragraphs (a) through (f) of this section, CMS may terminate the provider agreement in accordance with Section 489.53.

(h) Consultation with Quality Improvement Organizations (QIOs) —

(1) *General.* Except as provided in paragraph (h)(3) of this section, in cases where a medical opinion is necessary to determine a physician's or hospital's liability under Section 1867(d)(1) of the Act, CMS requests the appropriate QIO (with a contract under Part B of title XI of the Act) to review the alleged section 1867(d) violation and provide a report on its findings in accordance with paragraphs (h)(2)(iv) and (v) of this section. CMS provides to the QIO all information relevant to the case and within its possession or control. CMS, in consultation with the OIG, also provides to the QIO a list of relevant questions to which the QIO must respond in its report.

(2) *Notice of review and opportunity for discussion and additional information*. The QIO shall provide the physician and hospital reasonable notice of its review, a reasonable opportunity for discussion, and an opportunity for the physician and hospital to submit additional information before issuing its report. When a QIO receives a request for consultation under paragraph (h)(1) of this section, the following provisions apply—

(i) The QIO reviews the case before the 15th calendar day and makes its tentative findings.

(ii) Within 15 calendar days of receiving the case, the QIO gives written notice, sent by certified mail, return receipt requested, to the physician or the hospital (or both if applicable).

(iii)(A) The written notice must contain the following information:

(1) The name of each individual who may have been the subject of the alleged violation.

(2) The date on which each alleged violation occurred.

(3) An invitation to meet, either by telephone or in person, to discuss the case with the QIO, and to submit additional information to the QIO within 30 calendar days of receipt of the notice, and a statement that these rights will be waived if the invitation is not accepted. The QIO must receive the information and hold the meeting within the 30-day period.

(4) A copy of the regulations at 42 C.F.R. 489.24.

(B) For purposes of paragraph (h)(2)(iii)(A) of this section, the date of receipt is presumed to be 5 days after the certified mail date on the notice, unless there is a reasonable showing to the contrary.

(iv) The physician or hospital (or both where applicable) may request a meeting with the QIO. This meeting is not designed to be a formal adversarial hearing or a mechanism for discovery by the physician or hospital. The meeting is intended to afford the physician

and/or the hospital a full and fair opportunity to present the views of the physician and/or hospital regarding the case. The following provisions apply to that meeting:

(A) The physician and/or hospital has the right to have legal counsel present during that meeting. However, the QIO may control the scope, extent, and manner of any questioning or any other presentation by the attorney. The QIO may also have legal counsel present.

(B) The QIO makes arrangements so that, if requested by CMS or the OIG, a verbatim transcript of the meeting may be generated. If CMS or OIG requests a transcript, the affected physician and/or the affected hospital may request that CMS provide a copy of the transcript.

(C) The QIO affords the physician and/or the hospital an opportunity to present, with the assistance of counsel, expert testimony in either oral or written form on the medical issues presented. However, the QIO may reasonably limit the number of witnesses and length of such testimony if such testimony is irrelevant or repetitive. The physician and/or hospital, directly or through counsel, may disclose patient records to potential expert witnesses without violating any non-disclosure requirements set forth in part 476 of this chapter.

(D) The QIO is not obligated to consider any additional information provided by the physician and/or the hospital after the meeting, unless, before the end of the meeting, the QIO requests that the physician and/or hospital submit additional information to support the claims. The QIO then allows the physician and/or the hospital an additional period of time, not to exceed 5 calendar days from the meeting, to submit the relevant information to the QIO.

(v) Within 60 calendar days of receiving the case, the QIO must submit to CMS a report on the QIO's findings. CMS provides copies to the OIG and to the affected physician and/or the affected hospital. The report must contain the name of the physician and/or the hospital, the name of the individual, and the dates and times the individual arrived at and was transferred (or discharged) from the hospital. The report provides expert medical opinion regarding whether the individual involved had an emergency medical condition, whether the individual's emergency medical condition was stabilized, whether the individual was transferred appropriately, and whether there were any medical utilization or quality of care issues involved in the case.

(vi) The report required under paragraph (h)(2)(v) of this section should not state an opinion or conclusion as to whether section 1867 of the Act or Section 489.24 has been violated.

(3) If a delay would jeopardize the health or safety of individuals or when there was no screening examination, the QIO review described in this section is not required before the OIG may impose civil monetary penalties or an exclusion in accordance with section 1867(d)(1) of the Act and 42 C.F.R. part 1003 of this title.

(4) If the QIO determines after a preliminary review that there was an appropriate medical screening examination and the individual did not have an emergency medical condition, as defined by paragraph (b) of this section, then the QIO may, at its discretion, return the case to CMS and not meet the requirements of paragraph (h) except for those in paragraph (h)(2)(v).

(i) *Release of QIO assessments.* Upon request, CMS may release a QIO assessment to the physician and/or hospital, or the affected individual, or his or her representative. The QIO physician's identity is confidential unless he or she consents to its release. (See Section 476.132 and 476.133 of this chapter.)

(j) *Availability of on-call physicians*. In accordance with the on-call list requirements specified in Section 489.20(r)(2), a hospital must have written policies and procedures in place —

(1) To respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control; and

(2) To provide that emergency services are available to meet the needs of individuals with emergency medical conditions if a hospital elects to —

(i) Permit on-call physicians to schedule elective surgery during the time that they are on-call;

(ii) Permit on-call physicians to have simultaneous on-call duties; and

(iii) Participate in a formal community call plan. Notwithstanding participation in a community call plan, hospitals are still required to perform medical screening examinations on individuals who present seeking treatment and to conduct appropriate transfers. The formal community plan must include the following elements:

(A) A clear delineation of on-call coverage responsibilities; that is, when each hospital participating in the plan is responsible for on-call coverage.

(B) A description of the specific geographic area to which the plan applies.

(C) A signature by an appropriate representative of each hospital participating in the plan.

(D) Assurances that any local and regional EMS system protocol formally includes information on community on-call arrangements.

(E) A statement specifying that even if an individual arrives at a hospital that is not designated as the on-call hospital, that hospital still has an obligation under Section 489.24 to provide a medical screening examination and stabilizing treatment within its capability, and that hospitals participating in the community call plan must abide by the regulations under Section 489.24 governing appropriate transfers.

(F) An annual assessment of the community call plan by the participating hospitals.

Source: **CMS State Operations Manual, Appendix V, Part II Interpretive Guidelines—Responsibilities of Medicare Participating Hospitals in Emergency Cases www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf**

Part II - Interpretive Guidelines - Responsibilities of Medicare Participating Hospitals in Emergency Cases

The Interpretive Guidelines is a tool for surveyors where the regulation is broken into regulatory citations (tag numbers), followed by the regulation language and provides detailed interpretation of the regulation(s) to surveyors.

Basic Section 1866 Commitments Relevant to Section 1867 Responsibilities – Tags A-2400/C2400 – A2405/C2405

(Rev. 46, Issued: 05-29-09, Effective/Implementation: 05-29-09)

Tag A-2400/C-2400

(Rev. 46, Issued: 05-29-09, Effective/Implementation: 05-29-09)

§489.20(l)

[The provider agrees to the following:]

(l) In the case of a hospital as defined in §489.24 (b) to comply with §489.24 .

Interpretive Guidelines: §489.20(l)

The term "hospital" is defined in §489.24(b) as including critical access hospitals as defined in §1861(mm)(1) of the Act. Therefore, a critical access hospital that operates a dedicated emergency department (as that term is defined below) is subject to the requirements of EMTALA.

Section 42 CFR 489.20(l) of the provider's agreement requires that hospitals comply with 42 CFR 489.24, special responsibilities of Medicare hospitals in emergency cases. Under the provisions of §489.24, hospitals with an emergency department that participate in Medicare are required under EMTALA to do the following:

- Provide an appropriate MSE to any individual who comes to the emergency department;
- Provide necessary stabilizing treatment to an individual with an EMC or an individual in labor;
- Provide for an appropriate transfer of the individual if either the individual requests the transfer or the hospital does not have the capability or capacity to

provide the treatment necessary to stabilize the EMC (or the capability or capacity to admit the individual);

- Not delay examination and/or treatment in order to inquire about the individual's insurance or payment status;

- Obtain or attempt to obtain written and informed refusal of examination, treatment or an appropriate transfer in the case of an individual who refuses examination, treatment or transfer; and

- Not take adverse action against a physician or qualified medical personnel who refuses to transfer an individual with an emergency medical condition, or against an employee who reports a violation of these requirements.

Further, any participating Medicare hospital is required to accept appropriate transfers of individuals with emergency medical conditions if the hospital has the specialized capabilities not available at the transferring hospital, and has the capacity to treat those individuals.

Hospitals are required to adopt and enforce a policy to ensure compliance with the requirements of §489.24. Noncompliance with EMTALA requirements will lead CMS to initiate procedures for termination from the Medicare program. Noncompliance may also trigger the imposition of civil monetary penalties by the Office of the Inspector General.

Surveyors review the following documents to help determine if the hospital is in compliance with the requirement(s):

- Review the bylaws, rules, and regulations of the medical staff to determine if they reflect the requirements of §489.24 and the related requirements at §489.20.

- Review the emergency department policies and procedure manuals for procedures related to the requirements of §489.24 and the related requirements at §489.20.

If a hospital violates §489.24, surveyors are to cite a corresponding violation of §489.20(l), Tag A-2400/C-2400.

Tag A-2401/C-2401

(Rev. 46, Issued: 05-29-09, Effective/Implementation: 05-29-09)
§489.20(m)

[The provider agrees to the following:]

In the case of a hospital as defined in §489.24(b), to report to CMS or the State survey agency any time it has reason to believe it may have received an individual who has been transferred in an unstable emergency medical condition from another hospital in violation of the requirements of §489.24(e).

Interpretive Guidelines: §489.20 (m)

A hospital (recipient) that suspects it may have received an improperly transferred (transfer of an unstable individual with an emergency medical condition who was not provided an appropriate transfer according to §489.24(e)(2)), individual is required to promptly report the incident to CMS or the State Agency (SA) within 72 hours of the occurrence. If a recipient hospital fails to report an improper transfer, the hospital may be subject to termination of it's provider agreement according to 42 CFR489.53(a).

Surveyors are to look for evidence that the recipient hospital knew, or suspected the individual had been to a hospital prior to the recipient hospital, and had not been transferred in accordance with §489.24(e). Evidence may be obtained in the medical record or through interviews with the individual, family members or staff.

Review the emergency department log and medical records of patients received as transfers. Look for evidence that:

- The hospital had agreed in advance to accept the transfers;
- The hospital had received appropriate medical records;
- All transfers had been effected through qualified personnel, transportation equipment and medically appropriate life support measures; and
- The hospital had available space and qualified personnel to treat the patients.

Tag A-2402/C-2402

(Rev. 46, Issued: 05-29-09, Effective/Implementation: 05-29-09)

§489.20(q)

[The provider agrees to the following:]

In the case of a hospital as defined in §489.24 (b)—

(1) To post conspicuously in any emergency department or in a place or places likely to be noticed by all individuals entering the emergency department, as well as those individuals waiting for examination and treatment in areas other than traditional emergency department (that is, entrance, admitting area, waiting room, treatment area) a sign (in a form specified by the Secretary) specifying the rights of individuals under section 1867 of the Act with respect to examination and treatment of emergency medical conditions and women in labor; and

(2) To post conspicuously (in a form specified by the Secretary) information indicating whether or not the hospital or rural primary care hospital (e.g., critical access hospital) participates in the Medicaid program under a State plan approved under Title XIX;

Interpretive Guidelines: §489.20(q)(1) and (2)

Section 1866(a)(1)(N)(iii) of the Act requires the posting of signs which specify the rights of individuals with EMCs and women in labor.

To comply with the requirements hospital signage must at a minimum:

- Specify the rights of individuals with EMCs and women in labor who come to the emergency department for health care services;
- Indicate whether the facility participates in the Medicaid program;
- The wording of the sign(s) must be clear and in simple terms and language(s) that are understandable by the population served by the hospital; and
- The sign(s) must be posted in a place or places likely to be noticed by all individuals entering the emergency department, as well as those individuals waiting for examination and treatment (e.g., entrance, admitting area, waiting room, treatment area).

Tag A-2403/C-2403

(Rev. 46, Issued: 05-29-09, Effective/Implementation: 05-29-09)

§489.20(r)

[The provider agrees to the following:]

In the case of a hospital as defined in §489.24(b) (including both the transferring and receiving hospitals), to maintain—

(1) Medical and other records related to individuals transferred to or from the hospital for a period of 5 years from the date of transfer;

Interpretive Guidelines: §489.20(r)(1)

The medical records of individuals transferred to or from the hospital must be retained in their original or legally reproduced form in hard copy, microfilm, microfiche, optical disks, computer disks, or computer memory for a period of 5 years from the date of transfer.

Tag A-2404/C-2404

(Rev. 46, Issued: 05-29-09, Effective/Implementation: 05-29-09)

§489.20(r)(2)

[The provider agrees to the following:

In the case of a hospital as defined in §489.24(b) (including both the transferring and receiving hospitals), to maintain--]

(2) An on-call list of physicians who are on the hospital's medical staff or who have privileges at the hospital, or who are on staff or have privileges at another hospital participating in a formal community call plan, in accordance with §489.24(j)(2)(iii), available to provide treatment necessary after the initial examination to stabilize individuals with emergency medical conditions who are receiving services under §489.24 in accordance with the resources available to the hospital;

§489.24(j) - Availability of On-call Physicians

In accordance with the on-call requirements specified in §489.20(r)(2), a hospital must have written policies and procedures in place--

(1) To respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control;

(2) To provide that emergency services are available to meet the needs of individuals with emergency medical conditions if a hospital elects to—

(i) Permit on-call physicians to schedule elective surgery during the time they are on call

(ii) Permit on-call physicians to have simultaneous on-call duties;

(iii) Participate in a formal community call plan. Notwithstanding participation in a community call plan, hospitals are still required to perform medical screening examinations on individuals who present seeking treatment and to conduct appropriate transfers. The formal community call plan must include the following elements:

(A) A clear delineation of on-call coverage responsibilities; that is, when each hospital participating in the plan is responsible for on-call coverage.

(B) A description of the specific geographic area to which the plan applies.

(C) A signature by an appropriate representative of each hospital participating in the plan.

(D) Assurances that any local and regional EMS system protocol formally includes information on community-call arrangements.

(E) A statement specifying that even if an individual arrives at a hospital that is not designated as the on-call hospital, that hospital still has an obligation under §489.24 to provide a medical screening examination and stabilizing treatment within its capability, and that hospitals participating in the community call plan must abide by the regulations under §489.24 governing appropriate transfers.

(F) An annual assessment of the community call plan by the participating hospitals.

Interpretive Guidelines §489.20(r)(2) and §489.24(j)

On-Call List Requirements and Options

Section 1866(a)(1)(I)(iii)of the Act states, as a requirement for participation in the Medicare program, that hospitals must maintain a list of physicians who are on-call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition. This on-call list requirement is a general provider agreement requirement for all hospitals and is thus technically an "EMTALA-related" requirement rather than a specific requirement of the EMTALA portion of the Act. When determining compliance with the on-call list requirement as part of an EMTALA survey it must be remembered that the on-call list requirement applies not only to hospitals with dedicated emergency departments, but also to hospitals subject to EMTALA requirements to accept appropriate transfers. (See discussion of §489.24(f).) The on-call list clearly identifies and ensures that the hospital's personnel is prospectively aware of which physicians, including specialists and sub-specialists, are available to provide stabilizing treatment for individuals with emergency medical conditions.

The list of on-call physicians must be composed of physicians who are current members of the medical staff or who have hospital privileges. If the hospital participates in a community call plan then the list must also include the names of physicians at other hospitals who are on-call pursuant to the plan. The list must be up-to-date, and accurately reflect the current privileges of the physicians on-call. Physician group names are not acceptable for identifying the on-call physician. Individual physician names are to be identified on the list with their accurate contact information.

Hospital administrators and the physicians who provide the on-call services have flexibility regarding how to configure an on-call coverage system. Several options to enhance this flexibility are permitted under the regulations. It is crucial, however, that hospitals are aware of their responsibility to ensure that they are providing sufficient on-call services to the meet the needs of their community in accordance with the resources they have available. CMS expects a hospital to strive to provide adequate specialty on-call coverage consistent with the services provided at the hospital and the resources the hospital has available. (73 FR 48662).

<u>Permitted On-Call Options</u>

Community Call Plan

CMS permits hospitals to satisfy their on-call obligations through participation in a community call plan (CCP). It is strictly voluntary. Under such a community on-call plan, a hospital may augment its on-call list by adding to it physicians at another hospital. There are different ways a CCP could be organized. For example, if there are two hospitals that choose to participate in community call, Hospital A could be designated as the on-call facility for the first 15 days of the month and Hospital B could be designated as the on-call facility for the remaining days of the month. Alternatively, Hospital A

could be designated as on-call for cases requiring specialized interventional cardiac care, while Hospital B could be designated as on-call for neurosurgical cases.
Ideally, a CCP could allow various physicians in a certain specialty in the aggregate to be on continuous call (24 hours a day, 7 days a week) without putting a continuous call obligation at the participating hospitals on any one physician. Even if this ideal cannot be achieved, given the resources of the participating hospitals, at a minimum, hospitals choosing to participate in a CCP should to be able to provide more on-call specialty coverage than they would on their own.

The plan must clearly articulate which on-call services will be provided on which dates/times by each hospital participating in the plan. Furthermore, the DED in each hospital must have specific information based on the allocation of on-call responsibilities in the plan readily available as part of the on-call list, so that personnel who are providing required services to individuals protected under EMTALA know which specialists based in which hospital(s) are available on-call to provide the necessary specialist services.

Participation in a community call plan does not mean that on-call physicians must travel from the hospital where they practice to the hospital needing their on-call services. Instead, this arrangement facilitates appropriate transfers to the hospital providing the specialty on-call services pursuant to the plan. The hospital where the individual initially presents still has an EMTALA obligation to conduct a medical screening examination, and, for individuals found to have an emergency medical condition, to provide stabilizing treatment within its capability and capacity. However, when the individual is appropriately transferred pursuant to a CCP for further stabilizing treatment, it can generally be assumed that the transferring hospital has provided treatment within its capability and capacity and that its on-call list is adequate for that specialty. For example, if an individual requires the services of a neurologist on a date when the neurologist on-call pursuant to the CCP is based at hospital B, and that neurologist is part of hospital A's on-call list, then a transfer to hospital B to obtain the services of the neurologist on-call would be in order, assuming all other transfer requirements have been met.

In those cases where, for example, hospitals A and B participate in a CCP and a physician who is a member of the medical staff or has privileges at both hospitals is on-call directly at hospital B, but only indirectly through the CCP to hospital A, there is no regulatory prohibition against the on-call physician going to hospital A to provide the stabilizing treatment, rather than transferring the individual to hospital B. The treating and on-call physician might consider which approach is in the best interests of the patient and also maintains the availability of the on-call specialist pursuant to the CCP.

The regulations establish a number of specific requirements for community call plans:

- The plan must include the geographic parameters of the on-call coverage, indicating what patient origin areas the plan expects to service (e.g., certain communities, counties, regions, municipalities). CMS does not stipulate geographic criteria that a community call plan must meet, since the intent of the plan is to promote flexibility amongst the participating hospitals in

developing a call plan that best meets the needs of their communities and utilizes the resources within the region. Similarly, there is no requirement that all hospitals within a defined geographic area must participate in the community call plan.

Regardless of the geographic specifications of the community call plan, the existence of a CCP in a specific area does not eliminate the EMTALA obligations of hospitals with respect to making appropriate transfers. Among other things this means that:

- hospitals participating in the community call plan are not relieved of their recipient hospital obligations to accept appropriate transfers from hospitals not participating in the plan.

- non-participating hospitals must accept appropriate transfers, regardless of whether the transferring hospital participates in a CCP with the recipient hospital or any other hospital.

- non-participating hospitals must provide stabilizing treatment within their capability and capacity before seeking to transfer an individual to another hospital, regardless of whether the recipient hospital is providing on-call services to other hospitals pursuant to a CCP.

In other words, all Medicare-participating hospitals must fulfill their transfer responsibilities under EMTALA, notwithstanding the presence or absence of a transfer agreement and regardless of whether the transferring or recipient hospital is participating in a formal community call plan (73 FR 48667).

- The community call plan for each participating hospital must show evidence that the duly authorized representative of each hospital has officially signed the plan. The regulations do not require that the plan be signed by an appropriate representative as part of the annual assessment but it is expected that updated signatures would be included in any subsequent revision of the CCP.

- The delivery of pre-hospital medical services is quite varied throughout the country and there are no specific EMTALA requirements that pertain to the development of EMS protocols. However, if there are EMS protocols in effect in part or all of the areas served by the CCP, then there must be an attestation by the CCP-participating hospitals that the CCP arrangement information has been communicated to the EMS providers and will be updated as needed so that EMS providers have the opportunity to consider this information when developing protocols. In addition, hospitals which are in the process of developing and refining their own CCPs may want to consider including input from the EMS providers that serve their DEDs so

as to facilitate the efficient implementation of the CCP. For communities that do not have formalized EMS protocols, hospitals participating in a CCP would still be well-advised to inform individual EMS providers of the CCP arrangements amongst the hospitals in the geographic area specified in the plan.

- The formal language of the CCP must contain a statement that each hospital participating in the CCP will continue to follow the regulations requiring the provision of MSEs, and stabilizing treatment for individuals determined to have EMCs.

- Hospitals must conduct an annual reassessment of their CCP, including an analysis of the specialty on-call needs of the communities for which the CCP is effective (73 FR 48665). It is expected that the CCP would expand specialty coverage to the communities served by the plan and improve, within the hospitals' capabilities and capacities, the adequacy of the on-call list for the hospitals participating in the plan. CMS expects the annual assessment to support a Quality Assurance/Performance Improvement approach to the functioning of the CCP, and that hospitals would, as necessary and feasible, adjust the CCP based on the annual reassessment. Hospitals participating in the CCP have flexibility to determine how to design and implement the assessment.

Simultaneous Call

Hospitals are permitted to allow physicians to be on-call simultaneously at two or more facilities. Hospitals are also permitted to adopt a policy that does not allow physicians to take simultaneous call at more than one hospital. If a hospital permits simultaneous call, then it must have written policies and procedures to follow when the on-call physician is not available to respond because he/she has been called to another hospital. All hospitals where the physician is on-call need to be aware of the details of the simultaneous call arrangements for the physician and have back-up plans established.

Scheduled Elective Surgery

Hospitals are permitted to allow physicians to perform elective surgery or other procedures while they are on-call. Hospitals are also permitted to adopt a policy that does not allow physicians to perform elective surgery or other procedures while they are on-call. (Critical Access Hospitals (CAHs) should be aware that if they reimburse physicians for being on-call, there are Medicare payment policy regulations, outside the scope of EMTALA requirements, that the CAH might want to consider before making a decision to permit on-call physicians to schedule elective procedures.)

When a physician has agreed to be on-call at a particular hospital during a particular period of time, but also has scheduled elective surgery or an elective diagnostic or therapeutic procedure during that time as permitted by hospital policy, that physician and

the hospital must have planned back-up in the event the physician is called while performing elective surgery and is unable to respond to an on-call request in a reasonable time.

Medical Staff Exemptions

There is no EMTALA or Medicare provider agreement requirement for all physicians on the medical staff and/or having hospital privileges to take call. A hospital policy allowing exemptions to medical staff members (e.g., senior physicians) would not in of itself violate EMTALA-related Medicare provider agreement requirements. However, if a hospital permits physicians to selectively take call only for their own established patients who present to the ED for evaluation, then the hospital must be careful to assure that it maintains adequate on-call services, and that the selective call policy is not a substitute for the on-call services required by the Medicare provider agreement.

Other On-call List Regulatory Requirements

A hospital must have written on-call policies and procedures and must clearly define the responsibilities of the on-call physician to respond, examine and treat patients with an EMC. Among other things, the policies and procedures must address the steps to be taken if a particular specialty is not available or the on-call physician cannot respond due to circumstances beyond his/her control (e.g., transportation failures, personal illness, etc.). The policies and procedures must also ensure that the hospital provides emergency services that meet the needs of an individual with an EMC if the hospital chooses to employ any of the on-call options permitted under the regulations, i.e., community call, simultaneous call, or elective procedures while on-call. In other words, there must be a back-up plan to these optional arrangements. For instance, some hospitals may employ the use of "jeopardy" or back-up call schedules to be used only under extreme circumstances. The hospital must be able to demonstrate that hospital staff is aware of and able to execute the back-up procedures.

Assessment of On-call List Adequacy by Surveyors

CMS expects that a hospital should strive to provide adequate on-call coverage consistent with the services provided at the hospital and the resources the hospital has available, including the availability of specialists. (42 FR 48662). CMS does not have specified requirements regarding how frequently on-call physicians are expected to be available to provide on-call coverage. However, CMS recognizes that in order to supply safe and effective care it would not be prudent for a hospital to expect one physician to be on-call every day of the week, every week of the year. There is also no pre-determined ratio CMS uses to identify how many days a hospital must provide medical staff on-call coverage for a particular specialty based on the number of physicians on staff for that particular specialty. In particular, CMS has no rule stating that whenever there are at least three physicians in a specialty, the hospital must provide 24-hour/7-day coverage in that specialty.

If a hospital participates in a community call plan, its on-call list must reflect this. The plan does not have to be pre-approved or require formal authorization by CMS or any local, State or Federal agency, in order to be instituted. However, during a complaint investigation, the design and implementation of the CCP will come under review.

Generally, in determining a hospital's on-call list compliance, CMS will consider all relevant factors in a case-specific manner, including the number of physicians on the medical staff/holding hospital privileges, other demands on these physicians, the frequency with which individuals with EMCs typically require the stabilizing services of the hospital's on-call physicians, and the provisions the hospital has made for situations in which a physician on-call is not available or is unable to respond due to circumstances beyond his/her control.

For instance, if the hospital under investigation performs a significant amount of interventional cardiac catheterizations and holds itself out to the public through various advertising methods as a center of excellence in providing this specialized procedure to the community, it would be reasonable to expect that there would be adequate on-call coverage by a physician who is able to perform an emergent interventional cardiac procedure on individuals who present to that hospital's DED in need of such an intervention or who are appropriately transferred to that hospital for such an intervention. On the other hand, it may not be reasonable to expect a CAH to have an interventional radiologist on call if that service is not routinely provided at the CAH or in the local vicinity of the CAH, unless the CAH participates in a community call plan that provides for this service.

On-call Physician Appearance Requirements

Although the on-call list requirement is found in Section 1866, which is the provider agreement section of the Act, Section 1867, the EMTALA section of the Act, provides for enforcement actions against both a physician and a hospital when a physician who is on the hospital's on-call list fails or refuses to appear within a reasonable period of time after being notified to appear. Hospitals would be well-advised to make physicians who are on-call aware of the hospital's on-call policies and the physician's EMTALA obligations when on call.

If a physician is listed as on-call and requested to make an in-person appearance to evaluate and treat an individual, that physician must respond in person in a reasonable amount of time. If an individual presents to Hospital A with an EMC that requires the specialty services provided by Hospital B pursuant to the CCP, then the physician who is based at Hospital B is required to report to Hospital B to provide the stabilizing treatment for the individual who presented to Hospital A and was subsequently transferred to Hospital B.

When a physician is on-call for the hospital and seeing patients with scheduled appointments in his/her private office, it is generally not acceptable to refer emergency cases to his or her office for examination and treatment of an EMC. The physician must

come to the hospital to examine the individual if requested to do so by the treating physician. If, however, it is medically indicated, the treating physician may send an individual needing the specialized services of the on-call physician to the physician's office if it is a provider-based part of the hospital (i.e., department of the hospital sharing the same CMS certification number as the hospital) It must be clear that this transport is not done for the convenience of the specialist but that there is a genuine medical reason to move the individual, that all individuals with the same medical condition, regardless of their ability to pay, are similarly moved to the specialist's office, and that the appropriate medical personnel accompany the individual to the office.

If it is permitted under the hospital's policies, an on-call physician has the option of sending a representative, i.e., directing a licensed non-physician practitioner as his or her representative to appear at the hospital and provide further assessment or stabilizing treatment to an individual. This determination should be based on the individual's medical need and the capabilities of the hospital and the applicable State scope of practice laws, hospital by-laws and rules and regulations. There are some circumstances in which the non-physician practitioner can provide the specialty treatment more expeditiously than the physician on-call. It is important to note, however, that the designated on-call physician is ultimately responsible for providing the necessary services to the individual in the DED, regardless of who makes the in-person appearance. Furthermore, in the event that the treating physician disagrees with the on-call physician's decision to send a representative and requests the actual appearance of the on-call physician, then the on-call physician is required under EMTALA to appear in person. Both the hospital and the on-call physician who fails or refuses to appear in a reasonable period of time may be subject to sanctions for violation of the EMTALA statutory requirements.

There is no EMTALA prohibition against the treating physician consulting on a case with another physician, who may or may not be on the hospital's on-call list, by telephone, video conferencing, transmission of test results, or any other means of communication. CMS is aware that it is increasingly common for hospitals to use telecommunications to exchange imaging studies, laboratory results, EKGs, real-time audio and video images of patients and/or other clinical information with a consulting physician not on the hospital's premises. Such practices may contribute to improved patient safety and efficiency of care. In some cases it may be understood by the hospitals and physicians who establish such remote consulting arrangements that the physician consultant is not available for an in-person assessment of the individual at the treating physician's hospital. However, if a physician:

- is on a hospital's on-call list;
- has been requested by the treating physician to appear at the hospital; and
- fails or refuses to appear within a reasonable period of time;

then the hospital and the on-call physician may be subject to sanctions for violation of the EMTALA statutory requirements.

It is an entirely separate issue, outside the scope of EMTALA enforcement, whether or not insurers or other third party payers, including Medicare, will provide reimbursement to physicians who provide remote consultation services. Hospitals and/or physicians interested in Medicare reimbursement policy for telemedicine or telehealth services should consult Medicare Benefit Policy Manual, Pub. 100-02, Chapter 18, §270.

If a physician who is on-call, either directly, or indirectly pursuant to a CCP, refuses or fails to appear at the hospital where he/she is directly on call in a reasonable period of time, then that physician as well as the hospital may be found to be in violation of EMTALA. Likewise, if a physician who is on-call typically directs the individual to be transferred to another hospital instead of making an appearance as requested, then that physician as well as the hospital may be found to be in violation of EMTALA. While CMS' enforcement of the EMTALA section of the Act and regulations and the EMTALA-related provisions of the provider agreement section of the Act and regulations are directed solely against hospitals, it is important to note that Section 1867 of the Act also provides for the Office of the Inspector General (OIG) to levy civil monetary penalties or take other actions against hospitals or physicians for EMTALA violations. CMS refers cases it has investigated to the OIG when CMS finds violations that appear to fall within the OIG's EMTALA jurisdiction. Section 1867(d)(1)(C) of the Act specifically provides for penalties against both a hospital and the physician when a physician who is on-call either fails to appear or refuses to appear within a reasonable period of time. Thus, a hospital would be well-advised to establish in its on-call policies and procedures specific guidelines-- e.g., the maximum number of minutes that may elapse between receipt of a request and the physician's appearance for what constitutes a reasonable response time, and to make sure that its on-call physicians and other staff are aware of these time-sensitive requirements.

If a physician on-call does not fulfill his/her on-call obligation, but the hospital arranges in a timely manner for another of its physicians in that specialty to assess/stabilize an individual as requested by the treating physician in the DED, then the hospital would not be in violation of CMS' on-call requirements. However, if a physician on-call does not fulfill his/her on-call obligation and the individual is, as a result, transferred to another hospital, then the hospital may be in violation of CMS's requirements and both the hospital and the on-call physician may be subject to enforcement action by the OIG under the Act.

Tag A-2405/C-2405

(Rev. 46, Issued: 05-29-09, Effective/Implementation: 05-29-09)

Section 489.20(r)(3) - A central log on each individual who "comes to the emergency department," as defined in §489.24(b), seeking assistance and whether he or she refused treatment, was refused treatment, or whether he or she was transferred, admitted and treated, stabilized and transferred, or discharged.

Interpretive Guidelines: §489.20(r)(3)

The purpose of the central log is to track the care provided to each individual who comes to the hospital seeking care for an emergency medical condition.

Each hospital has the discretion to maintain the log in a form that best meets the needs of the hospital. The central log includes, directly or by reference, patient logs from other areas of the hospital that may be considered dedicated emergency departments, such as pediatrics and labor and delivery where a patient might present for emergency services or receive a medical screening examination instead of in the "traditional" emergency department. These additional logs must be available in a timely manner for surveyor review. The hospital may also keep its central log in an electronic format.

Review the emergency department log covering at least a 6-month period that contains information on all individuals coming to the emergency department and check for completeness, gaps in entries or missing information.

Section 489.24 - Special Responsibilities of Medicare Hospitals in Emergency Cases (Section 1867 EMTALA Requirements – Tags A2406/C2406 – A2411/C2411)

Tag A-2406/C-2406

(Rev. 60, Issued: 07-16-10, Effective: 07-16-10, Implementation: 07-16-10)

§489.24(a) - Applicability of Provisions of this Section

(1) In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) "comes to the emergency department", as defined in paragraph (b) of this section, the hospital must—

(i) Provide an appropriate medical screening examination within the

capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations and who meets the requirements of §482.55 of this chapter concerning emergency services personnel and direction; and

Interpretive Guidelines §489.24(a)(1)(i)

A "hospital with an emergency department" is defined in §489.24(b) as a hospital with a dedicated emergency department. An EMTALA obligation is triggered for such a hospital when an individual comes by him or herself, with another person, to a hospital's **dedicated emergency department** (as that term is defined above) and a request is made by the individual or on the individual's behalf, or a prudent layperson observer would conclude from the individual's appearance or behavior a need, for examination or treatment of a **medical condition.** In such a case, the hospital has incurred an obligation to provide an appropriate medical screening examination (MSE) for the individual and stabilizing treatment or an appropriate transfer. The purpose of the MSE is to determine whether or not an emergency medical condition exits.

If an individual who is not a hospital patient comes elsewhere on **hospital property** (that is, the individual comes to the hospital but not to the dedicated emergency department), an EMTALA obligation on the part of the hospital may be triggered if either the individual requests examination or treatment for an **emergency** medical condition or if a prudent layperson observer would believe that the individual is suffering from an **emergency** medical condition. The term "hospital property" means the entire main hospital campus as defined in §413.65(a), including the parking lot, sidewalk and driveway or hospital departments, including any building owned by the hospital that are within 250 yards of the hospital).

If an individual is registered as an outpatient of the hospital and they present on hospital property but not to a dedicated emergency department, the hospital does not incur an obligation to provide a medical screening examination for that individual if they have begun to receive a scheduled course of outpatient care. Such an individual is protected by the hospital Conditions of Participation (CoPs) that protect patient's health and safety and to ensure that quality care is furnished to all patients in Medicare-participating hospital. If such an individual experiences an EMC while receiving outpatient care, the hospital does not have an obligation to conduct an MSE for that patient. As discussed in greater detail below, such a patient has adequate protections under the Medicare CoPs and state law.

If an individual is initially screened in a department or facility on-campus outside of the ED, the individual could be moved to another hospital department or facility on-campus to receive further screening or stabilizing treatment without such movement being regarded as a transfer, as long as: (1) all persons with the same medical condition are

moved in such circumstances, regardless of their ability to pay for treatment; (2) there is bona fide medical reason to move the individual; and (3) appropriate medical personnel accompany the individual. The same is also true for an individual who presents to the dedicated emergency department (e.g., patient with an eye injury in need of stationary ophthalmology equipment located in the eye clinic) and must be moved to another hospital-owned facility or department on-campus for further screening or stabilizing treatment. The movement of the individual between hospital departments is not considered an EMTALA transfer under this section, since the individual is simply being moved from one department of a hospital to another department or facility of the same hospital.

Hospitals should not move individuals to off-campus facilities or departments (such as an urgent care center or satellite clinic) for a MSE. If an individual comes to a hospital-owned facility or department, which is off-campus and operates under the hospital's Medicare provider number, §1867 (42 CFR 489.24) will not apply to that facility and/or department unless it meets the definition of a dedicated emergency department.

If, however, such a facility does not meet the definition of a dedicated ED, it must screen and stabilize the patient to the best of its ability or execute an appropriate transfer if necessary to another hospital or to the hospital on whose Medicare provider number it is operated. Hospital resources and staff available at the main campus are likewise available to individuals seeking care at the off campus facilities or departments within the capability of the hospital. Movement of the individual to the main campus of the hospital is not considered a transfer since the individual is simply being moved from one department of a hospital to another department or facility of the same hospital. In addition, a transfer from such an entity (i.e., an off-campus facility that meets the definition of a dedicated ED) to a nonaffiliated hospital (i.e., a hospital that does not own the off-campus facility) is allowed where the facility at which the individual presented cannot stabilize the individual and the benefits of transfer exceed the risks of transfer. In other words, there is no requirement under EMTALA that the individual be always transferred back to the hospital that owns and operates the off-campus dedicated ED. Rather, the requirement of EMTALA is that the individual be transferred to an appropriate facility for treatment.

If a request were made for emergency care in a hospital department **off** the hospital's main campus that does not meet the definition of a dedicated emergency department, EMTALA would not apply. However, such an off-campus facility must have policies and procedures in place as how to handle patients in need of immediate care. For example, the off-campus facility policy may direct the staff to contact the emergency medical services/911 (EMS) to take the patient to an emergency department (not necessarily the emergency department of the hospital that operates the off-campus department, but rather the closest emergency department) or provide the necessary care if it is within the hospital's capability. Therefore, a hospital off-campus facility that does not meet the definition of a dedicated emergency department does not have an EMTALA obligation and not required to be staffed to handle potential EMC.

Medicare **hospitals** that do not provide emergency services must meet the standard of §482.12 (f) , which requires hospitals to have written policies and procedures for the appraisal of emergencies, initial treatment within its capability and capacity, and makes an appropriate referral to a hospital that is capable of providing the necessary emergency services.

If a hospital has an EMTALA obligation, it must screen individuals to determine if an EMC exists. It is not appropriate to merely "log in" an individual and not provide a MSE. An MSE is the process required to reach, with reasonable clinical confidence, the point at which it can be determined whether the individual has an EMC or not. An MSE is not an isolated event. It is an ongoing process that begins, but typically does not end, with triage.

Triage entails the clinical assessment of the individual's presenting signs and symptoms at the time of arrival at the hospital, in order to prioritize when the individual will be seen by a physician or other qualified medical personnel (QMP).

Individuals coming to the emergency department must be provided an MSE appropriate to the individuals' presenting signs and symptoms, as well as the capability and capacity of the hospital. Depending on the individual's presenting signs and symptoms, an appropriate MSE can involve a wide spectrum of actions, ranging from a simple process involving only a brief history and physical examination to a complex process that also involves performing ancillary studies and procedures, such as (but not limited to) lumbar punctures, clinical laboratory tests, CT scans, and/or other diagnostic tests and procedures. The medical record must reflect continued monitoring according to the individual's needs until it is determined whether or not the individual has an EMC and, if he/she does, until he/she is stabilized or appropriately transferred. There should be evidence of this ongoing monitoring prior to discharge or transfer.

The MSE must be the same MSE that the hospital would perform on any individual coming to the hospital's dedicated emergency department with those signs and symptoms, regardless of the individual's ability to pay for medical care. If a hospital applies in a nondiscriminatory manner (i.e., a different level of care must not exist based on payment status, race, national origin, etc.) a screening process that is reasonably calculated to determine whether an EMC exists, it has met its obligations under EMTALA. If the MSE is appropriate and does not reveal an EMC, the hospital has no further obligation under 42 CFR 489.24.

Regardless of a positive or negative individual outcome, a hospital would be in violation of the anti-dumping statute if it fails to meet any of the medical screening requirements under 42 CFR 489.24. The clinical outcome of an individual's condition is not a proper basis for determining whether an appropriate screening was provided or whether a person transferred was stable. However, the outcome may be a "red flag" indicating that a more thorough investigation is needed. Do not make decisions base on clinical information that was not available at the time of stabilizing or transfer. If an individual was

misdiagnosed, but the hospital utilized all of its resources, a violation of the screening requirement did not occur.

It is not impermissible under EMTALA for a hospital to follow normal registration procedures for individuals who come to the emergency department. For example, a hospital may ask the individual for an insurance card, so long as doing so does not delay the medical screening examination. In addition, the hospital may seek other information (not payment) from the individual's health plan about the individual such as medical history. And, in the case of an individual with an emergency medical condition, once the hospital has conducted the medical screening examination and has initiated stabilizing treatment, it may seek authorization for all services from the plan, again, as long as doing so does not delay the implementation of the required MSE and stabilizing treatment.

A hospital that is not a managed care plan's network of designated providers cannot refuse to screen and treat (or appropriately transfer, if the medical benefits of the transfer outweigh the risks or if the individual requests the transfer) individuals who are enrolled in the plan who come to the hospital if that hospital participates in the Medicare program.

Once an individual has presented to the hospital seeking emergency care, the determination of whether an EMC exists is made by the examining physician(s) or other qualified medical personnel of the hospital.

Medicare participating hospitals that provide emergency services must provide a medical screening examination to any individual regardless of diagnosis (e.g., labor, AIDS), financial status (e.g., uninsured, Medicaid), race, and color, national origin (e.g. Hispanic or Native American surnames), and/or disability, etc.

A hospital, regardless of size or patient mix, must provide screening and stabilizing treatment within the scope of its abilities, as needed, to the individuals with emergency medical conditions who come to the hospital for examination and treatment.

"Labor" is defined to mean the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman experiencing contractions is in true labor, unless a physician, certified nurse-midwife, or other qualified medical person acting within his or her scope of practice as defined in hospital medical staff bylaws and State law, certifies that, after a reasonable time of observation, the woman is in false labor.

An infant that is born alive is a "person" and an "individual" under 1 U.S.C. 8(a) and the screening requirement of EMTALA applies to "any individual" who comes to the emergency department. If an infant was born alive in a dedicated emergency department, and a request was made on that infant's behalf for screening for a medical condition (or if a prudent layperson would conclude, based on the infant's appearance or behavior, that the infant needed examination or treatment for a medical condition), the hospital and physician could be liable for violating EMTALA for failure to provide such a medical screening examination.

If an infant is born alive elsewhere on the hospital's campus (i.e., not in the hospital's dedicated emergency department) and a prudent layperson observer would conclude, based on the born-alive infant's appearance or behavior, that the infant was suffering from an emergency medical condition, the hospital and its medical staff are required to perform a medical screening examination on the infant to determine whether or not an emergency medical condition exists. Whether in the DED or elsewhere on the hospital's campus, if the physician or other authorized qualified medical personnel performing the medical screening examination determines that the infant is suffering from an emergency medical condition, the hospital has an obligation under EMTALA to provide stabilizing treatment or an appropriate transfer. If the hospital admits the infant, its obligation under EMTALA ends.

A minor (child) can request an examination or treatment for an EMC. The hospital is required by law to conduct the examination if requested by an individual or on the individual's behalf to determine if an EMC exists. Hospital personnel should not delay the MSE by waiting for parental consent. If after screening the minor, it is determined than no EMC is present, the staff can wait for parental consent before proceeding with further examination and treatment.

On-campus provider-based entities (such as rural health clinics or physician offices) are not subject to EMTALA, therefore it would be inappropriate to move individuals to these facilities for a MSE or stabilizing treatment under this Act.

If an individual is not on hospital property (which includes a hospital owned and operated ambulance), this regulation is not applicable. Hospital property includes ambulances owned and operated by the hospital, even if the ambulance is not on the hospital campus. An individual in a non-hospital owned ambulance, which is on hospital property is considered to have come to the hospital's emergency department. An individual in a non- hospital owned ambulance not on the hospital's property is not considered to have come to the hospital's emergency department when the ambulance personnel contact "Hospital A" by telephone or telemetry communications. If an individual is in an ambulance, regardless of whether the ambulance is owned by the hospital, a hospital may divert individuals when it is in "diversionary" status because it does not have the staff or facilities to accept any additional emergency patients at that time. However, if the ambulance is owned by the hospital, the diversion of the ambulance is only appropriate if the hospital is being diverted pursuant to community-wide EMS protocols. Moreover, if any ambulance (regardless of whether or not owned by the hospital) disregards the hospital's instructions and brings the individual on to hospital campus, the individual has come to the hospital and the hospital has incurred an obligation to conduct a medical screening examination for the individual.

Hospitals that deliberately delay moving an individual from an EMS stretcher to an emergency department bed do not thereby delay the point in time at which their EMTALA obligation begins. Furthermore, such a practice of "parking" patients arriving via EMS, refusing to release EMS equipment or personnel, jeopardizes patient health and

adversely impacts the ability of the EMS personnel to provide emergency response services to the rest of the community. Hospitals that "park" patients may also find themselves in violation of 42 CFR 482.55, the Hospital Condition of Participation for Emergency Services, which requires that hospitals meet the emergency needs of patients in accordance with acceptable standards of practice.

On the other hand, this does not mean that a hospital will necessarily have violated EMTALA and/or the hospital CoPs if it does not, in every instance, immediately assume from the EMS provider all responsibility for the individual, regardless of any other circumstances in the ED. For example, there may be situations when a hospital does not have the capacity or capability at the time of the individual's presentation to provide an immediate medical screening examination (MSE) and, if needed, stabilizing treatment or an appropriate transfer. So, if the EMS provider brought an individual to the dedicated ED at a time when ED staff was occupied dealing with multiple major trauma cases, it could under those circumstances be reasonable for the hospital to ask the EMS provider to stay with the individual until such time as there were ED staff available to provide care to that individual. However, even if a hospital cannot immediately complete an appropriate MSE, it must still assess the individual's condition upon arrival to ensure that the individual is appropriately prioritized, based on his/her presenting signs and symptoms, to be seen by a physician or other QMP for completion of the MSE. The hospital should also assess whether the EMS provider can appropriately monitor the individual's condition.

Should a hospital, which is not in diversionary status, fail to accept a telephone or radio request for transfer or admission, the refusal could represent a violation of other Federal or State requirements (e.g., Hill-Burton). If you suspect a violation of related laws, refer the case to the responsible agency for investigation.

The following two circumstances will not trigger EMTALA:

- The use of a hospital's helipad by local ambulance services or other hospitals for the transport of individuals to tertiary hospitals located throughout the State does not trigger an EMTALA obligation for the hospital that has the helipad on its property when the helipad is being used for the purpose of transit as long as the sending hospital conducted the MSE prior to transporting the individual to the helipad for medical helicopter transport to a designated recipient hospital. The sending hospital is responsible for conducting the MSE prior to transfer to determine if an EMC exists and implementing stabilizing treatment or conducting an appropriate transfer. Therefore, if the helipad serves simply as a point of transit for individuals who have received a MSE performed prior to transfer to the helipad, the hospital with the helipad is not obligated to perform another MSE prior to the individual's continued travel to the recipient hospital. If, however, while at the helipad, the individual's condition deteriorates, the hospital at which the helipad is located must provide another MSE and stabilizing treatment within its capacity **if requested** by medical personnel accompanying the individual.

- If as part of the EMS protocol, EMS activates helicopter evacuation of an individual with a potential EMC, the hospital that has the helipad does not have an EMTALA obligation if they are not the recipient hospital, **unless a request** is made by EMS personnel, the individual or a legally responsible person acting on the individual's behalf for the examination or treatment of an EMC.

Hospitals are not relieved of their EMTALA obligation to screen, provide stabilizing treatment and/or an appropriate transfer to individuals because of prearranged community or State plans that have designated specific hospitals to care for selected individuals (e.g., Medicaid patients, psychiatric patients, pregnant women). Hospitals located in those States which have State/local laws that require particular individuals, such as psychiatric or indigent individuals, to be evaluated and treated at designated facilities/hospitals may violate EMTALA if the hospital disregards the EMTALA requirements and does not conduct an MSE and provide stabilizing treatment or conduct an appropriate transfer prior to referring the individual to the State/local facility. If, after conducting the MSE and ruling out an EMC (or after stabilizing the EMC) the sending hospital needs to transfer an individual to another hospital for treatment, it may elect to transfer the individual to the hospital so designated by these State or local laws. Hospitals are also prohibited from discharging individuals who have not been screened or who have an emergency medical condition to non-hospital facilities for purposes of compliance with State law. The existence of a State law requiring transfer of certain individuals to certain facilities is not a defense to an EMTALA violation for failure to provide an MSE or failure to stabilize an EMC therefore hospitals must meet the federal EMTALA requirements or risk violating EMTALA.

If a screening examination reveals an EMC and the individual is told to wait for treatment, but the individual leaves the hospital, the hospital did not "dump" the individual unless:

- The individual left the emergency department based on a "suggestion" by the hospital;

- The individual's condition was an emergency, but the hospital was operating beyond its capacity and did not attempt to transfer the individual to another facility, or

- If an individual leaves a hospital Against Medical Advice (AMA) or LWBS, on his or her own free will (no coercion or suggestion) the hospital is not in violation of EMTALA.

Hospital resources and staff available to inpatients at the hospital for emergency services must likewise be available to individuals coming to the hospital for examination and treatment of an EMC because these resources are within the capability of the hospital. For example, a woman in labor who presents at a hospital providing obstetrical services must be treated with the resources available whether or not the hospital normally provides unassigned emergency obstetrical services.

The MSE must be conducted by an individual(s) who is determined qualified by hospital by-laws or rules and regulations and who meets the requirements of §482.55 concerning emergency services personnel and direction. The designation of the qualified medical personnel (QMP) should be set forth in a document approved by the governing body of the hospital. If the rules and regulations of the hospital are approved by the board of trustees or other governing body, those personnel qualified to perform the medical screening examinations may be set forth in the rules and regulations, or the hospital by-laws. It is not acceptable for the hospital to allow informal personnel appointments that could frequently change.

(ii) If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment, as defined in paragraph (d) of this section, or an appropriate transfer as defined in paragraph (e) of this section. If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under this section ends, as specified in paragraph (d)(2) of this section.

Interpretive Guidelines §489.24(a)(1)(ii)
Refer to Tag A-2407/C-2407 for stabilizing treatment and inpatients, and Tag A-2409/C-2409 for an appropriate transfer for EMTALA.

EMTALA does not apply to hospital inpatients. The existing hospital CoPs protect individuals who are already patients of a hospital and who experience an EMC. Hospitals that fail to provide treatment to these patients may be subject to further enforcement actions.

If the surveyor discovers during the investigation that a hospital did not admit an individual in good faith with the intention of providing treatment (i.e., the hospital used the inpatient admission as a means to avoid EMTALA requirements), then the hospital is considered liable under EMTALA and actions may be pursued.

§489.24(a)(2)

(i) When a waiver has been issued in accordance with Section 1135 of the Act that includes a waiver under Section 1135(b)(3) of the Act, sanctions under this section for an inappropriate transfer or for the direction or relocation of an individual to receive medical screening at an alternate location, do not apply to a hospital with a dedicated emergency department if the following conditions are met:

(A) The transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period.

(B) The direction or relocation of an individual to receive medical screening at an alternate location is pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan.

(C) The hospital does not discriminate on the basis of an individual's source of payment or ability to pay.

(D) The hospital is located in an emergency area during an emergency period, as those terms are defined in Section 1135(g)(1) of the Act.

(E) There has been a determination that a waiver of sanctions is necessary.

(ii) A waiver of these sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect until the termination of the applicable declaration of a public health emergency, as provided under Section 1135(e)(1)(B) of the Act.

Interpretive Guidelines: §489.24(a)(2)

What can be Waived Under Section 1135?

In accordance with Section 1135(b)(3) of the Act, hospitals and CAHs operating under an EMTALA waiver will not be sanctioned for:

- *Redirecting an individual who "comes to the emergency department," as that term is defined at §489.24(b), to an alternate location for an MSE, pursuant to a State emergency preparedness plan or, as applicable, a State pandemic preparedness plan. Even when a waiver is in effect there is still the expectation that everyone who comes to the ED will receive an appropriate MSE, if not in the ED, then at the alternate care site to which they are redirected or relocated.*

- *Inappropriately transferring an individual protected under EMTALA, when the transfer is necessitated by the circumstances of the declared emergencies. Transfers may be inappropriate under EMTALA for a number of reasons.*

However, even if a hospital/CAH is operating under an EMTALA waiver, the hospital/CAH would not be exempt from sanctions if it discriminates among individuals based on their ability to pay for services, or the source of their payment for services when redirecting or relocating them for the MSE or when making inappropriate transfers.

All other EMTALA-related requirements at 42 CFR 489.20 and EMTALA requirements at 42 CFR 489.24 continue to apply, even when a hospital is operating under an EMTALA waiver. For example, the statute does not provide for a waiver of a recipient hospital's obligation to accept an appropriate transfer of an individual protected under EMTALA. (As a reminder, even without a waiver, a hospital is obligated to accept an appropriate EMTALA transfer only when that recipient hospital has specialized capabilities required by the individual and the requisite capacity at the time of the transfer request.)

Waiver of EMTALA requirements in accordance with a Section 1135 waiver does not affect a hospital's or CAH's obligation to comply with State law or regulation that may separately impose requirements similar to those under EMTALA law and regulations. Facilities are encouraged to communicate with their State licensure authorities as to the availability of waivers under State law.

When Can a Waiver Be Issued?

In accordance with Section 1135 of the Act, an EMTALA waiver may be issued only when:

- *The President has declared an emergency or disaster pursuant to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act; and*

- *The Secretary has declared a public health emergency (PHE) pursuant to Section 319 of the Public Health Service Act; and*

- *The Secretary has exercised his/her waiver authority pursuant to Section 1135 of the Act and notified Congress at least 48 hours in advance of exercising his/her waiver authority.*

In exercising his/her waiver authority, the Secretary may choose to delegate to the Centers for Medicare & Medicaid Services (CMS) the decision as to which Medicare, Medicaid, or CHIP requirements specified in Section 1135 should be temporarily waived or modified, and for which health care providers or groups of providers such waivers are necessary. Specifically, the Secretary may delegate to CMS decision-making about whether and for which hospitals/CAHs to waive EMTALA sanctions as specified in Section 1135(b)(3).

In addition, in order for an EMTALA waiver to apply to a specific hospital or CAH:

- *The hospital or CAH must activate its disaster protocol; and*

- *The State must have activated an emergency preparedness plan or pandemic preparedness plan in the emergency area, and any redirection of individuals for an MSE must be consistent with such plan. It is not necessary for the State to activate its plan statewide, so long as it is activated in the area where the hospital*

is located. It is also not necessary for the State plan to identify the specific location of the alternate screening sites to which individuals will be directed, although some may do so.

How Long Does an EMTALA Waiver Last?

Except in the case of waivers related to pandemic infectious disease, an EMTALA waiver is limited in duration to 72 hours beginning upon activation of the hospital's/CAH's disaster protocol. In the case of a public health emergency (PHE) involving pandemic infectious disease, the general EMTALA waiver authority will continue in effect until the termination of the declaration of the PHE. However, application of this general authority to a specific hospital/CAH or groups of hospitals and CAHs may limit the waiver's application to a date prior to the termination of the PHE declaration, since case-specific applications of the waiver authority are issued only to the extent they are necessary, as determined by CMS.

Furthermore, if a State emergency/pandemic preparedness plan is deactivated in the area where the hospital or CAH is located prior to the termination of the public health emergency, the hospital or CAH no longer meets the conditions for an EMTALA waiver and that hospital/CAH waiver would cease to be in effect as of the deactivation date. Likewise, if a hospital or CAH deactivates its disaster protocol prior to the termination of the public health emergency, the hospital or CAH no longer meets the conditions for an EMTALA waiver and that hospital/CAH waiver would cease to be in effect as of the deactivation date.

What is the Process for Seeking an EMTALA Waiver?

Section 1135 provides for waivers of certain Medicare, Medicaid, or CHIP requirements, including waivers of EMTALA sanctions, but only to the extent necessary, to ensure sufficient health care items and services are available to meet the needs of Medicare, Medicaid, and CHIP beneficiaries. The waivers also ensure that health care providers who provide such services in good faith but are unable to comply with one or more of the specified requirements may be reimbursed for such items and services and exempted from sanctions for noncompliance, absent any fraud or abuse.

When the Secretary has exercised his/her waiver authority and delegated to CMS decision-making about specific EMTALA waivers, CMS policy in exercising its authority for granting EMTALA waivers is as follows:

Localized Emergency Area: *In the case of localized disasters, such as those related to floods or hurricanes, CMS may exercise its discretion to advise hospitals/CAHs in the affected areas that they are covered by the EMTALA waiver,* ***without requiring individual applications for each waiver.*** *However, hospitals or CAHs that activate their disaster protocol and expect to take advantage of the area-wide waiver must notify their State Survey Agency (SA) at the time they activate their disaster protocol.*

> ***Nationwide Emergency Area:*** *In the case of a nationwide emergency area, CMS may also exercise its discretion to advise hospitals/CAHs in a specific geographical area(s) that they are covered by the EMTALA waiver* ***for a time-limited period****. CMS expects to do this only if the State has activated its emergency or pandemic preparedness plan in the affected area(s), and if there is other evidence of need for the waiver for a broad group of hospitals or CAHs. CMS will rely upon SAs to advise their CMS Regional Office (RO) whether and where a State's preparedness plan has been activated, as well as when the plan has been deactivated.*

In the absence of CMS notification of area-wide applications of the waiver, hospitals/CAHs must contact CMS and request that the waiver provisions be applied to their facility. In all cases, the Act envisions that individuals protected under EMTALA will still receive appropriate MSEs somewhere (even if the MSE is not conducted not at the hospital or CAH where they present), and that individuals who are transferred for stabilization of their emergency medical condition will be sent to a facility capable of providing stabilizing services, regardless of whether a waiver is in effect.

Unless CMS advises otherwise, in cases of a public health emergency involving pandemic infectious disease, hospitals/CAHs in areas covered by time-limited, area-wide applications of the EMTALA waiver that seek to extend the waiver's application to a later date within the waiver period (that is, within the period of the PHE declaration) must submit individual requests for extension. The requests must demonstrate their need for continued application of the waiver. Such requests must be received at least three calendar days prior to expiration of the time-limited waiver. Extensions of an EMTALA waiver in emergencies that do not involve pandemic infectious disease are not available.

Waiver Request Process

Hospitals or CAHs seeking an EMTALA waiver must demonstrate to CMS that application of the waiver to their facility is necessary, and that they have activated their disaster protocol. CMS will confirm with the SA whether the State's preparedness plan has been activated in the area where the hospital or CAH is located. CMS will also seek to confirm when the hospital activated its disaster protocol, whether other measures may address the situation in a manner that does not require a waiver, and other factors important to the ability of the hospital to demonstrate that a waiver is needed.

What will CMS do in response to EMTALA complaints concerning events occurring during the waiver period?

EMTALA enforcement is a complaint-driven process. CMS will assess any complaints/allegations related to alleged EMTALA violations concerning the MSE or transfer during the waiver period to determine whether the hospital or CAH in question was operating under an EMTALA waiver at the time of the complaint, and, if so, whether

the nature of the complaint involves actions or requirements not covered by the EMTALA waiver and warrants further on-site investigation by the SA.

§489.24(c) Use of Dedicated Emergency Department for Non-emergency Services

If an individual comes to a hospital's dedicated emergency department and a request is made on his or her behalf for examination or treatment for a medical condition, but the nature of the request makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition.

Interpretive Guidelines §489.24(c)

Any individual with a medical condition that presents to a hospital's ED must receive an MSE that is appropriate for their medical condition. The objective of the MSE is to determine whether or not an emergency medical condition exists. This does not mean that all EMTALA screenings must be equally extensive. If the nature of the individual's request makes clear that the medical condition is not of an emergency nature, the MSE is reflective of the individual presenting complaints or symptoms. A hospital may, if it chooses, have protocols that permit a QMP (e.g., registered nurse) to conduct specific MSE(s) if the nature of the individual's request for examination and treatment is within the scope of practice of the QMP (e.g., a request for a blood pressure check and that check reveals that the patient's blood pressure is within normal range). Once the individual is screened and it is determined the individual has only presented to the ED for a nonemergency purpose, the hospital's EMTALA obligation ends for that individual at the completion of the MSE. Hospitals are not obligated under EMTALA to provide screening services beyond those needed to determine that there is no EMC.

For a hospital to be exempted from its EMTALA obligations to screen individuals presenting at its emergency department for nonemergency tests (e.g., individual has consulted with physician by telephone and the physician refers the individual to a hospital emergency department for a nonemergency test) the hospital must be able to document that it is only being asked to collect evidence, not analyze the test results, or to otherwise examine or treat the individual. Furthermore, a hospital may be exempted from its EMTALA obligations to screen individuals presenting to its dedicated emergency department if the individual had a previously scheduled appointment.

If an individual presents to an ED and requests pharmaceutical services (medication) for a medical condition, the hospital generally would have an EMTALA obligation. Surveyors are encouraged to ask probing questions of the hospital staff to determine if the hospital in fact had an EMTALA obligation in this situation (e.g., did the individual present to the ED with an EMC and informed staff they had not taken their medication? Was it obvious from the nature of the medication requested that it was likely that the patient had an EMC?). The circumstances surrounding why the request is being made

would confirm if the hospital in fact has an EMTALA obligation. If the individual requires the medication to resolve or provide stabilizing treatment of an EMC, then the hospital has an EMTALA obligation. Hospitals are not required by EMTALA to provide medication to individuals who do not have an EMC simply because the individual is unable to pay or does not wish to purchase the medication from a retail pharmacy or did not plan appropriately to secure prescription refills.

If an individual presents to a dedicated emergency department and requests services that are not for a medical condition, such as preventive care services (immunizations, allergy shots, flu shots) or the gathering of evidence for criminal law cases (e.g., sexual assault, blood alcohol test), the hospital is not obligated to provide a MSE under EMTALA to this individual.

Attention to detail concerning blood alcohol testing (BAT) in the ED is instrumental when determining if a MSE is to be conducted. If an individual is brought to the ED and law enforcement personnel request that emergency department personnel draw blood for a **BAT only** and does not request examination or treatment for a medical condition, such as intoxication and a prudent lay person observer would not believe that the individual needed such examination or treatment, then the EMTALA's screening requirement is not applicable to this situation because the only request made on behalf of the individual was for evidence. However, if for example, the individual in police custody was involved in a motor vehicle accident or may have sustained injury to him or herself and presents to the ED a MSE would be warranted to determine if an EMC exists.

When law enforcement officials request hospital emergency personnel to provide clearance for incarceration, the hospital has an EMTALA obligation to provide a MSE to determine if an EMC exists. If no EMC is present, the hospital has met its EMTALA obligation and no further actions are necessary for EMTALA compliance.

Surveyors will evaluate each case on its own merit when determining a hospital's EMTALA obligation when law enforcement officials request screening or BAT for use as evidence in criminal proceedings. This principle also applies to sexual assault cases.

Tag A-2407/C-2407

(Rev. 46, Issued: 05-29-09, Effective/Implementation: 05-29-09)

§489.24(d) Necessary Stabilizing Treatment for Emergency Medical Conditions

(1) General. Subject to the provisions of paragraph (d)(2) of this section, if any individual (whether or not eligible for Medicare benefits) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either--

(i) Within the capabilities of the staff and facilities available at the hospital, for further medical examination and treatment as required to stabilize the medical condition.

Interpretive Guidelines §489.24(d)(1)(i)

A hospital is obligated to provide the services specified in the statute and this regulation regardless of whether a hospital will be paid. After the medical screening has been implemented and the hospital has determined that an emergency medical condition exists, the hospital must provide stabilizing treatment within its capability and capacity.

Capabilities of a medical facility mean that there is physical space, equipment, supplies, and specialized services that the hospital provides (e.g., surgery, psychiatry, obstetrics, intensive care, pediatrics, trauma care).

Capabilities of the staff of a facility means the level of care that the personnel of the hospital can provide within the training and scope of their professional licenses. This includes coverage available through the hospitals on-call roster.

The capacity to render care is not reflected simply by the number of persons occupying a specialized unit, the number of staff on duty, or the amount of equipment on the hospital's premises. Capacity includes whatever a hospital customarily does to accommodate patients in excess of its occupancy limits §489.24 (b). If a hospital has customarily accommodated patients in excess of its occupancy limits by whatever mean (e.g., moving patients to other units, calling in additional staff, borrowing equipment from other facilities) it has, in fact, demonstrated the ability to provide services to patients in excess of its occupancy limits.

A hospital may appropriately transfer (see Tag A-2409/C-2409) an individual before the sending hospital has used and exhausted all of its resources available if the individual requests the transfer to another hospital for his or her treatment and refuses treatment at the sending hospital.

To comply with the MSE and stabilization requirements of §1867 all individuals with similar medical conditions are to be treated consistently. Compliance with local, State, or regionally approved EMS transport of individuals with an emergency is usually deemed to indicate compliance with §1867; however a copy of the protocol should be obtained and reviewed at the time of the survey.

If community wide plans exist for specific hospitals to treat certain EMCs (e.g., psychiatric, trauma, physical or sexual abuse), the hospital must meet its EMTALA obligations (screen, stabilize, and or appropriately transfer) prior to transferring the individual to the community plan hospital. An example of a community wide plan would be a trauma system hospital. A trauma system is a comprehensive system providing injury prevention services and timely and appropriate delivery of emergency medical treatment for people with acute illness and traumatic injury. These systems are designed so that patients with catastrophic injuries will have the quickest possible access to an established trauma center or a hospital that has the capabilities to provide comprehensive emergency medical care. These systems ensure that the severely injured patient can be rapidly cared for in the facility that is most appropriately prepared to treat the severity of injury.

Community plans (not a formal community call plan provided for under §489.24(j)(iii)) are designed to provide an organized, pre-planned response to patient needs to assure the best patient care and efficient use of limited health care resources. Community plans are designed to augment physician's care if the necessary services are not within the capability of the hospital but does not mandate patient care nor transfer patterns. Patient health status frequently depends on the appropriate use of the community plans. The matching of the appropriate facility with the needs of the patient is the focal point of this plan and assures every patient receives the best care possible. Therefore, a sending hospital's appropriate transfer of an individual in accordance with community wide protocols in instances where it cannot provide stabilizing treatment would be deemed to indicate compliance with §1867.

If an individual seeking care is a member of a managed health care plan (e.g., HMO, PPO or CMP), the hospital is obligated to comply with the requirements of §489.24 regardless of the individual's payor source or financial status. The hospitals is obligated to provide the services necessary to determine if an EMC is present and provide stabilizing treatment if indicated. This is true regardless if the individual is enrolled in a managed care plan that restricts its enrollees' choice of health care provider. EMTALA is a requirement imposed on hospitals, and the fact that an individual who comes to the hospital is enrolled in a managed care plan that does not contract with that hospital has no bearing on the obligation of the hospital to conduct an MSE and to at lease initiate stabilizing treatment. A managed health care plan may only state the services for which it will pay or decline payment, but that does not excuse the hospital from compliance with EMTALA.

Section 42 CFR 489.24(b) defines **stabilized** to mean:

> "… that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or with respect to an "emergency medical condition" as defined in this section under paragraph (2) of that definition, that a woman has delivered the child and the placenta."

The regulation sets the standard determining when a patient is stabilized.

If a hospital is unable to stabilize an individual within its capability, an appropriate transfer should be implemented. To be considered stable the emergency medical condition that caused the individual to seek care in the dedicated ED must be resolved, although the underlying medical condition may persist. For example, an individual presents to a hospital complaining of chest tightness, wheezing, and shortness of breath and has a medical history of asthma. The physician completes a medical screening examination and diagnoses the individual as having an asthma attack that is an emergency medical condition. Stabilizing treatment is provided (medication and oxygen) to alleviate the acute respiratory symptoms. In this scenario the EMC was resolved and the hospital's EMTALA obligation is therefore ended, but the underlying medical condition of asthma still exists. After stabilizing the individual, the hospital no longer has an EMTALA obligation. The physician may discharge the individual home, admit him/her to the hospital, or transfer (the "appropriate transfer" requirement under EMTALA does not apply to this situation since the individual has been stabilized) the individual to another hospital depending on his/her needs. The preceding example does not reflect a change in policy, rather it is a clarification as to when an appropriate transfer is to be implemented to decrease hospitals risk of being in violation of EMTALA due to inappropriate transfers

An individual will be deemed stabilized if the treating physician or QMP attending to the individual in the emergency department/hospital has determined, within reasonable clinical confidence, that the emergency medical condition has been resolved.

For those individuals whose EMCs have been resolved the physician or QMP has several options:

- **Discharge home with follow-up instructions.** An individual is considered stable and ready for discharge when, within reasonable clinical confidence, it is determined that the individual has reached the point where his/her continued care, including diagnostic work-up and/or treatment, could be reasonably performed as an outpatient or later as an inpatient, provided the individual is given a plan for appropriate follow-up care as part of the discharge instructions. The EMC that caused the individual to present to the dedicated ED must be resolved, but the underlying medical condition may persist. Hospitals are expected within reason to assist/provide discharged individuals the necessary information to secure the

necessary follow-up care to prevent relapse or worsening of the medical condition upon release from the hospital; or

- **Inpatient admission for continued care.**

Hospitals are responsible for treating and stabilizing, within their capacity and capability, any individual who presents him/herself to a hospital with an EMC. The hospital must provide care until the condition ceases to be an emergency or until the individual is properly transferred to another facility. An inappropriate transfer or discharge of an individual with an EMC would be a violation of EMTALA.

If a hospital is alleged to have violated EMTALA by transferring an unstable individual without implementing an appropriate transfer according to §489.24(e), and the hospital believes that the individual was stable (EMC resolved) the burden of proof is the responsibility of the transferring hospital. When interpreting the facts the surveyor should assess whether or not the individual was stable. Was it reasonable to believe that the transferring hospital should have been knowledgeable of the potential complications during transport? To determine whether the individual was stable and treated appropriately surveyors will request that the QIO physician review the case.
If the treating physician is in doubt that an individual's EMC is stabilized the physician should implement an appropriate transfer (see Tag A-2409/C-2409) to prevent a potential violation of EMTALA, if his/her hospital cannot provide further stabilizing treatment.

If a physician is not physically present at the time of transfer, then the qualified medical personnel (as determined by hospital bylaws or other board-approved documents) must consult with a physician to determine if an individual with an EMC is to be transferred to another facility for further stabilizing treatment.

The failure of a receiving facility to provide the care it maintained it could provide to the individual when the transfer was arranged should not be construed to mean that the individual's condition worsened as a result of the transfer.

In the case of psychiatric emergencies, if an individual expressing suicidal or homicidal thoughts or gestures, if determined dangerous to self or others, would be considered to have an EMC.

Psychiatric patients are considered stable when they are protected and prevented from injuring or harming him/herself or others. The administration of chemical or physical restraints for purposes of transferring an individual from one facility to another may stabilize a psychiatric patient for a period of time and remove the immediate EMC but the underlying medical condition may persist and if not treated for longevity the patient may experience exacerbation of the EMC. Therefore, practitioners should use great care when determining if the medical condition is in fact stable after administering chemical or physical restraints.

A hospital's EMTALA obligation ends when a physician or qualified medical person has made a decision:

- That no emergency medical condition exists (even though the underlying medical condition may persist);
- That an emergency medical condition exists and the individual is appropriately transferred to another facility; or
- That an emergency medical condition exists and the individual is admitted to the hospital for further stabilizing treatment.

(ii) For transfer of the individual to another medical facility in accordance with paragraph (e) of this section.

Interpretive Guidelines: §489.24(d)(1)(ii)

When a hospital has exhausted all of its capabilities in attempting to resolve the EMC, it must effect an appropriate transfer of the individual (see Tag A-2409/C-2409). Section 42 CFR 489.24(b) defines **transfer** to mean:

> "… the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (i) has been declared dead, or (ii) leaves the facility without the permission of any such person."

If an individual is admitted as an inpatient, EMCs must be stabilized either by the hospital to which an individual presents or the hospital to which the individual is transferred. If a woman is in labor, the hospital must deliver the baby and the placenta or transfer appropriately. She may not be transferred unless she, or a legally responsible person acting on her behalf, requests a transfer and a physician or other qualified medical personnel, in consultation with a physician, certifies that the benefits to the woman and/or the unborn child outweigh the risks associated with the transfer.

If the individual's condition requires immediate medical stabilizing treatment and the hospital is not able to attend to that individual because the emergency department is operating beyond its capacity, then the hospital should transfer the individual to a hospital that has the capability and capacity to treat the individual's EMC.

(2) Exception: Application to Inpatients.

(i) If a hospital has screened an individual under paragraph (a) of this section 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

Interpretive Guidelines: §489.24(d)(2)(i)

A hospital's EMTALA obligation ends when the individual has been admitted in good faith for inpatient hospital services whether or not the individual has been stabilized. An individual is considered to be "admitted" when the decision is made to admit the individual to receive inpatient hospital services with the expectation that the patient will remain in the hospital at least overnight. Typically, we would expect that this would be documented in the patient's chart and medical record at the time that a physician signed and dated the admission order. Hospital policies should clearly delineate, which practitioners are responsible for writing admission orders.

A hospital continues to have a responsibility to meet the patient emergency needs in accordance with hospital CoPs at 42 CFR Part 482. The hospital CoPs protect individuals who are admitted, and they do not permit the hospital to inappropriately discharge or transfer any patient to another facility. The hospital CoPs that are most relevant in this case are as follows: emergency services, governing body, discharge planning, quality assurance and medical staff.
Hospitals are responsible for assuring that inpatients receive acceptable medical care upon admission. Hospital services for inpatients should include diagnostic services and therapeutic services for medical diagnosis, treatment, and care of the injured, disabled or sick persons with the intention of treating patients.
If during an EMTALA investigation there is a question as to whether an individual was admitted so that a hospital could avoid its EMTALA obligation, the SA surveyor is to consult with RO personnel to determine if the survey should be expanded to a survey of the hospital CoPs. After completion of the survey, the case is to be forwarded to the RO for violation determination. If it is determined that the hospital admitted the individual solely for the purpose of avoiding its EMTALA obligation, then the hospital is liable under EMTALA and may be subject to further enforcement action.

(ii) This section is not applicable to an inpatient who was admitted for elective (non-emergency) diagnosis or treatment.

Interpretive Guidelines: §489.24(d)(2)(ii)

Individuals admitted to the hospital for elective medical services are not protected by EMTALA. The hospital CoPs protect all classifications of inpatients, elective and emergent.

(iii) A hospital is required by the conditions of participation for hospitals under Part 482 of this chapter to provide care to its inpatients in accordance with those conditions of participation.

Interpretive Guidelines: §489.24(d)(2)(iii)

If an inpatient develops an EMC, the hospital is required to meet the patient's emergency needs in accordance with acceptable standards of practice. The hospital CoPs protects patients who are admitted, and the hospital may not discharge or transfer any patient to another facility inappropriately. The protective CoPs are found at 42 CFR Part 482. The five CoPs that are most relevant in affording patients protection in cases when patients with an EMC is admitted are as follows:

- Emergency services (§482.55)
- Governing body (§482.12)
- Discharge planning (§482.43)
- Quality assessment and performance improvement (§482.21)
- Medical staff (§482.22)

If a hospital is noncompliant with any of the above COPs, the hospital will be subject to enforcement action.

(3) Refusal to consent to treatment.

A hospital meets the requirements of paragraph (d)(1)(i) of this section with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of the examination and treatment, but the individual (or a person acting on the individual's behalf) does not consent to the examination or treatment. The medical record must contain a description of the examination, treatment, or both if applicable, that was refused by or on behalf of the individual. The hospital must take all reasonable steps to secure the individual's written informed refusal (or that of the person acting on his or her behalf). The written document should indicate that the person has been informed of the risks and benefits of the examination or treatment, or both.

Interpretive Guidelines: §489.24(d)(3)

The medical record should reflect that screening, further examination, and or treatment were offered by the hospital prior to the individual's refusal.

In the event an individual refuses to consent to further examination or treatment, the hospital must indicate in writing the risks/benefits of the examination and/or treatment; the reasons for refusal; a description of the examination or treatment that was refused; and the steps taken to try to secure the written, informed refusal if it was not secured.

Hospitals may not attempt to coerce individuals into making judgments against their interest by informing them that they will have to pay for their care if they remain but that their care will be free or at a lower cost if they transfer to another hospital.

An individual may only refuse examination, treatment, or transfer on behalf of a patient if the patient is incapable of making an informed choice for him/herself.

Tag A-2408/C-2408

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§489.24(d)(4) and (5)

(4) Delay in Examination or Treatment.

(i) A participating hospital may not delay providing an appropriate medical screening examination required under paragraph (a) of this section or further medical examination and treatment required under paragraph (d)(1) of this section in order to inquire about the individual's method of payment or insurance status.

(ii) A participating hospital may not seek, or direct an individual to seek, authorization from the individual's insurance company for screening or stabilization services to be furnished by a hospital, physician, or non-physician practitioner to an individual until after the hospital has provided the appropriate medical screening examination required under paragraph (a) of this section, and initiated any further medical examination and treatment that may be required to stabilize the emergency medical condition under paragraph (d)(1) of this section.

(iii) An emergency physician or non-physician practitioner is not precluded from contacting the individual's physician at any time to seek advice regarding the individual's medical history and needs that may be relevant to the medical treatment and screening of the patient, as long as this consultation does not inappropriately delay services required under paragraph (a) or paragraphs (d)(1) and (d)(2) of this section.

(iv) Hospitals may follow reasonable registration processes for individuals for whom examination or treatment is required by this section, including asking whether an individual is insured and, if so, what that insurance is, as long as that inquiry does not delay screening or treatment. Reasonable registration processes may not unduly discourage individuals from remaining for further evaluation.

Interpretive Guidelines §489.24(d)(4)(i),(ii),(iii) and (iv)

Hospitals should not delay providing a medical screening examination or necessary stabilizing treatment by inquiring about an individual's ability to pay for care. All individuals who present to a hospital and request an MSE for a medical condition (or have a request for an MSE made on their behalf) must receive that screening examination, regardless of the answers the individual may give to the insurance questions asked during the registration process. In addition, a hospital may not delay screening or treatment to any individual while it verifies the information provided.

Hospitals may follow reasonable registration processes for individuals presenting with an EMC. Reasonable registration processes may include asking whether an individual is insured and, if so, what the insurance is, as long as this inquiry do not delay screening, treatment or unduly discourage individuals from remaining for further evaluation. The registration process permitted in the dedicated ED typically consists of collecting demographic information, insurance information, whom to contact in an emergency and other relevant information.

If a managed care member comes to a hospital that offers emergency services, the hospital must provide the services required under the EMTALA statute without regard for the individual's insurance status or any prior authorization requirement of such insurance.

This requirement applies equally to both the referring and the receiving (recipient) hospital. Therefore, it may be a violation if the receiving hospital delays acceptance of the transfer of an individual with an unstabilized EMC pending receipt or verification of financial information. It would not be a violation if the receiving hospital delayed acceptance of the transfer of an individual with a stabilized EMC pending receipt or verification of financial information because EMTALA protections no longer apply once a patient is stabilized.

If a delay in screening was due to an unusual internal crisis whereby it was simply not within the capability of the hospital to provide an appropriate screening examination at the time the individual came to the hospital (e.g., mass casualty occupying all the hospital's resources for a time period), surveyors are to interview hospital staff members to elicit the facts surrounding the circumstances to help determine if there was a violation of EMTALA.

(5) Refusal to Consent to Transfer.

A hospital meets the requirements of paragraph (d)(1)(ii) of this section with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with paragraph (e) of this section and informs the individual (or a person acting on his or her behalf) of the risks and benefits to the individual of the transfer, but the individual (or a person acting on the individual's behalf) does not consent to the transfer. The hospital must take all reasonable steps to secure the individual's written informed refusal (or that of a person acting on his or her behalf). The written document must indicate the person has been informed of the risks and benefits of the transfer and state the reasons for the individual's refusal. The medical record must contain a description of the proposed transfer that was refused by or on behalf of the individual.

Interpretive Guidelines: §489.24 (d)(5)

For individuals who refuse to consent to a transfer, the hospital staff must inform the individual of the risks and benefits and document the refusal and, if possible, place a signed informed consent to refusal of the transfer in the individual's medical record.

If an individual or the individual's representative refuses to be transferred and also refuses to sign a statement to that effect, the hospital may document such refusals as they see fit.

Tag A-2409/C-2409

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§489.24(e) Restricting Transfer Until the Individual Is Stabilized

(1) General. If an individual at a hospital has an emergency medical condition that has not been stabilized (as defined in paragraph (b) of this section), the hospital may not transfer the individual unless—

(i) The transfer is an appropriate transfer (within the meaning of paragraph (e)(2) of this section); and

(ii)

(A) The individual (or a legally responsible person acting on the individual's behalf) requests the transfer, after being informed of the hospital's obligations under this section and of the risk of transfer. The request must be in writing and indicate the reasons for the request as well as indicate that he or she is aware of the risks and benefits of the transfer;

(B) A physician (within the meaning of Section 1861(r)(1) of the Act) has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman or the unborn child, from being transferred. The certification must contain a summary of the risks and benefits upon which it is based; or

(C) If a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as determined by the hospital in its bylaws or rules and regulations) has signed a certification described in paragraph (e)(1)(ii)(B) of this section after a physician (as defined in Section 1861(r)(1) of the Act) in consultation with the qualified medical person, agrees with the certification and subsequently countersigns the certification. The certification must contain a summary of the risks and benefits upon which it is based.

(2) A transfer to another medical facility will be appropriate only in those cases in which-

(i) The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(ii) The receiving facility--

(A) Has available space and qualified personnel for the treatment of the individual; and

(B) Has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(iii) The transferring hospital sends to the receiving facility all medical records (or copies thereof) related to the emergency condition which the individual has presented that are available at the time of the transfer, including available history, records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) required under paragraph (e)(1)(ii) of this section, and the name and address of any on-call physician (described in paragraph (g) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment. Other records (e.g., test results not yet

available or historical records not readily available from the hospital's files) must be sent as soon as practicable after transfer; and

(iv) The transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.

Interpretive Guidelines: §489.24(e)

The EMTALA regulations at 42 CFR 489.24(b) define "transfer" as " …the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (i) has been declared dead, or (ii) leaves the facility without the permission of any such person."

The requirements in 42 CFR 489.24(e) apply to transfers to another hospital.

Transfer of Individuals with Unstabilized EMCs

In the case of individuals found to have an EMC a hospital is required under EMTALA rules at 42 CFR 489.24(d) to provide stabilizing treatment within the capabilities of the staff and facilities available in the hospital, or to provide a transfer to another hospital as required by 42 CFR 489.24(e). Transfer of the individual to another hospital may be reasonable and permissible, but the regulations establish a number of requirements that each transfer must meet in order to comply with EMTALA. If an individual's EMC has not been stabilized, prior to transferring the individual to another hospital, the sending hospital is required under EMTALA to pursue a transfer **because either:**

- the individual requests the transfer; **or**
- the expected benefits of the transfer outweigh the increased risks of the transfer.

In either case, the transfer must also always meet the four requirements of an "appropriate" transfer.

If an individual is moved to a diagnostic facility located at another hospital for diagnostic procedures not available at the transferring hospital, and the hospitals arrange to return the individual to the transferring hospital, the transfer requirements must still be met by the sending hospital. The recipient hospital is not obligated to meet the EMTALA transfer requirements when implementing an appropriate transfer back to the transferring hospital. However, it is reasonable to expect the recipient hospital with the diagnostic capability to communicate (e.g., telephonic report or documentation within the medical record) with the transferring hospital its findings of the medical condition and a status report of the individual during and after the procedure.

The transfer requirements apply only to individuals who have been determined to have an EMC that has not been stabilized. The hospital has no further EMTALA obligation to an individual who has been determined not to have an EMC or whose EMC has been stabilized, or who has been admitted as an inpatient (See discussion related to the requirements of 42 CFR 489.24(d), concerning stabilizing treatment.) However, the hospital has other obligations to the individual under the Hospital Conditions of Participation.

These transfer requirements do not apply to an individual who is moved to another part of the hospital, because technically the patient has not been transferred. This is also the case when an individual who presents to an off-campus dedicated emergency department is found to have an EMC and is moved to the hospital's main campus for stabilizing treatment that cannot be provided at the off-campus site.

Transfer at the Request of the Individual

A transfer may be made at the request of the individual with an EMC or of a person legally responsible for that individual. The hospital must assure that the individual or legally responsible person is first informed of the hospital's obligations under EMTALA, e.g., its obligation to provide stabilizing treatment within its capability and capacity, regardless of the individual's ability to pay. The hospital must also assure that the individual has been advised of the medical risks associated with transfer. After the hospital has communicated this information, the individual's request for a transfer must be in writing. The request must include the reason(s) why the transfer is being requested and a statement that the individual is aware of the risks and benefits associated with the transfer. The individual or individual's representative must sign the written request.

Transfer with a Physician Certification

Alternatively, a transfer may be made when a physician certifies that the expected benefits of the transfer outweigh the risks. Specifically, a physician must certify that the medical benefits to the individual with the EMC that could reasonably be expected from provision of appropriate treatment at another hospital outweigh the increased risks that result from being transferred. In the case of a pregnant woman in labor, the physician must certify that the expected benefits outweigh the risk to both the pregnant woman and the unborn child. Under certain circumstances qualified medical personnel other than a physician may sign the certification. A qualified medical person (QMP) may sign the certification of benefits versus risks of a transfer only after consultation with a physician who agrees with the transfer. The physician must subsequently countersign the certification. The physician's countersignature must be obtained within the established timeframe according to hospital policies and procedures. Hospital by-laws or rules or regulations must specify the criteria and process for granting medical staff privileges to QMPs, and, in accordance with the hospital or CAH Conditions of Participation, each individual QMP must be appropriately privileged.

The date and time of the physician (or the QMP) certification should closely match the date and time of the transfer.

Section 1861(r)(i) of the Act defines **physicians** as:

> A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action. (This provision is not to be construed to limit the authority of a doctor or medicine or osteopathy to delegate tasks to other qualified health care personnel to the extent recognized under State law or a State's regulatory mechanism).

The regulation at §489.24 (e)(1) requires an express written certification. Physician certification cannot simply be implied from the findings in the medical record and the fact that the patient was transferred.

The certification must state the reason(s) for transfer. The narrative rationale need not be a lengthy discussion of the individual's medical condition reiterating facts already contained in the medical record, but it should give a complete picture of the benefits to be expected from appropriate care at the receiving (recipient) facility and the risks associated with the transfer, including the time away from an acute care setting necessary to effect the transfer. The risks and benefits certification should be specific to the condition of the patient upon transfer.

This rationale may be included on the certification form or in the medical record. In cases where the individual's medical record does not include a certification, the hospital may be given the opportunity to retrieve the certification. Certifications may not be backdated.

Women in Labor

- Regardless of practices within a State, a woman in labor may be transferred only if she or her representative requests the transfer or if a physician or other qualified medical personnel signs a certification that the benefits outweigh the risks. If the hospital does not provide obstetrical services, the benefits of a transfer may outweigh the risks. A hospital cannot cite State law or practice as the basis for transfer.

- Hospitals that are not capable of handling high-risk deliveries or high-risk infants often have written transfer agreements with facilities capable of handling high-risk cases. The hospital must still meet the screening, treatment, and transfer requirements.

Four Requirements for an Appropriate Transfer

1. **§489.24 (e)(2)(i) - The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;**

Before implementing a transfer of an individual with an unstablized EMC, a hospital is required to provide stabilizing treatment within its capability and capacity. See discussion of stabilizing treatment, 42 CFR 489.24(d). This includes treatment to minimize the transfer risk to the health of the individual and, in the case of a pregnant woman in labor, the health of the unborn child.

If Hospital A participates in a community call plan with Hospital B and an individual with an EMC requires the services of an on-call specialist who, pursuant to the community call plan, is on-call at Hospital B to respond to the specialty needs of individuals at Hospital A, then generally a transfer of the individual to Hospital B is warranted. However, Hospital A is still required to provide treatment within its on-site capability and capacity to minimize the risks of transfer, and all other transfer requirements must also be met, notwithstanding the participation in the community call plan.

2. **§489.24(e)(2)(ii) - The receiving facility--**

    (A) Has available space and qualified personnel for the treatment of the individual; and

    (B) Has agreed to accept transfer of the individual and to provide appropriate medical treatment;

    The transferring hospital must obtain permission from the receiving (recipient) hospital to transfer an individual. The transferring hospital should document its communication with the receiving (recipient) hospital, including the date and time of the transfer request and the name and title of the person accepting the transfer.

3. **§489.24 (e)(2)(iii) - The transferring hospital sends to the receiving facility all medical records (or copies thereof) related to the emergency condition which the individual has presented that are available at the time of the transfer, including available history, records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) required under paragraph (e)(1)(ii) of this section, and the name and address of any on-call physician (described in paragraph (g) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment. Other records (e.g., test results not yet available or historical records not readily available from the hospital's files) must be sent as soon as practicable after transfer;**

   Necessary medical records must accompany individuals being transferred to another hospital. If a transfer is in an individual's best interest, it should not be delayed until records are retrieved or test results come back from the laboratory. Whatever medical records are available at the time the individual is transferred should be sent to the receiving (recipient) hospital with the patient. Test results that become available after the individual is transferred should be telephoned to the receiving (recipient) hospital, and then mailed or sent via electronic transmission consistent with HIPAA provisions on the transmission of electronic data.

4. **§489.24 (e)(2)(iv) - The transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.**

   Emergency medical technicians may not always be "qualified personnel" for purposes of transferring an individual under these regulations. Depending on the individual's condition, there may be situations in which a physician's presence or some other specialist's presence might be necessary. The physician at the sending hospital (not at the receiving hospital) has the responsibility to determine the appropriate mode, equipment, and attendants for transfer.

   While the sending hospital is ultimately responsible for ensuring that the transfer is affected appropriately, the hospital may meet its obligations as it sees fit. These regulations do not require that a hospital operate an emergency medical transportation service.

Tag A-2410/C-2410

(Rev. 46, Issued: 05-29-09, Effective/Implementation: 05-29-09)

§489.24(e)(3)

(3) A participating hospital may not penalize or take adverse action against a physician or a qualified medical person described in paragraph (e)(1)(ii)(C) of this section because the physician or qualified medical person refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized, or against any hospital employee because the employee reports a violation of a requirement of this section.

Interpretive Guidelines: §489.24 (e)(3)

A "participating hospital" means a hospital that has entered into a provider agreement under §1866 of the Act.

Hospital employees reporting alleged EMTALA violations are also protected by this regulation.

Tag A-2411/C-2411

(Rev. 46, Issued: 05-29-09, Effective/Implementation: 05-29-09)

§489.24(f) Recipient Hospital Responsibilities

A participating hospital that has specialized capabilities or facilities (including, but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive care units, or, with respect to rural areas, regional referral centers (which, for purposes of this subpart, mean hospitals meeting the requirements of referral centers found at §412.96 of this chapter)) may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual.

(1) The provisions of this paragraph (f) apply to any participating hospital with specialized capabilities, regardless of whether the hospital has a dedicated emergency department.

(2) The provisions of this paragraph (f) do not apply to an individual who has been admitted to a referring hospital under the provisions of paragraph (d)(2)(i) of this section.

Interpretive Guidelines: §489.24(f)

A Medicare-participating hospital that has specialized capabilities or facilities may not refuse to accept an appropriate transfer from another hospital of an individual with an unstabilized emergency medical condition who is protected under EMTALA and requires such specialized capabilities or facilities. This assumes that, in addition to its specialized capabilities, the recipient hospital has the capacity to treat the individual, and that the transferring, i.e. referring, hospital lacks that capability or capacity. Hospitals with specialized capabilities or facilities may include, but are not limited to, hospitals with burn units, shock trauma units, neonatal intensive care units or hospitals that are regional referral centers that serve rural areas as defined by the requirements at 42 CFR 412.96.

This requirement to accept an appropriate transfer applies to any Medicare-participating hospital with specialized capabilities, regardless of whether the hospital has a dedicated emergency department. In other words, while some obligations under EMTALA apply only to hospitals that have a dedicated emergency department, e.g., requirements related to providing a medical screening examination, the EMTALA recipient hospital obligation can also apply to hospitals that do not have a dedicated emergency department. For example, if an individual is found to have an emergency medical condition that requires specialized psychiatric capabilities, a psychiatric hospital that participates in Medicare and has capacity is obligated to accept an appropriate transfer of that individual. It does not matter if the psychiatric hospital does not have a dedicated emergency department.

The regulation states that a recipient hospital's EMTALA obligations do not extend to individuals who are inpatients of another hospital. Thus, a hospital may not be cited for violating EMTALA if it refuses to accept the transfer of an inpatient from the referring hospital.

Section 489.24(b) defines inpatient: "Inpatient means an individual who is admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services as described in §409.10(a) of this chapter with the expectation that he or she will remain at least overnight and occupy a bed even though the situation later develops that the individual can be discharged or transferred to another hospital and does not actually use a hospital bed overnight."

Individuals who are placed in observation status are not inpatients, even if they occupy a bed overnight. Therefore, placement in an observation status of an individual who came to the hospital's DED does not terminate the EMTALA obligations of that hospital or a recipient hospital toward the individual.

There is no EMTALA obligation for a Medicare-participating hospital with specialized capabilities to accept transfers from hospitals located outside the boundaries of the United States. In accordance with Section 210(i) of the Social Security Act, the term "United States," when used in a geographical sense, means the States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa. Hospitals that request transfers must recognize that the appropriate transfer of individuals with unstabilized emergency medical conditions that require specialized services should

not routinely be made over great distances, bypassing closer hospitals with the needed capability and capacity.

A hospital with specialized capabilities or facilities that has the necessary capacity to treat an individual with an emergency medical condition may not condition or attempt to condition its acceptance of an appropriate transfer of an individual protected under EMTALA on the use of a particular mode of transport or transport service. It is the treating physician at the transferring hospital who decides how the individual is transported to the recipient hospital and what transport service will be used, since this physician has assessed the individual personally. The transferring hospital is required to arrange transport that minimizes the risk to the individual who is being transferred, in accordance with the requirements of §489.24(e)(2)(B)(iv).

A hospital with specialized capabilities that delays the treatment of an individual with an emergency medical condition who arrives as a transfer from another facility could be in violation of EMTALA, depending on the circumstances of that delay. For instance, if there is evidence that the recipient hospital unreasonably delayed the treatment of certain individuals and expedited the treatment of other individuals, based on their ability to pay for the services or some other form of discrimination, then the recipient hospital may be in violation of EMTALA. Hospitals that deliberately delay moving an individual from an EMS stretcher do not thereby delay the point in time at which their EMTALA obligation begins. Furthermore, such a practice of "parking" individuals arriving via EMS, refusing to release EMS personnel or equipment, can potentially jeopardize the health and safety of the transferred individual and other individuals in the community who may need EMS services at that time. On the other hand, this does not mean that a hospital will necessarily have violated EMTALA and/or the hospital CoPs if it does not, in every instance, immediately assume from the EMS provider all responsibility for the individual, regardless of any other circumstances in the hospital.

Lateral transfers, that is, transfers between facilities of comparable resources and capabilities, are not required by §489.24(f), because the benefits of such a transfer would not be likely to outweigh the risks of the transfer, except when the transferring hospital has a serious capacity problem, a mechanical failure of equipment, or similar situations, such as loss of power or significant flooding.

Assessment of whether the transferring hospital with the requisite capabilities lacked the capacity to provide stabilizing treatment, or of whether the recipient hospital lacked the capacity to accept an appropriate transfer requires a review of the hospital's general practices in adjusting its capacity. If a hospital generally has a record of accommodating additional patients by various means, such as moving patients from one unit to another, calling in additional staff, and temporarily borrowing additional equipment from other facilities, then that hospital would be expected under EMTALA to take reasonable steps to respond to the treatment needs of an individual requiring stabilizing treatment for an emergency medical condition. The determination of a hospital's capacity would depend on the case-specific circumstances and the hospital's previous implementation of capacity management actions.

The criteria for classifying hospitals as rural regional referral centers are defined in 42 CFR 412.96. A designated rural regional referral center is obligated to accept appropriate transfers of individuals who require the hospital's specialized capabilities if the hospital has the capacity to treat the individual.

APPENDIX D

California Hospital Licensing Laws on Emergency Services and Care

Source: California Health and Safety Code Sections 1317-1317.9a and 1799.111
www.leginfo.legislature.ca.gov

1317. Emergency services; discrimination; liability of facility or health care personnel

(a) Emergency services and care shall be provided to any person requesting the services or care, or for whom services or care is requested, for any condition in which the person is in danger of loss of life, or serious injury or illness, at any health facility licensed under this chapter that maintains and operates an emergency department to provide emergency services to the public when the health facility has appropriate facilities and qualified personnel available to provide the services or care.

(b) In no event shall the provision of emergency services and care be based upon, or affected by, the person's ethnicity, citizenship, age, preexisting medical condition, insurance status, economic status, ability to pay for medical services, or any other characteristic listed or defined in subdivision (b) or (e) of Section 51 of the Civil Code, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental disability is medically significant to the provision of appropriate medical care to the patient.

(c) Neither the health facility, its employees, nor any physician and surgeon, dentist, clinical psychologist, or podiatrist shall be liable in any action arising out of a refusal to render emergency services or care if the refusal is based on the determination, exercising reasonable care, that the person is not suffering from an emergency medical condition, or that the health facility does not have the appropriate facilities or qualified personnel available to render those services.

(d) Emergency services and care shall be rendered without first questioning the patient or any other person as to his or her ability to pay therefor. However, the patient or his or her legally responsible relative or guardian shall execute an agreement to pay therefor or otherwise supply insurance or credit information promptly after the services are rendered.

(e) If a health facility subject to this chapter does not maintain an emergency department, its employees shall nevertheless exercise reasonable care to determine whether an emergency exists and shall direct the persons seeking emergency care to a nearby facility that can render the needed services, and shall assist the persons seeking emergency care in obtaining the services, including transportation services, in every way reasonable under the circumstances.

(f) No act or omission of any rescue team established by any health facility licensed under this chapter, or operated by the federal or state government, a county, or by the Regents of the University of California, done or omitted while attempting to resuscitate any person who is in immediate danger of loss of life shall impose any liability upon the health facility, the officers, members of the staff, nurses, or employees of the health facility, including, but not limited to, the members of the rescue team, or upon the federal or state government or a county, if good faith is exercised.

(g) "Rescue team," as used in this section, means a special group of physicians and surgeons, nurses, and employees of a health facility who have been trained in cardiopulmonary resuscitation and have been designated by the health facility to attempt, in cases of emergency, to resuscitate persons who are in immediate danger of loss of life.

(h) This section shall not relieve a health facility of any duty otherwise imposed by law upon the health facility for the designation and training of members of a rescue team or for the provision or maintenance of equipment to be used by a rescue team.

1317.1. Definitions

Unless the context otherwise requires, the following definitions shall control the construction of this article and Section 1371.4:

(a) (1) "Emergency services and care" means medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a physician and surgeon, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.

(2) (A) "Emergency services and care" also means an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.

(B) The care and treatment necessary to relieve or eliminate a psychiatric emergency medical condition may include admission or transfer to a psychiatric unit within a general acute care hospital, as defined in subdivision (a) of Section 1250, or to an acute psychiatric hospital, as defined in subdivision (b) of Section 1250, pursuant to subdivision (k). Nothing in this subparagraph shall be construed to permit a transfer that is in conflict with the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code).

(C) For the purposes of Section 1371.4, emergency services and care as defined in subparagraph (A) shall not apply to Medi-Cal managed care plan contracts entered into with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), and Chapter 8.75 (commencing with Section 14590) of Part 3 of Division 9 of the Welfare and Institutions Code, to the extent that those services are excluded from coverage under those contracts.

(D) This paragraph does not expand, restrict, or otherwise affect the scope of licensure or clinical privileges for clinical psychologists or other medical personnel.

(b) "Emergency medical condition" means 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 any of the following:

(1) Placing the patient's health in serious jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction of any bodily organ or part.

(c) "Active labor" means a labor at a time at which either of the following would occur:

(1) There is inadequate time to effect safe transfer to another hospital prior to delivery.

(2) A transfer may pose a threat to the health and safety of the patient or the unborn child.

(d) "Hospital" means all hospitals with an emergency department licensed by the state department.

(e) "State department" means the State Department of Public Health.

(f) "Medical hazard" means a material deterioration in medical condition in, or jeopardy to, a patient's medical condition or expected chances for recovery.

(g) "Board" means the Medical Board of California.

(h) "Within the capability of the facility" means those capabilities that the hospital is required to have as a condition of its emergency medical services permit and services specified on Services Inventory Form 7041 filed by the hospital with the Office of Statewide Health Planning and Development.

(i) "Consultation" means the rendering of an opinion or advice, prescribing treatment, or the rendering of a decision regarding hospitalization or transfer by telephone or other means of communication. When determined to be medically necessary, jointly by the treating physician and surgeon, or by other appropriate licensed persons acting within their scope of licensure, under the supervision of a physician and surgeon, and the consulting physician and surgeon, "consultation" includes review of the patient's medical record, examination, and treatment of the patient in person by a consulting physician and surgeon, or by other appropriate licensed persons acting within their scope of licensure under the supervision of a consulting physician and surgeon, who is qualified to give an opinion or render the necessary treatment in order to stabilize the patient. A request for consultation shall be made by the treating physician and surgeon, or by other appropriate licensed persons acting within their scope of licensure under the supervision of a treating physician and surgeon, provided the request is made with the contemporaneous approval of the treating physician and surgeon. The treating physician and surgeon may request to communicate directly with the consulting physician and surgeon, and when determined to be medically necessary, jointly by the treating physician and surgeon and the consulting physician and surgeon, the consulting physician and surgeon shall examine and treat the patient in person. The consulting physician and surgeon is ultimately responsible for providing the necessary consultation to the patient, regardless of who makes the in-person appearance.

(j) A patient is "stabilized" or "stabilization" has occurred when, in the opinion of the treating physician and surgeon, or other appropriate licensed persons acting within their scope of licensure under the supervision of a treating physician and surgeon, the patient's medical condition is such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from, or occur during, the release or transfer of the patient as provided for in Section 1317.2, Section 1317.2a, or other pertinent statute.

(k) (1) "Psychiatric emergency medical condition" means a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

(A) An immediate danger to himself or herself or to others.

(B) Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

(2) This subdivision does not expand, restrict, or otherwise affect the scope of licensure or clinical privileges for clinical psychologists or medical personnel.

(l) This section shall not be construed to expand the scope of licensure for licensed persons providing services pursuant to this section.

1317.2. Transfer for nonmedical reasons; conditions

A person needing emergency services and care shall not be transferred from a hospital to another hospital for any nonmedical reason (such as the person's inability to pay for any emergency service or care) unless each of the following conditions are met:

(a) The person is examined and evaluated by a physician and surgeon, including, if necessary, consultation, prior to transfer.

(b) The person has been provided with emergency services and care so that it can be determined, within reasonable medical probability, that the transfer or delay caused by the transfer will not create a medical hazard to the person.

(c) A physician and surgeon at the transferring hospital has notified and has obtained the consent to the transfer by a physician and surgeon at the receiving hospital and confirmation by the receiving hospital that the person meets the hospital's admissions criteria relating to appropriate bed, personnel, and equipment necessary to treat the person.

(d) The transferring hospital provides for appropriate personnel and equipment that a reasonable and prudent physician and surgeon in the same or similar locality exercising ordinary care would use to effect the transfer.

(e) All the person's pertinent medical records and copies of all the appropriate diagnostic test results that are reasonably available are transferred with the person.

(f) The records transferred with the person include a "Transfer Summary" signed by the transferring physician and surgeon that contains relevant transfer information. The form of the "Transfer Summary" shall, at a minimum, contain the person's name, address, sex, race, age, insurance status, and medical condition; the name and address of the transferring physician and surgeon or emergency department personnel authorizing the transfer; the time and date the person was first presented at the transferring hospital; the name of the physician and surgeon at the receiving hospital consenting to the transfer and the time and date of the consent; the time and date of the transfer; the reason for the transfer; and the declaration of the signor that the signor is assured, within reasonable medical probability, that the transfer creates no medical hazard to the patient. Neither the transferring physician and surgeon nor transferring hospital shall be required to duplicate, in the "Transfer Summary," information contained in medical records transferred with the person.

(g) The transfer conforms with regulations established by the state department. These regulations may prescribe minimum protocols for patient transfers.

(h) The patient shall be asked if there is a preferred contact person to be notified and, prior to the transfer, the hospital shall make a reasonable attempt to contact that person and alert him or her about the proposed transfer, in accordance with subdivision (b) of Section 56.1007 of the Civil Code. If the patient is not able to respond, the hospital shall make a reasonable effort to ascertain the identity of the preferred contact person or the next of kin and alert him or her about

the transfer, in accordance with subdivision (b) of Section 56.1007 of the Civil Code. The hospital shall document in the patient's medical record any attempts to contact a preferred contact person or next of kin.

(i) This section shall not apply to a transfer of a patient for medical reasons.

(j) This section shall not prohibit the transfer or discharge of a patient when the patient or the patient's representative requests a transfer or discharge and gives informed consent to the transfer or discharge against medical advice.

1317.2a. Legal obligation to provide care; acceptance of patients; county hospitals; liability of third-party payors

(a) A hospital which has a legal obligation, whether imposed by statute or by contract, to the extent of that contractual obligation, to any third-party payor, including, but not limited to, a health maintenance organization, health care service plan, nonprofit hospital service plan, insurer, or preferred provider organization, a county, or an employer to provide care for a patient under the circumstances specified in Section 1317.2 shall receive that patient to the extent required by the applicable statute or by the terms of the contract, or, when the hospital is unable to accept a patient for whom it has a legal obligation to provide care whose transfer will not create a medical hazard as specified in Section 1317.2, it shall make appropriate arrangements for the patient's care.

(b) A county hospital shall accept a patient whose transfer will not create a medical hazard as specified in Section 1317.2 and who is determined by the county to be eligible to receive health care services required under Part 5 (commencing with Section 17000) of Division 9 of the Welfare and Institutions Code, unless the hospital does not have appropriate bed capacity, medical personnel, or equipment required to provide care to the patient in accordance with accepted medical practice. When a county hospital is unable to accept a patient whose transfer will not create a medical hazard as specified in Section 1317.2, it shall make appropriate arrangements for the patient's care. The obligation to make appropriate arrangements as set forth in this subdivision does not mandate a level of service or payment, modify the county's obligations under Part 5 (commencing with Section 17000) of Division 9 of the Welfare and Institutions Code, create a cause of action, or limit a county's flexibility to manage county health systems within available resources. However, the county's flexibility shall not diminish a county's responsibilities under Part 5 (commencing with Section 17000) of Division 9 of the Welfare and Institutions Code or the requirements contained in Chapter 2.5 (commencing with Section 1440).

(c) The receiving hospital shall provide personnel and equipment reasonably required in the exercise of good medical practice for the care of the transferred patient.

(d) Any third-party payor, including, but not limited to, a health maintenance organization, health care service plan, nonprofit hospital service plan, insurer, or preferred provider organization, or employer which has a statutory or contractual obligation to provide or indemnify emergency medical services on behalf of a patient shall be liable, to the extent of the contractual obligation to the patient, for the reasonable charges of the transferring hospital and the treating physicians for the emergency services provided pursuant to this article, except that the patient shall be responsible for uncovered services, or any deductible or copayment obligation. Notwithstanding this section, the liability of a third-party payor which has contracted with health care providers for the provision of these emergency services shall be set by the terms of that contract. Notwithstanding this section, the liability of a third-party payor that is licensed by the Insurance

Commissioner or the Director of the Department of Managed Health Care and has a contractual obligation to provide or indemnify emergency medical services under a contract which covers a subscriber or an enrollee shall be determined in accordance with the terms of that contract and shall remain under the sole jurisdiction of that licensing agency.

(e) A hospital which has a legal obligation to provide care for a patient as specified by subdivision (a) of Section 1317.2a to the extent of its legal obligation, imposed by statute or by contract to the extent of that contractual obligation, which does not accept transfers of, or make other appropriate arrangements for, medically stable patients in violation of this article or regulations adopted pursuant thereto shall be liable for the reasonable charges of the transferring hospital and treating physicians for providing services and care which should have been provided by the receiving hospital.

(f) Subdivisions (d) and (e) do not apply to county obligations under Section 17000 of the Welfare and Institutions Code.

(g) Nothing in this section shall be interpreted to require a hospital to make arrangements for the care of a patient for whom the hospital does not have a legal obligation to provide care.

1317.3. Policies and transfer protocols; discrimination; failure to adopt policies and protocols; submission for approval

(a) As a condition of licensure, each hospital shall adopt, in consultation with the medical staff, policies and transfer protocols consistent with this article and regulations adopted hereunder.

(b) As a condition of licensure, each hospital shall adopt a policy prohibiting discrimination in the provision of emergency services and care based on ethnicity, citizenship, age, preexisting medical condition, insurance status, economic status, ability to pay for medical services, or any characteristic listed or defined in subdivision (b) or (e) of Section 51 of the Civil Code, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental disability is medically significant to the provision of appropriate medical care to the patient. Transfer by a hospital of a patient who requires evaluation for involuntary psychiatric treatment, as determined by the receiving hospital or other receiving health facility, based upon the decision of a professional person duly authorized by law to make that decision, shall not constitute discrimination for the purposes of this section, if the transferring hospital has not been designated as an evaluation facility by a county pursuant to Section 5150 of the Welfare and Institutions Code, and if the transfer is in compliance with Section 1317.2.

(c) As a condition of licensure, each hospital shall require that physicians and surgeons who serve on an “on-call” basis to the hospital’s emergency room cannot refuse to respond to a call on the basis of the patient’s ethnicity, citizenship, age, preexisting medical condition, insurance status, economic status, ability to pay for medical services, or any characteristic listed or defined in subdivision (b) or (e) of Section 51 of the Civil Code, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental disability is medically significant to the provision of appropriate medical care to the patient. If a contract between a physician and surgeon and hospital for the provision of emergency room coverage presently prevents the hospital from imposing those conditions, the conditions shall be included in the contract as soon as is legally permissible. Nothing in this section shall be construed as requiring that any physician serve on an “on-call” basis.

(d) As a condition of licensure, all hospitals shall inform all persons presented to an emergency room or their representatives if any are present and the person is unable to understand verbal or written communication, both orally and in writing, of the reasons for the transfer or refusal to provide emergency services and care and of the person's right to emergency services and care prior to transfer or discharge without regard to ability to pay. Nothing in this subdivision requires notification of the reasons for the transfer in advance of the transfer where a person is unaccompanied and the hospital has made a reasonable effort to locate a representative, and because of the person's physical or mental condition, notification is not possible. All hospitals shall prominently post a sign in their emergency rooms informing the public of their rights. Both the posted sign and written communication concerning the transfer or refusal to provide emergency services and care shall give the address of the department as the government agency to contact in the event the person wishes to complain about the hospital's conduct.

(e) If a hospital does not timely adopt the policies and protocols required in this article, the hospital, in addition to denial or revocation of any of its licenses, shall be subject to a fine not to exceed one thousand dollars ($1,000) each day after expiration of 60 days' written notice from the state department that the hospital's policies or protocols required by this article are inadequate unless the delay is excused by the state department upon a showing of good and sufficient cause by the hospital. The notice shall include a detailed statement of the state department's reasons for its determination and suggested changes to the hospital's protocols which would be acceptable to the state department.

(f) Each hospital's policies and protocols required in or under this article shall be submitted for approval to the state department by December 31, 1988.

1317.4. Records of transfers; reports of violations summary to legislature; proceedings to impose fine

(a) All hospitals shall maintain records of each transfer made or received, including the "Memorandum of Transfer" described in subdivision (f) of Section 1317.2, for a period of three years.

(b) All hospitals making or receiving transfers shall file with the state department annual reports on forms prescribed by the department which shall describe the aggregate number of transfers made and received according to the person's insurance status and reasons for transfers.

(c) The receiving hospital, and all physicians, other licensed emergency room health personnel, and certified prehospital emergency personnel at the receiving hospital who know of apparent violations of this article or the regulations adopted hereunder shall, and the corresponding personnel at the transferring hospital and the transferring hospital may, report the apparent violations to the state department on a form prescribed by the state department within one week following its occurrence. The state department shall promptly send a copy of the form to the hospital administrator and appropriate medical staff committee of the transferring hospital and the local emergency medical services agency, unless the state department concludes that the complaint does not allege facts requiring further investigation, or is otherwise unmeritorious, or the state department concludes, based upon the circumstances of the case, that its investigation of the allegations would be impeded by disclosure of the form. When two or more persons required to report jointly have knowledge of an apparent violation, a single report may be made by a member of the team selected by mutual agreement in accordance with hospital protocols. Any individual, required to report by this section, who disagrees with the proposed joint report has a right and duty to separately report.

A failure to report under this subdivision shall not constitute a violation within the meaning of Section 1290 or 1317.6.

(d) No hospital, government agency, or person shall retaliate against, penalize, institute a civil action against, or recover monetary relief from, or otherwise cause any injury to a physician or other personnel for reporting in good faith an apparent violation of this article or the regulations adopted hereunder to the state department, hospital, medical staff, or any other interested party or government agency.

(e) No hospital, government agency, or person shall retaliate against, penalize, institute a civil action against, or recover monetary relief from, or otherwise cause any injury to a physician who refused to transfer a patient when the physician determines, within reasonable medical probability, that the transfer or delay caused by the transfer will create a medical hazard to the person.

(f) Any person who violates subdivision (d) or (e) of Section 1317.4 is subject to a civil money penalty of no more than ten thousand dollars ($10,000) per violation. The remedy specified in this section shall be in addition to any other remedy provided by law.

(g) The state department shall on an annual basis publish and provide to the Legislature a statistical summary by county on the extent of economic transfers of emergency patients, the frequency of medically hazardous transfers, the insurance status of the patient populations being transferred and all violations finally determined by the state department describing the nature of the violations, hospitals involved, and the action taken by the state department in response. These summaries shall not reveal the identity of individual persons transferred.

(h) Proceedings by the state department to impose a fine under Section 1317.3 or 1317.6, and proceedings by the board to impose a fine under Section 1317.6, shall be conducted as follows:

(1) If a hospital desires to contest a proposed fine, the hospital shall within 15 business days after service of the notice of proposed fine notify the director in writing of its intention to contest the proposed fine. If requested by the hospital, the director or the director's designee, shall hold, within 30 business days, an informal conference, at the conclusion of which he or she may affirm, modify, or dismiss the proposed fine. If the director or the director's designee affirms, modifies, or dismisses the proposed fine, he or she shall state with particularity in writing his or her reasons for that action, and shall immediately transmit a copy thereof to the hospital. If the hospital desires to contest a determination made after the informal conference, the hospital shall inform the director in writing within 15 business days after it receives the decision by the director or director's designee. The hospital shall not be required to request an informal conference to contest a proposed fine, as specified in this section. If the hospital fails to notify the director in writing that it intends to protest the proposed fine within the times specified in this subdivision, the proposed fine shall be deemed a final order of the state department and shall not be subject to further administrative review.

(2) If a hospital notifies the director that it intends to contest a proposed fine, the director shall immediately notify the Attorney General. Upon notification, the Attorney General shall promptly take all appropriate action to enforce the proposed fine in a court of competent jurisdiction for the county in which the hospital is located.

(3) A judicial action to enforce a proposed fine shall be filed by the Attorney General after a hospital notifies the director of its intent to contest the proposed fine. If a judicial proceeding

is prosecuted under the provisions of this section, the state department shall have the burden of establishing by a preponderance of the evidence that the alleged facts supporting the proposed fine occurred, that the alleged facts constituted a violation for which a fine may be assessed under Section 1317.3, 1317.4, or 1317.6, and the proposed fine is appropriate. The state department shall also have the burden of establishing by a preponderance of the evidence that the assessment of the proposed fine should be upheld. If a hospital timely notifies the state department of its decision to contest a proposed fine, the fine shall not be due and payable unless and until the judicial proceeding is terminated in favor of the state department.

(4) Action brought under the provisions of this section shall be set for trial at the earliest possible date and shall take precedence on the court calendar over all other cases except matters to which equal or superior precedence is specifically granted by law. Times for responsive pleading and for hearing any such proceeding shall be set by the judge of the court with the object of securing a decision as to subject matters at the earliest possible time.

(5) If the proposed fine is dismissed or reduced, the state department shall take action immediately to ensure that the public records reflect in a prominent manner that the proposed fine was dismissed or reduced.

(6) In lieu of a judicial proceeding, the state department and the hospital may jointly elect to submit the matter to binding arbitration, in which case, the department shall initiate arbitration proceedings. The parties shall agree upon an arbitrator designated by the American Arbitration Association in accordance with the Association's established rules and procedures. The arbitration hearing shall be set within 45 days of the parties' joint election, but in no event less than 28 days from the date of selection of an arbitrator. The arbitration hearing may be continued up to 15 days if necessary at the arbitrator's discretion. The decision of arbitrator shall be based upon substantive law and shall be binding on all parties, subject to judicial review. This review shall be limited to whether there was substantial evidence to support the decision of the arbitrator.

(7) Proceedings by the board to impose a fine under Section 1317.6 shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

1317.4a. Transfer of patient to psychiatric unit to treat psychiatric emergency medical condition; heath care service plan information and notification; subsequent transfer to facility within plan

(a) Notwithstanding subdivision (j) of Section 1317.1, a patient may be transferred for admission to a psychiatric unit within a general acute care hospital, as defined in subdivision (a) of Section 1250, or an acute psychiatric hospital, as defined in subdivision (b) of Section 1250, for care and treatment that is solely necessary to relieve or eliminate a psychiatric emergency medical condition, as defined in subdivision (k) of Section 1317.1, provided that, in the opinion of the treating provider, the patient's psychiatric emergency medical condition is such that, within reasonable medical probability, no material deterioration of the patient's psychiatric emergency medical condition is likely to result from, or occur during, a transfer of the patient. A provider shall notify the patient's health care service plan, or the health plan's contracting medical provider of the need for the transfer if identification of the plan is obtained pursuant to paragraph (1) of subdivision (b).

(b) A hospital that transfers a patient pursuant to subdivision (a) shall do both of the following:

(1) Seek to obtain the name and contact information of the patient' s health care service plan. The hospital shall document its attempt to ascertain this information in the patient's medical record. The hospital's attempt to ascertain the information shall include requesting the patient's health care service plan member card, asking the patient, the patient's family member, or other person accompanying the patient if he or she can identify the patient's health care service plan, or using other means known to the hospital to accurately identify the patient's health care service plan.

(2) Notify the patient's health care service plan or the health plan's contracting medical provider of the transfer, provided that the identification of the plan was obtained pursuant to paragraph (1). The hospital shall provide the plan or its contracting medical provider with the name of the patient, the patient's member identification number, if known, the location and contact information, including a telephone number, for the location where the patient will be admitted, and the preliminary diagnosis.

(c) (1) A hospital shall make the notification described in paragraph (2) of subdivision (b) by either following the instructions on the patient's health care service plan member card or by using the contact information provided by the patient's health care service plan. A health care service plan shall provide all noncontracting hospitals in the state to which one of its members would be transferred pursuant to paragraph (1) of subdivision (b) with specific contact information needed to make the contact required by this section. The contact information provided to hospitals shall be updated as necessary, but no less than once a year.

(2) A hospital making the transfer pursuant to subdivision (a) shall not be required to make more than one telephone call to the health care service plan, or its contracting medical provider, provided that in all cases the health care service plan, or its contracting medical provider, shall be able to reach a representative of the provider upon returning the call, should the plan, or its contracting medical provider, need to call back. The representative of the hospital who makes the telephone call may be, but is not required to be, a physician and surgeon.

(d) If a transfer made pursuant to subdivision (a) is made to a facility that does not have a contract with the patient's health care service plan, the plan may subsequently require and make provision for the transfer of the patient receiving services pursuant to this section and subdivision (a) of Section 1317.1 from the noncontracting facility to a general acute care hospital, as defined in subdivision (a) of Section 1250, or an acute psychiatric hospital, as defined in subdivision (b) of Section 1250, that has a contract with the plan or its delegated payer, provided that in the opinion of the treating provider the patient's psychiatric emergency medical condition is such that, within reasonable medical probability, no material deterioration of the patient's psychiatric emergency medical condition is likely to result from, or occur during, the transfer of the patient.

(e) Upon admission, the hospital to which the patient was transferred shall notify the health care service plan of the transfer, provided that the facility has the name and contact information of the patient's health care service plan. The facility shall not be required to make more than one telephone call to the health care service plan, or its contracting medical provider, provided that in all cases the health care service plan, or its contracting medical provider, shall be able to reach a representative of the facility upon returning the call, should the plan, or its contracting medical provider, need to call back. The representative of the facility who makes the telephone call may be, but is not required to be, a physician and surgeon.

(f) Nothing in this subdivision shall be construed to require providers to seek authorization to provide emergency services and care, as defined in paragraph (2) of subdivision (a) of Section 1317.1, to a patient who has a psychiatric emergency medical condition, as defined in subdivision (k) of Section 1317.1, that is not otherwise required by law.

1317.5. Violations; investigations

(a) All alleged violations of this article and the regulations adopted hereunder shall be investigated by the state department. The state department, with the agreement of the local EMS agency, may refer violations of this article to the local EMS agency for investigation. The investigation shall be conducted pursuant to procedures established by the state department and shall be completed no later than 60 days after the report of apparent violation is received by the state department.

(b) At the conclusion of its investigation, the state department or the local EMS agency shall refer any alleged violation by a physician to the Medical Board of California unless it is determined that the complaint is without a reasonable basis.

1317.6. Penalties; maximum fine; revocation or suspension of license

(a) Hospitals found by the state department to have committed or to be responsible for a violation of this article or the regulations adopted pursuant thereto shall be subject to a civil penalty by the state department in an amount not to exceed twenty-five thousand dollars ($25,000) for each hospital violation. In determining the amount of the fine for a hospital violation, the state department shall take into account all of the following:

(1) Whether the violation was knowing or unintentional.

(2) Whether the violation resulted or was reasonably likely to result in a medical hazard to the patient.

(3) The frequency or gravity of the violation.

(4) Other civil fines which have been imposed as a result of the violation under Section 1395 of Title 42 of the United States Code.

(b) Notwithstanding this section, the director shall refer any alleged violation by a hospital owned and operated by a health care service plan involving a plan member or enrollee to the Department of Managed Health Care unless the director determines the complaint is without reasonable basis. The Department of Managed Health Care shall have sole authority and responsibility to enforce this article with respect to violations involving hospitals owned and operated by health care service plans in their treatment of plan members or enrollees.

(c) Physicians and surgeons found by the board to have committed, or to be responsible for, a violation of this article or the regulations adopted pursuant thereto shall be subject to any and all penalties which the board may lawfully impose and may be subject to a civil penalty by the board in an amount not to exceed five thousand dollars ($5,000) for each violation. A civil penalty imposed under this subdivision shall not duplicate federal fines, and the board shall credit any federal fine against a civil penalty imposed under this subdivision.

(d) The board may impose fines when it finds any of the following:

(1) The violation was knowing or willful.

(2) The violation was reasonably likely to result in a medical hazard.

(3) There are repeated violations.

(e) It is the intent of the Legislature that the state department has primary responsibility for regulating the conduct of hospital emergency departments and that fines imposed under this section should not be duplicated by additional fines imposed by the federal government as a result of the conduct which constituted a violation of this section. To effectuate the Legislature's intent, the Governor shall inform the Secretary of the federal Department of Health and Human Services of the enactment of this section and request the federal department to credit any penalty assessed under this section against any subsequent civil monetary penalty assessed pursuant to Section 1395dd of Title 42 of the United States Code for the same violation.

(f) There shall be a cumulative maximum limit of thirty thousand dollars ($30,000) in fines assessed against hospitals under this article and under Section 1395dd of Title 42 of the United States Code for the same circumstances. To effectuate this cumulative maximum limit, the state department shall do both of the following:

(1) As to state fines assessed prior to the final conclusion, including judicial review, if available, of an action against a hospital by the federal Department of Health and Human Services under Section 1395dd of Title 42 of the United States Code (for the same circumstances finally deemed to have been a violation of this article or the regulations adopted hereunder, because of the state department action authorized by this article), remit and return to the hospital within 30 days after conclusion of the federal action, that portion of the state fine necessary to assure that the cumulative maximum limit is not exceeded.

(2) Immediately credit against state fines assessed after the final conclusion, including judicial review, if available, of an action against a hospital by the federal Department of Health and Human Services under Section 1395dd of Title 42 of the United States Code, which results in a fine against a hospital (for the same circumstances finally deemed to have been a violation of this article or the regulations adopted hereunder, because of the state department action authorized by this article), the amount of the federal fine, necessary to assure the cumulative maximum limit is not exceeded.

(g) Any hospital found by the state department pursuant to procedures established by the state department to have committed a violation of this article or the regulations adopted hereunder may have its emergency medical service permit revoked or suspended by the state department.

(h) Any administrative or medical personnel who knowingly and intentionally violates any provision of this article, may be charged by the local district attorney with a misdemeanor.

(i) Notification of each violation found by the state department of the provisions of this article or the regulations adopted hereunder shall be sent by the state department to the Joint Commission for the Accreditation of Hospitals, the state emergency medical services authority, and local emergency medical services agencies.

(j) Any person who suffers personal harm and any medical facility which suffers a financial loss as a result of a violation of this article or the regulations adopted hereunder may recover, in a civil action against the transferring or receiving hospital, damages, reasonable attorney's fees, and other appropriate relief. Transferring and receiving hospitals from which inappropriate transfers of persons are made or refused in violation of this article and the regulations adopted hereunder shall be liable for the reasonable charges of the receiving or transferring hospital for providing the services and care which should have been provided. Any person potentially harmed by a violation of this article or the regulations adopted hereunder, or the local district attorney or the Attorney General, may bring a civil action against the responsible hospital or administrative or medical

personnel, to enjoin the violation, and if the injunction issues, the court shall award reasonable attorney's fees. The provisions of this subdivision are in addition to other civil remedies and do not limit the availability of the other remedies.

(k) The civil remedies established by this section do not apply to violations of any requirements established by any county or county agency.

1317.7. Government agencies not preempted

This article does not preempt any county or any other governmental agency acting within its authority from regulating emergency care or patient transfers, including the imposition of more specific duties, consistent with the requirements of this article and its implementing regulations. Any inconsistent requirements imposed by the Medi-Cal program shall preempt this article with respect to Medi-Cal beneficiaries. To the extent hospitals and physicians enter into contractual relationships with county or other governmental agencies which impose more stringent transfer requirements, those contractual agreements shall control.

1317.8. Severability

If any provision of this article is declared unlawful or unconstitutional in any judicial action, the remaining provisions of this chapter shall remain in effect.

1317.9a. Exercise of professional judgment

(a) This article shall not be construed as altering or repealing Section 2400 of the Business and Professions Code.

(b) Nothing in Sections 1317 *et seq.* and 1798.170 *et seq.* shall prevent a physician from exercising his or her professional judgment in conflict with any state or local regulation adopted pursuant to Section 1317 *et seq.* or 1798.170 *et seq.*, so long as the judgment conforms with Sections 1317, 1317.1, and, except for subdivision (g), Section 1317.2, and acting in compliance with the state or local regulation would be contrary to the best interests of the patient.

1799.111. General acute care hospitals or acute psychiatric hospitals; detention or release; persons exhibiting mental disorders

(a) Subject to subdivision (b), a licensed general acute care hospital, as defined in subdivision (a) of Section 1250, that is not a county-designated facility pursuant to Section 5150 of the Welfare and Institutions Code, a licensed acute psychiatric hospital, as defined in subdivision (b) of Section 1250, that is not a county-designated facility pursuant to Section 5150 of the Welfare and Institutions Code, licensed professional staff of those hospitals, or any physician and surgeon, providing emergency medical services in any department of those hospitals to a person at the hospital shall not be civilly or criminally liable for detaining a person if all of the following conditions exist during the detention:

(1) The person cannot be safely released from the hospital because, in the opinion of the treating physician and surgeon, or a clinical psychologist with the medical staff privileges, clinical privileges, or professional responsibilities provided in Section 1316.5, the person, as a result of a mental disorder, presents a danger to himself or herself, or others, or is gravely disabled. For purposes of this paragraph, "gravely disabled" means an inability to provide for his or her basic personal needs for food, clothing, or shelter.

(2) The hospital staff, treating physician and surgeon, or appropriate licensed mental health professional, have made, and documented, repeated unsuccessful efforts to find appropriate mental health treatment for the person.

(A) Telephone calls or other contacts required pursuant to this paragraph shall commence at the earliest possible time when the treating physician and surgeon has determined the time at which the person will be medically stable for transfer.

(B) In no case shall the contacts required pursuant to this paragraph begin after the time when the person becomes medically stable for transfer.

(3) The person is not detained beyond 24 hours.

(4) There is probable cause for the detention.

(b) If the person is detained pursuant to subdivision (a) beyond eight hours, but less than 24 hours, both of the following additional conditions shall be met:

(1) A discharge or transfer for appropriate evaluation or treatment for the person has been delayed because of the need for continuous and ongoing care, observation, or treatment that the hospital is providing.

(2) In the opinion of the treating physician and surgeon, or a clinical psychologist with the medical staff privileges or professional responsibilities provided for in Section 1316.5, the person, as a result of a mental disorder, is still a danger to himself or herself, or others, or is gravely disabled, as defined in paragraph (1) of subdivision (a).

(c) In addition to the immunities set forth in subdivision (a), a licensed general acute care hospital, as defined in subdivision (a) of Section 1250 that is not a county-designated facility pursuant to Section 5150 of the Welfare and Institutions Code, a licensed acute psychiatric hospital as defined by subdivision (b) of Section 1250 that is not a county-designated facility pursuant to Section 5150 of the Welfare and Institutions Code, licensed professional staff of those hospitals, or any physician and surgeon, providing emergency medical services in any department of those hospitals to a person at the hospital shall not be civilly or criminally liable for the actions of a person detained up to 24 hours in those hospitals who is subject to detention pursuant to subdivision (a) after that person's release from the detention at the hospital, if all of the following conditions exist during the detention:

(1) The person has not been admitted to a licensed general acute care hospital or a licensed acute psychiatric hospital for evaluation and treatment pursuant to Section 5150 of the Welfare and Institutions Code.

(2) The release from the licensed general acute care hospital or the licensed acute psychiatric hospital is authorized by a physician and surgeon or a clinical psychologist with the medical staff privileges or professional responsibilities provided for in Section 1316.5, who determines, based on a face-to-face examination of the person detained, that the person does not present a danger to himself or herself or others and is not gravely disabled, as defined in paragraph (1) of subdivision (a). In order for this paragraph to apply to a clinical psychologist, the clinical psychologist shall have a collaborative treatment relationship with the physician and surgeon. The clinical psychologist may authorize the release of the person from the detention, but only after he or she has consulted with the physician and surgeon. In the event of a clinical or professional disagreement regarding the release of a person subject to the detention, the detention shall be maintained unless the hospital's medical director overrules the decision of the physician and surgeon opposing the release. Both the physician and surgeon and the clinical psychologist shall enter their findings, concerns, or objections in the person's medical record.

(d) Nothing in this section shall affect the responsibility of a general acute care hospital or an acute psychiatric hospital to comply with all state laws and regulations pertaining to the use of seclusion and restraint and psychiatric medications for psychiatric patients. Persons detained under this section shall retain their legal rights regarding consent for medical treatment.

(e) A person detained under this section shall be credited for the time detained, up to 24 hours, in the event he or she is placed on a subsequent 72-hour hold pursuant to Section 5150 of the Welfare and Institutions Code.

(f) The amendments to this section made by the act adding this subdivision shall not be construed to limit any existing duties for psychotherapists contained in Section 43.92 of the Civil Code.

(g) Nothing in this section is intended to expand the scope of licensure of clinical psychologists.

APPENDIX E

CoP for Emergency Services:

Hospital *Interpretive Guidelines*

Source: **CMS State Operations Manual, Appendix A, Hospitals, Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, pages 67-71 www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf**

A-0091

(Rev. 37, Issued: 10-17-08; Effective/Implementation Date: 10-17-08)

§482.12(f) Standard: Emergency Services

Interpretive Guidelines §482.12(f)

The hospital must ensure the emergency services requirements are met.

A-0092

(Rev. 37, Issued: 10-17-08; Effective/Implementation Date: 10-17-08)

§482.12(f)(1) If emergency services are provided at the hospital, the hospital must comply with the requirements of §482.55.

A-0093

(Rev. 37, Issued: 10-17-08; Effective/Implementation Date: 10-17-08)

§482.12(f)(2) If emergency services are not provided at the hospital, the governing body must assure that the medical staff has written policies and procedures for appraisal of emergencies, initial treatment, and referral when appropriate.

Interpretive Guidelines §482.12(f)(2)

This requirement applies hospital-wide (all on-campus and off-campus locations) to hospitals that do not provide emergency services.

Hospitals without emergency departments must have appropriate policies and procedures in place for addressing individuals' emergency care needs 24 hours per day and 7 days per week, including the following:

- **Appraisal of Persons with Emergencies:** A hospital must have medical staff policies and procedures for conducting appraisals of persons with emergencies. The policies and procedures must ensure that:

  - As required by 42 CFR 482.23(b), an RN is immediately available, as needed, to provide bedside care to any patient and that,

  - Among such RN(s) who are immediately available at all times, there must be an RN(s) who is/are qualified, through a combination of education, licensure, and training, to conduct an assessment that enables them to recognize the fact that a person has a need for emergency care.

  The policies and procedures for appraisal should provide that the MD/DO (on-site or on-call) would directly provide appraisals of emergencies or provide medical direction of on-site staff conducting appraisals.

- **Initial Treatment**: A hospital must have medical staff policies and procedures for providing the initial treatment needed by persons with emergency conditions. Among the RN(s) who must be available at all times in a hospital as required by 42 CFR 482.23(b), there must be RN(s) who are qualified, through a combination of education, licensure, and training, to provide initial treatment to a person experiencing a medical emergency. The on-site or on-call physician could provide initial treatment directly or provide medical oversight and direction to other staff. This requirement, taken together with other hospital regulatory requirements, suggests that a prudent hospital would evaluate the patient population the hospital routinely cares for in order to anticipate potential emergency care scenarios and develop the policies, procedures, and staffing that would enable it to provide safe and adequate initial treatment of an emergency.

- **Referral when Appropriate:** A hospital must have medical staff policies and procedures to address situations in which a person's emergency needs may exceed the hospital's capabilities. The policies and procedures should be designed to enable hospital staff members who respond to emergencies to: (a) recognize when a person requires a referral or transfer, and (b) assure appropriate handling of the transfer. This includes arrangement for appropriate transport of the patient. Further, in accordance with the Discharge Planning CoP at 42 CFR 482.43(d), the hospital must transfer patients to appropriate facilities, i.e., those with the appropriate capabilities to handle the patient's condition. The regulation also requires that necessary medical information be sent along with the patient being transferred. This enables the receiving hospital to treat the medical emergency more efficiently.

- **Patient Transportation and Emergency Medical Services (EMS)**

  A hospital may arrange transportation of the referred patient by several methods, including using the hospital's own ambulance service, the receiving hospital's ambulance service, a contracted ambulance service, or, in extraordinary circumstances, alerting EMS via calling 9-1-1. There is no specific Medicare prohibition on a hospital with or without an emergency department calling 9-1-1 in order to obtain transport of a patient to another hospital. Use of 9-1-1 to obtain transport does not, however, relieve the hospital of its obligation to arrange for the patient's transfer to an appropriate facility and to provide the necessary medical information along with the patient.

A hospital policy or practice that relies on calling 9-1-1 in order for EMS to substitute its emergency response capabilities for those the hospital is required to maintain, as described above, is not consistent with the Medicare CoPs. For example, a hospital may not rely upon 9-1-1 to provide appraisal and initial treatment of medical emergencies that occur at the hospital. Such policy or practice should be considered as condition-level non-compliance with the applicable CoP, 42 CFR 482.55 or 42 CFR 482.12(f).

Survey Procedures §482.12(f)(2)

- Verify that the medical staff has adopted written policies and procedures for the management of medical emergencies.
- Review emergency care policies and procedures. Are they consistent with the expectations articulated above for appraisal, initial treatment, and referral? Do they address emergency procedures for all on-campus and off-campus locations?

- Interview hospital staff at various locations. Can they state their duties and what they are to do if an individual seeks or needs emergency care at their location?

A-0094
(Rev. 37, Issued: 10-17-08; Effective/Implementation Date: 10-17-08)

§482.12(f)(3) If emergency services are provided at the hospital but are not provided at one or more off-campus departments of the hospital, the governing body of the hospital must assure that the medical staff has written policies and procedures in effect with respect to the off-campus department(s) for appraisal of emergencies and referral when appropriate.
Interpretive Guidelines §482.12(f)(3)

This requirement applies to any off-campus hospital department/location that does not qualify as a dedicated emergency department in accordance with 42 CFR 489.24(b) and is part of a hospital that provides emergency services. Such departments/locations must have and must implement medical staff policies and procedures for the appraisal of emergencies and referral when appropriate.

- **Appraisal of Persons with Emergencies:** A hospital must have medical staff policies and procedures for conducting appraisals of persons with emergencies at off-campus departments/locations that are not dedicated emergency departments. The policies and procedures must ensure that clinical personnel -- who are qualified, through a combination of education, licensure, and training, to conduct an assessment that enables them to recognize the fact that a person has a need for emergency care -- are available during all hours of operation at the off-campus department/location.

- **Referral when Appropriate:** A hospital must have medical staff policies and procedures to address situations in which a person's emergency needs may exceed the capabilities of the off-campus departments/locations that are not dedicated emergency departments. The policies and procedures should be designed to enable staff members at such locations to: (a) recognize when a person requires a referral or transfer, and (b) assure appropriate handling of the transfer. This includes arrangement for appropriate transport of the patient along with the transfer of the patient's medical information so that the receiving hospital may treat the medical emergency more efficiently.

- **Initial Treatment:** Although there is no specific regulatory requirement for such off-campus departments or locations to provide initial treatment of emergencies, nevertheless they are expected to provide treatment and stabilization consistent with the complexity of services, the type and qualifications of clinical staff, and the resources available at that location. This expectation is based on the requirements of the Outpatient Services CoP that hospital outpatient services meet the needs of the patients in accordance with acceptable standards of practice, outpatient services must be appropriately organized and integrated with inpatient services, and outpatient services must have appropriate professional and nonprofessional personnel available. For example, an off-campus cardiac rehabilitation clinic would be expected to have the appropriate qualified staff, equipment (such as a crash cart), and policies and procedures in place to appropriately provide appraisal, initial interventions, and referral of a patient who experiences a cardiac emergency.

- A hospital policy or practice that relies on calling 9-1-1 in order for EMS to substitute its emergency response capabilities for those the hospital is required to maintain at its off-campus departments/locations, as described above, is not consistent with the Medicare CoPs. However, given the more limited emergency capabilities that may be present in some off-campus departments or locations, calling 9-1-1 to respond to an emergency might be appropriate.

See the hospital emergency services CoP (42 CFR 482.55) for the emergency requirements for the hospital's locations that provide emergency services.

Survey Procedures §482.12(f)(3)

- Review emergency care policies and procedures. Determine if they address emergency procedures for all off-campus locations.

- Interview off-campus hospital department staff. Can they state their duties and what they are to do if an individual seeks emergency care?

APPENDIX F

Knox-Keene Act Provisions

Source: **California Health and Safety Code Sections 1262.8 and 1371.4**
www.leginfo.legislature.ca.gov
Title 28, California Code of Regulations, Section 1300.71.4
www.calregs.com

California Health and Safety Code Section 1262.8

1262.8. (a) Poststabilization care; billing prohibited; prior authorization; duties of health care service plan or contracting medical provider; transfer of patient

A noncontracting hospital shall not bill a patient who is an enrollee of a health care service plan for post-stabilization care, except for applicable co-payments, coinsurance, and deductibles, unless one of the following conditions are met:

(1) The patient or the patient's spouse or legal guardian refuses to consent, pursuant to subdivision (f), for the patient to be transferred to the contracting hospital as requested and arranged for by the patient's health care service plan.

(2) The hospital is unable to obtain the name and contact information of the patient's health care service plan as provided in subdivision (c).

(b) If a patient with an emergency medical condition, as defined by Section 1317.1, is covered by a health care service plan that requires prior authorization for post-stabilization care, a noncontracting hospital, except as provided in subdivision (n), shall, prior to providing post-stabilization care, do all of the following once the emergency medical condition has been stabilized, as defined by Section 1317.1:

(1) Seek to obtain the name and contact information of the patient' s health care service plan. The hospital shall document its attempt to ascertain this information in the patient's medical record, which shall include requesting the patient's health care service plan member card or asking the patient, or a family member or other person accompanying the patient, if he or she can identify the patient's health care service plan, or any other means known to the hospital for accurately identifying the patient's health care service plan.

(2) Contact the patient's health care service plan, or the health plan's contracting medical provider, for authorization to provide post-stabilization care, if identification of the plan was obtained pursuant to paragraph (1).

(A) The hospital shall make the contact described in this subparagraph by either following the instructions on the patient's health care service plan member card or using the contact information provided by the patient's health care service plan pursuant to subdivision (j) or (k).

(B) A representative of the hospital shall not be required to make more than one telephone call to the health care service plan, or its contracting medical provider, provided that in all cases the health care service plan, or its contracting medical provider, shall be able to reach a representative of the hospital upon returning the call, should the plan, or its contracting medical provider, need to call back. The representative of the hospital who makes the telephone call may be, but is not required to be, a physician and surgeon.

(3) Upon request of the patient's health care service plan, or the health plan's contracting medical provider, provide to the plan, or its contracting medical provider, the treating physician and surgeon' s diagnosis and any other relevant information reasonably necessary for the health care service plan or the plan's contracting medical provider to make a decision to authorize post-stabilization care or to assume management of the patient's care by prompt transfer.

(c) A noncontracting hospital that is not able to obtain the name and contact information of the patient's health care service plan pursuant to subdivision (b) is not subject to the requirements of this section.

(d)(1) A health care service plan, or its contracting medical provider, that is contacted by a noncontracting hospital pursuant to paragraph (2) of subdivision (b), shall, within 30 minutes from the time the noncontracting hospital makes the initial contact, do either of the following:

(A) Authorize post-stabilization care.

(B) Inform the noncontracting hospital that it will arrange for the prompt transfer of the enrollee to another hospital.

(2) If the health care service plan, or its contracting medical provider, does not notify the noncontracting hospital of its decision pursuant to paragraph (1) within 30 minutes, the post-stabilization care shall be deemed authorized, and the health care service plan, or its contracting medical provider, shall pay charges for the care, in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2) and any regulation adopted thereunder.

(3) If the health care service plan, or its contracting medical provider, notified the noncontracting hospital that it would assume management of the patient's care by prompt transfer, but either the health care service plan or its contracting medical provider fails to transfer the patient within a reasonable time, the post-stabilization care shall be deemed authorized, and the health care service plan, or its contracting medical provider, shall pay charges, in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) and any regulation adopted thereunder, for the care until the enrollee is transferred.

(4) If the health care service plan, or its contracting medical provider, provides authorization to the noncontracting hospital for specified post-stabilization care and services, the health care service plan, or its contracting medical provider, shall be responsible to pay for that authorized care.

(e) If a health care service plan, or its contracting medical provider, decides to assume management of the patient's care by prompt transfer, the health care service plan, or its contracting medical provider, shall do all of the following:

(1) Arrange and pay the reasonable charges associated with the transfer of the patient.

(2) Pay for all of the immediately required medically necessary care rendered to the patient prior to the transfer in order to maintain the patient's clinical stability.

(3) Be responsible for making all arrangements for the patient's transfer, including, but not limited to, finding a contracted facility available for the transfer of the patient.

(f) (1) If the patient, or the patient's spouse or legal guardian refuses to consent to the patient's transfer under subdivision (e), the noncontracting hospital shall promptly provide a written notice to the patient or the patient's spouse or legal guardian indicating that the patient will be financially responsible for any further post-stabilization care provided by the hospital.

(2) For patients whose primary language is one of the Medi-Cal threshold languages, the notice shall be delivered to them in their primary language.

(3) The Department of Managed Health Care shall translate the notice required by this subdivision in all Medi-Cal threshold languages and make the translations available to the hospitals subject to this section.

(4) The written notice provided pursuant to this subdivision shall include the following statement:

THIS NOTICE MUST BE PROVIDED TO YOU UNDER CALIFORNIA LAW

"You have received emergency care at a hospital that is not a part of your health plan's provider network. Under state law, emergency care must be paid by your health plan no matter where you get that care. The doctor who is caring for you has decided that you may be safely moved to another hospital for the additional care you need. Because you no longer need emergency care, your health plan has not authorized further care at this hospital. Your health plan has arranged for you to be moved to a hospital that is in your health plan's provider network.

If you agree to be moved, your health plan will pay for your care at that hospital. You will only have to pay for your deductible, co-payments, or coinsurance for care. You will not have to pay for your deductible, co-payments, or coinsurance for transportation costs to another hospital that is covered by your health plan.

IF YOU CHOOSE TO STAY AT THIS HOSPITAL FOR YOUR ADDITIONAL CARE, YOU WILL HAVE TO PAY THE FULL COST OF CARE NOW THAT YOU NO LONGER NEED EMERGENCY CARE. This cost may include the cost of the doctor or doctors, the hospital, and any laboratory, radiology, or other services that you receive.

If you do not think you can be safely moved, talk to the doctor about your concerns. If you would like additional help, you may contact:

Your health plan member services department. Look on your health plan member card for that phone number. You can file a grievance with your plan.

The HMO Helpline at 888-HMO-2219. The HMO Helpline is available 24 hours a day, 7 days a week. The HMO Helpline can work with your health plan to address your concerns, but you may still have to pay the full cost of care at this hospital if you stay."

(5) The hospital shall give one copy of the written notice required by this subdivision to the patient, or the patient's spouse or legal guardian, for signature and may retain a copy in the patient' s medical record.

(6) The hospital shall ensure prompt delivery of the notice to the patient or his or her spouse or legal guardian. The hospital shall obtain signed acceptance of the written notice required by this subdivision, and signed acceptance of any other documents the hospital requires for any further post-stabilization care, from the patient or the patient's spouse or legal guardian, and shall provide the health care service plan, or its contracting medical provider, with confirmation of the patient's, or his or her spouse or legal guardian's, receipt of the written notice.

(7) If the noncontracting hospital fails to meet the requirements of this subdivision, the hospital shall not bill the patient or the patient's health care service plan, or its contracting medical provider, for post-stabilization care provided to the patient.

(8) If the patient, or the patient's spouse or legal guardian, refuses to sign the notice, the noncontracting hospital shall document in the patient's medical record that the notice was provided and signature was refused. Upon the patient's refusal to sign, the patient shall assume financial responsibility for any further post-stabilization care provided by the hospital.

(9) The Department of Managed Health Care may, by regulation, modify the wording of the notice required under this subdivision for clarity, readability, and accuracy of the information provided.

(10) The Department of Managed Health Care may, in conjunction with consumer groups, health care service plans, and hospitals, modify the wording of the notice to include language regarding Medicare beneficiaries, if appropriate under Medicare rules. The initial modification shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340, et. seq.) of Part 1 of Division 3 of Title 2 of the Government Code).

(g) If post-stabilization care has been authorized by the health care service plan, the noncontracting hospital shall request the patient's medical record from the patient's health care service plan or its contracting medical provider.

(h) The health care service plan, or its contracting medical provider, shall, upon conferring with the noncontracting hospital, transmit any appropriate portion of the patient's medical record, if the records are in the plan's possession, via facsimile transmission or electronic mail, whichever method is requested by the noncontracting hospital's representative or the noncontracting physician and surgeon. The health care service plan, or its contracting medical provider, shall transmit the patient's medical record in a manner that complies with all legal requirements to protect the patient's privacy.

(i) A health care service plan, or its contracting medical provider, that requires prior authorization for post-stabilization care shall provide 24-hour access for patients and providers, including noncontracting hospitals, to obtain timely authorization for medically necessary post-stabilization care.

(j) A health care service plan shall provide all noncontracting hospitals in the state with specific contact information needed to make the contact required by this section. The contact information provided to hospitals shall be updated as necessary, but no less than once a year.

(k) In addition to meeting the requirements of subdivision (j), a health care service plan shall provide the contact information described in subdivision (j) to the Department of Managed Health Care. The contact information provided pursuant to this subdivision shall be updated as necessary, but no less than once a year. The receiving department shall post this contact information on its Internet Web site no later than January 1 of each calendar year.

(l) This section shall only apply to a noncontracting hospital.

(m) For purposes of this section, the following definitions shall apply:

(1) **"Health care service plan"** means a health care service plan licensed pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 that covers hospital, medical, or surgical expenses.

(2) **"Noncontracting hospital"** means a general acute care hospital, as defined in subdivision (a) of Section 1250 or an acute psychiatric hospital, as defined in subdivision (b) of Section 1250, that does not have a written contract with the patient's health care service plan to provide health care services to the patient.

(3) **"Poststabilization care"** means medically necessary care provided after an emergency medical condition has been stabilized, as defined by subdivision (j) of Section 1317.1.

(4) **"Contracting medical provider"** means a medical group, independent practice association, or any other similar organization that, pursuant to a signed written contract, has agreed to accept responsibility for provision or reimbursement of a noncontracting hospital for emergency and post-stabilization services provided to a health plan's enrollees.

(n) Subdivisions (b) to (h), inclusive, shall not apply to minor treatment procedures, if all of the following apply:

(1) The procedure is provided in the treatment area of the emergency department.

(2) The procedure concludes the treatment of the presenting emergency medical condition of a patient and is related to that condition, even though the treatment may not resolve the underlying medical condition.

(3) The procedure is performed according to accepted standards of practice.

(4) The procedure would result in the direct discharge or release of the patient from the emergency department following this care.

(o) Nothing in this section is intended to prevent a health care service plan or its contracting medical provider from assuming management of the patient's care at any time after the initial provision of post-stabilization care by the noncontracting hospital before the patient has been discharged. Upon the request of the health care service plan or its contracting medical provider, the noncontracting hospital shall provide the health care service plan or its contracting medical provider with any information specified in paragraph (3) of subdivision (b).

(p) Nothing in this section shall authorize a provider of health care services to bill a Medi-Cal beneficiary enrolled in a Medi-Cal managed care plan or otherwise alter the provisions of subdivision (a) of Section 14019.3 of the Welfare and Institutions Code.

California Health and Safety Code Section 1371.4

1371.4. (a) Emergency services and care; authorization; payments to providers; treatment following stabilization; payments to providers; assumption and delegation of responsibilities

A health care service plan that covers hospital, medical, or surgical expenses, or its contracting medical providers, shall provide 24-hour access for enrollees and providers, including, but not limited to, noncontracting hospitals, to obtain timely authorization for medically necessary care, for circumstances where the enrollee has received emergency services and care is stabilized, but the treating provider believes that the enrollee may not be discharged safely. A physician and surgeon shall be available for consultation and for resolving disputed requests for authorizations. A health care service plan that does not require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition or active labor need not satisfy the requirements of this subdivision.

(b) A health care service plan, or its contracting medical providers, shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee, except as provided in subdivision (c). As long as federal or state law requires that emergency services and care be provided without first questioning the patient's ability to pay, a health care service plan shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition.

(c) Payment for emergency services and care may be denied only if the health care service plan, or its contracting medical providers, reasonably determines that the emergency services and care were never performed; provided that a health care service plan, or its contracting medical providers, may deny reimbursement to a provider for a medical screening examination in cases when the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist. A health care service plan may require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition.

(d) If there is a disagreement between the health care service plan and the provider regarding the need for necessary medical care, following stabilization of the enrollee, the plan shall assume responsibility for the care of the patient either by having medical personnel contracting with the plan personally take over the care of the patient within a reasonable amount of time after the disagreement, or by having another general acute care hospital under contract with the plan agree to accept the transfer of the patient as provided in Section 1317.2, Section 1317.2a, or other pertinent statute. However, this requirement shall not apply to necessary medical care provided in hospitals outside the service area of the health care service plan. If the health care service plan fails to satisfy the requirements of this subdivision, further necessary care shall be deemed to have been authorized by the plan. Payment for this care may not be denied.

(e) A health care service plan may delegate the responsibilities enumerated in this section to the plan's contracting medical providers.

(f) Subdivisions (b), (c), (d), (g), and (h) shall not apply with respect to a nonprofit health care service plan that has 3,500,000 enrollees and maintains a prior authorization system that includes the availability by telephone within 30 minutes of a practicing emergency department physician.

(g) The Department of Managed Health Care shall adopt by July 1, 1995, on an emergency basis, regulations governing instances when an enrollee requires medical care following stabilization of an emergency medical condition, including appropriate timeframes for a health care service plan to respond to requests for treatment authorization.

(h) The Department of Managed Health Care shall adopt, by July 1, 1999, on an emergency basis, regulations governing instances when an enrollee in the opinion of the treating provider requires necessary medical care following stabilization of an emergency medical condition, including appropriate timeframes for a health care service plan to respond to a request for treatment authorization from a treating provider who has a contract with a plan.

(i) The definitions set forth in Section 1317.1 shall control the construction of this section.

(j) (1) A health care service plan that is contacted by a hospital pursuant to Section 1262.8 shall, within 30 minutes of the time the hospital makes the initial telephone call requesting information, either authorize post-stabilization care or inform the hospital that it will arrange for the prompt transfer of the enrollee to another hospital.

(2) A health care service plan that is contacted by a hospital pursuant to Section 1262.8 shall reimburse the hospital for post-stabilization care rendered to the enrollee if any of the following occur:

(A) The health care service plan authorizes the hospital to provide post-stabilization care.

(B) The health care service plan does not respond to the hospital' s initial contact or does not make a decision regarding whether to authorize post-stabilization care or to promptly transfer the enrollee within the timeframe set forth in paragraph (1).

(C) There is an unreasonable delay in the transfer of the enrollee, and the noncontracting physician and surgeon determines that the enrollee requires post-stabilization care.

(3) A health care service plan shall not require a hospital representative or a noncontracting physician and surgeon to make more than one telephone call pursuant to Section 1262.8 to the number provided in advance by the health care service plan. The representative of the hospital that makes the telephone call may be, but is not required to be, a physician and surgeon.

(4) An enrollee who is billed by a hospital in violation of Section 1262.8 may report receipt of the bill to the health care service plan and the department. The department shall forward that report to the State Department of Public Health.

(5) For purposes of this section, "post-stabilization care" means medically necessary care provided after an emergency medical condition has been stabilized.

Title 28, California Code of Regulations, Section 1300.71.4

1300.71.4. Emergency Medical Condition and Post-Stabilization Responsibilities for Medically Necessary Health Care Services.

The following rules set forth emergency medical condition and post-stabilization responsibilities for medically necessary health care services after stabilization of an emergency medical condition and until an enrollee can be discharged or transferred. These rules do not apply to a

specialized health care service plan contract that does not provide for medically necessary health care services following stabilization of an emergency condition.

(a) Prior to stabilization of an enrollee's emergency medical condition, or during periods of destabilization (after stabilization of an enrollee's emergency medical condition) when an enrollee requires immediate medically necessary health care services, a health care service plan shall pay for all medically necessary health care services rendered to an enrollee.

(b) In the case when an enrollee is stabilized but the health care provider believes that the enrollee requires additional medically necessary health care services and may not be discharged safely, the following applies:

(1) A health care service plan shall approve or disapprove a health care provider's request for authorization to provide necessary post-stabilization medical care within one half hour of the request.

(2) If a health care service plan fails to approve or disapprove a health care provider's request for authorization to provide necessary post-stabilization medical care within one half-hour of the request, the necessary post-stabilization medical care shall be deemed authorized. Notwithstanding the foregoing sentence, the health care service plan shall have the authority to disapprove payment for (A) the delivery of such necessary post-stabilization medical care or (B) the continuation of the delivery of such care; provided, that the health care service plan notifies the provider prior to the commencement of the delivery of such care or during the continuation of the delivery of such care (in which case, the plan shall not be obligated to pay for the continuation of such care from and after the time it provides such notice to the provider, subject to the remaining provisions of this paragraph) and in both cases the disruption of such care (taking into account the time necessary to effect the enrollee's transfer or discharge) does not have an adverse impact upon the efficacy of such care or the enrollee's medical condition.

(3) Notwithstanding the provisions of subsection (b) of this rule, a health care service plan shall pay for all medically necessary health care services provided to an enrollee which are necessary to maintain the enrollee's stabilized condition up to the time that the health care service plan effectuates the enrollee's transfer or the enrollee is discharged.

(c) In the case where a plan denies the request for authorization of post-stabilization medical care and elects to transfer an enrollee to another health care provider, the following applies:

(1) When a health care service plan responds to a health care provider's request for post-stabilization medical care authorization by informing the provider of the plan's decision to transfer the enrollee to another health care provider, the plan shall effectuate the transfer of the enrollee as soon as possible,

(2) A health care service plan shall pay for all medically necessary health care services provided to an enrollee to maintain the enrollee's stabilized condition up to the time that the health care service plan effectuates the enrollee's transfer.

(d) All requests for authorizations, and all responses to such requests for authorizations, of post-stabilization medically necessary health care services shall be fully documented. All provision of medically necessary health care services shall be fully documented. Documentation shall include, but not be limited to, the date and time of the request, the name of the health care provider making the request, and the name of the plan representative responding to the request.

APPENDIX G

Medicare Advantage Regulations

Source: Title 42, Code of Federal Regulations, Section 422.113
www.ecfr.gov

Sec. 422.113 Special rules for ambulance services, emergency and urgently needed services, and maintenance and post-stabilization care services.

(a) *Ambulance services.* The MA organization is financially responsible for ambulance services, including ambulance services dispatched through 911 or its local equivalent, where other means of transportation would endanger the beneficiary's health.

(b) *Emergency and urgently needed services—*

(1) *Definitions.*

(i) **"Emergency medical condition"** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

(A) Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;

(B) Serious impairment to bodily functions; or

(C) Serious dysfunction of any bodily organ or part.

(ii) **"Emergency services"** means covered inpatient and outpatient services that are—

(A) Furnished by a provider qualified to furnish emergency services; and

(B) Needed to evaluate or stabilize an emergency medical condition.

(iii) **"Urgently needed services"** means covered services that are not emergency services as defined this section, provided when an enrollee is temporarily absent from the MA plan's service (or, if applicable, continuation) area (or provided when the enrollee is in the service or continuation area but the organization's provider network is temporarily unavailable or inaccessible) when the services are medically necessary and immediately required—

(A) As a result of an unforeseen illness, injury, or condition; and

(B) It was not reasonable given the circumstances to obtain the services through the organization offering the MA plan.

(2) *MA organization financial responsibility.* The MA organization is financially responsible for emergency and urgently needed services—

(i) Regardless of whether the services are obtained within or outside the MA organization;

(ii) Regardless of whether there is prior authorization for the services.

(A) Instructions to seek prior authorization for emergency or urgently needed services may not be included in any materials furnished to enrollees (including wallet card instructions), and enrollees must be informed of their right to call 911.

(B) Instruction to seek prior authorization before the enrollee has been stabilized may not be included in any materials furnished to providers (including contracts with providers);

(iii) In accordance with the prudent layperson definition of *emergency medical condition* regardless of final diagnosis;

(iv) For which a plan provider or other MA organization representative instructs an enrollee to seek emergency services within or outside the plan; and

(v) With a limit on charges to enrollees for emergency department services that CMS will determine annually, or what it would charge the enrollee if he or she obtained the services through the MA organization, whichever is less.

(3) *Stabilized condition.* The physician treating the enrollee must decide when the enrollee may be considered stabilized for transfer or discharge, and that decision is binding on the MA organization.

(c) *Maintenance care and post-stabilization care services* (hereafter together referred to as "post-stabilization care services").

(1) *Definition.* **"Post-stabilization care services"** means covered services, related to an emergency medical condition, that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or, under the circumstances described in paragraph (c)(2)(iii) of this section, to improve or resolve the enrollee's condition.

(2) *MA organization financial responsibility.* The MA organization—

(i) Is financially responsible (consistent with Section 422.214) for post-stabilization care services obtained within or outside the MA organization that are pre-approved by a plan provider or other MA organization representative;

(ii) Is financially responsible for post-stabilization care services obtained within or outside the MA organization that are not pre-approved by a plan provider or other MA organization representative, but administered to maintain the enrollee's stabilized condition within 1 hour of a request to the MA organization for pre-approval of further post-stabilization care services;

(iii) Is financially responsible for post-stabilization care services obtained within or outside the MA organization that are not pre-approved by a plan provider or other MA organization representative, but administered to maintain, improve, or resolve the enrollee's stabilized condition if—

(A) The MA organization does not respond to a request for pre-approval within 1 hour;

(B) The MA organization cannot be contacted; or

(C) The MA organization representative and the treating physician cannot reach an agreement concerning the enrollee's care and a plan physician is not available for consultation. In this situation, the MA organization must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in Section 422.113(c)(3) is met; and

(iv) Must limit charges to enrollees for post-stabilization care services to an amount no greater than what the organization would charge the enrollee if he or she had obtained the services through the MA organization. For purposes of cost sharing, post-stabilization care services begin upon inpatient admission.

(3) *End of MA organization's financial responsibility.* The MA organization's financial responsibility for post-stabilization care services it has not pre-approved ends when—

(i) A plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care;

(ii) A plan physician assumes responsibility for the enrollee's care through transfer;

(iii) An MA organization representative and the treating physician reach an agreement concerning the enrollee's care; or

(iv) The enrollee is discharged.

APPENDIX H

Special Advisory Bulletin

Source: **U.S. Department of Health and Human Services**
Office of Inspector General and Health Care Financing Administration
(Editor's Note: HCFA is now called the Centers for Medicare & Medicaid Services.)
www.oig.hhs.gov/fraud/docs/alertsandbulletins/frdump.pdf
64 Fed.Reg. 61353 (Nov. 10, 1999)

OIG/HCFA SPECIAL ADVISORY BULLETIN ON THE PATIENT ANTI-DUMPING STATUTE

AGENCY: Office of Inspector General (OIG) and Health Care Financing Administration (HCFA), HHS.

ACTION: Notice.

SUMMARY: This **Federal Register** notice, developed jointly by the OIG and HCFA, sets forth the Special Advisory Bulletin addressing requirements of the patient anti-dumping statute and the obligations of hospitals to medically screen all patients seeking emergency services and provide stabilizing medical treatment as necessary to all patients, including enrollees of managed care plans, whose conditions warrant it. In developing this Special Advisory Bulletin, our goal is to provide clear and meaningful advice with regard to the application of the anti-dumping provisions, and to ensure greater public awareness of hospitals' obligations in providing emergency medical services to those individuals insured by managed care plans.

FOR FURTHER INFORMATION CONTACT:

Robin Schneider, Office of Counsel to the Inspector General, (202) 619-1306.

SUPPLEMENTARY INFORMATION:

Background

In an effort to identify and eliminate fraud, waste and abuse in the Department's health care programs, the OIG periodically develops and issues Special Fraud Alerts and, with the cooperation of HCFA, Advisory Bulletins to alert health care providers and program beneficiaries about potential problems. On December 7, 1998, the OIG and HCFA jointly published a **Federal Register** notice (63 FR 67486) seeking input and comments from interested parties on a proposed bulletin designed to address the principal requirements of the patient anti-dumping statute—known as the Emergency Medical Treatment and Labor Act (EMTALA)—(section 1867 of the Social Security Act (the Act)) and to discuss how the requirements of that statutory provision apply to individuals insured by managed care plans. Section 1867 of the Act imposes specific obligations on Medicare-participating hospitals that

offer emergency services with respect to individuals coming to the hospital and seeking treatment of possible emergency medical conditions. Specifically, the draft Special Advisory Bulletin sought to address: (1) The obligations of hospitals to provide appropriate medical screening examinations to all patients seeking emergency services and stabilizing treatment when necessary; (2) Some of the special concerns in the provision of emergency services to enrollees of managed care plans; (3) The rules governing Medicare and Medicaid managed care plans with respect to prior authorization requirements and payment for emergency services; and (4) what types of practices would serve to promote hospital compliance with the patient anti-dumping statute when managed care enrollees seek emergency services.

The proposed Special Advisory Bulletin attempted to be consistent with policies set forth in the *HCFA State Operations Manual on Provider Certification* (Transmittal No. 2, May 1998) which provides guidelines and investigative procedures for reviewing the responsibilities of Medicare participating hospitals. Hospitals should also be aware that regulations at 42 CFR part 422 implementing section 1852(d) of the Act govern Medicare+Choice organizations' obligations to pay for emergency services without regard to prior authorization or the treating hospital's relationship with the plan.

Summary of Major Issues Raised

The major issues raised by the over 150 commenters concerned dual staffing, prior authorization, the use of financial responsibility forms and advanced beneficiary notifications, and the handling of patient inquiries regarding the obligation to pay for emergency services. Additional comments were also received concerning voluntary withdrawal and the reporting of alleged patient dumping violations.

1. Dual Staffing

The majority of comments expressed concern about the impact of dual staffing in hospital emergency departments (EDs), and many expressed the view that dual staffing would lead to disparate standards in the ED by fostering "separate but unequal treatment." Possible disparate standards cited dealt with physician credentialing, drug formularies, equal access and use of ancillary services, consistency in specialty referrals, waiting times and quality assurance. A number of emergency physicians commenting on the proposed bulletin indicated that dual staffing would function to protect the financial interests of managed care organizations rather than provide the highest quality of care to individuals; many hospitals believed that dual staffing would add layers of bureaucracy to the system thereby disrupting and delaying patient care. Of course, there may be countervailing considerations relating to the benefits of flexibility and creativity in structuring health delivery systems, and there is a lack of data to support some assertions by those opposing dual staffing. For the Federal Government to prohibit in advance, on a national level, arrangements which might increase access to health care services would require some greater likelihood of risk or harm than we currently foresee. (In this context, we note that States are able to restrict or prohibit dual staffing arrangements within their borders.) It may or may not become evident that dual

staffing impedes the goals of EMTALA, or that it advances publicly beneficial goals of managed care and other innovations in health care delivery, such as coordination of services and health promotion. If we were to declare that all dual staffing arrangements violate EMTALA, we might unnecessarily prevent the development of health care delivery practices which could improve access to health care.

Thus, we have concluded that while dual staffing raises serious issues, it would not necessarily constitute a *per se* violation of the anti-dumping statute. However, certain practices or occurrences that could arise in a dually staffed emergency department or service could violate EMTALA. Examples of these potential violations are described below.

2. Prior Authorization

While supportive of the "no prior authorization" best practice outlined in the proposed bulletin, many commenters argued for expanding the reach of this approach beyond the current authority of HCFA and the OIG as well as the patient anti-dumping statute, by making the policy applicable not only to hospitals but also to health plans. Several commenters expressed concern that hospitals are being forced to accept the contracts offered by managed care plans, although they realize that if they comply with the prior authorization requirements in the contract, the hospital could be in violation of the patient anti-dumping statute. Commenters further indicated that unless prior authorization requirements are abandoned or prohibited altogether, huge bills could result for patients whose care had not been authorized in advance. Commenters also stated that the "prudent layperson" standard does not sufficiently protect a hospital's interest in receiving payment for the emergency services provided.

We were unable to resolve many of the commenters' concerns because we do not have the authority under the patient anti-dumping statute to mandate reimbursement for emergency services or to regulate non-Medicare and non-Medicaid managed care plans. However, we have amended the prior authorization section of the bulletin slightly to make it absolutely clear that an emergency physician is free to phone a physician in a managed care plan at any time for a medical consultation when it is in the best interest of the patient. Further, we have clarified that once stabilizing treatment is under way, a managed care plan may be contacted for payment authorization.

3. Use of Advance Beneficiary Notices (ABNs) or Other Financial Responsibility Forms

With regard to the use of ABNs, commenters indicated that Medicare requires ABNs to be provided to beneficiaries if the hospital is to be permitted to bill the beneficiary later for a non-covered service, even for services provided in an emergency context. Thus, if a Medicare managed care patient arrived at the hospital and the ED physician was concerned that the plan may not cover the service, the physician *must* have the patient sign an ABN or else be precluded from billing the patient for the service if the plan does not pay. Several comments indicated that many hospitals are using ABNs for non-Medicare patients as well,

even though these hospitals should be able to bill these patients for services in any case. A number of commenters opposed making it a "best practice" for hospitals not to ask patients to complete financial responsibility forms upon registration, indicating that it is common practice that standard consent forms are signed at the time of registration which include an agreement that the patient will pay for services not covered by insurance. Commenters expressed the view that as long as this practice does not cause delay in screening and stabilization, it would be very inefficient for a hospital to have to engage in "split registration."

It continues to be our view that a hospital would violate the patient anti-dumping statute if it delayed a medical screening examination or necessary stabilizing treatment in order to prepare an ABN and obtain a beneficiary signature. The best practice would be for a hospital *not to give* financial responsibility forms or notices to an individual, or otherwise attempt to obtain the individual's agreement to pay for services before the individual's stabilizing treatment is under way. This is because the circumstances surrounding the need for such services, and the individual's limited information about his or her medical condition, may not permit an individual to make a rational, informed consumer decision.

It normally is permissible to ask for general registration information prior to performing an appropriate medical screening examination. The hospital may not, however, condition such a screening and further treatment upon the individual's completion of a financial responsibility form or provision of a co-payment for any services. Such a practice could unduly deter the individual from remaining at the hospital to receive care to which he or she is entitled and which the hospital is obligated to provide regardless of ability to pay, and could cause unnecessary delay.

With respect to the use of financial responsibility forms, we believe that many commenters mistakenly interpreted the proposed bulletin as an attempt to derail the use of reasonable hospital registration procedures that do not conflict with the goals of the Patient Anti-Dumping Statute. We did not mean to give that impression. We are therefore clarifying this portion of the Special Advisory Bulletin consistent with the specific language set forth in the *HCFA State Operations Manual,* Interpretive Guidelines of May 1998, regarding registration processes permitted in the ED, which typically include the collection of demographic information, insurance information, whom to contact in an emergency and other relevant information. Specifically, the Interpretive Guidelines indicate that a hospital "may continue to follow reasonable registration processes for individuals presenting with an emergency medical condition." Reasonable registration processes should not unduly discourage individuals from remaining for further evaluation. Reasonable registration processes may include asking whether an individual is insured and, if so, what that insurance is, as long as this inquiry does not delay screening or treatment.

We are also clarifying that, while a reasonable registration process may go forward prior to screening for an individual who is not in an acute emergency situation, it would be

impermissible for a hospital to condition a screening examination or the commencement of necessary stabilizing treatment on completion of a financial responsibility form.

4. Inquiries Concerning Financial Liability for Emergency Services by the Individual

With regard to a hospital's handling of patient inquiries regarding the patient's obligation to pay for emergency services, we recommended in the proposed bulletin that such questions be answered by qualified personnel. We also recommended that hospital staff encourage a patient who believes that he or she may have an emergency medical condition to defer any further discussions of financial responsibility until after the provision of an appropriate medical screening examination and the provision of stabilizing treatment if the patient's condition warrants it. Many commenters disagreed with this recommendation, indicating that such a deferral may have the opposite of the intended result, since patients who are unable to determine their potential financial liability may be discouraged from staying at the hospital to receive an examination or treatment. As an alternative, commenters recommended that hospital staff be permitted to respond to patient inquiries with specific financial information so long as the hospital continues to offer, and encourages the patient to stay for, a medical screening examination. In addition, commenters were concerned that the absence of full and frank disclosure between physicians and patients regarding treatment options, insurance coverage and follow-up treatment would inhibit the examination and treatment process. These commenters recommended allowing conversations about financial liability issues to take place between hospital staff and patients so long as such discussions do not delay screening and treatment.

We have not substantially revised this section. We believe that it already makes clear that any inquiry about financial liability should be answered as fully as possible by a qualified individual. Alternatives suggested by the commenters would be acceptable if such alternatives did not conflict with a minimum effort to defer discussions about financial liability issues until after the provision of screening and the commencement of stabilizing treatment. This section does not suggest that a patient is not entitled to full disclosure, only that the hospital should always convey to the patient that screening and stabilization are its priorities regardless of the individual's insurance coverage or ability to pay and that the hospital should discuss, to the extent possible, the medical risks of leaving without a medical screening exam and/or stabilizing treatment.

5. Voluntary Withdrawal

Commenters also raised concerns about the hospital's obligation in the event of voluntary withdrawal by an individual, and the proposed bulletin's suggestion that a number of procedures be followed and documented when a patient elects to withdraw his or her request for treatment. Commenters believed that the proposed procedures do not make allowance for those times when a hospital is not aware of the individual's departure until after he or she has left the hospital. Commenters recommended that the steps set forth in the draft bulletin should apply only when the hospital knows of the withdrawal, that is, when possible, and that

when a person leaves without telling hospital staff, a hospital be required to document the fact that a patient simply left without notice and retain the log that shows that the person had been there and what time the hospital discovered that the patient had left. We have revised this section to some extent. However, it is our view that hospitals should be very concerned about patients leaving without being screened. Since every patient who presents seeking emergency services is entitled to a screening examination, a hospital could violate the patient anti-dumping statute if it routinely keeps patients waiting so long that they leave without being seen, particularly if the hospital does not attempt to determine and document why individual patients are leaving, and reiterate to them that the hospital is prepared to provide a medical screening if they stay.

In accordance with our assessment of the comments and issues raised, set forth below is the revised OIG/HCFA Special Advisory Bulletin addressing the patient dumping statute.

OBLIGATIONS OF HOSPITALS TO RENDER EMERGENCY CARE TO ENROLLEES OF MANAGED CARE PLANS

What are the Obligations of Medicare-Participating Hospitals That Offer Emergency Services to Individuals Seeking Such Services?

- The anti-dumping statute (section 1867 of the Social Security Act; 42 U.S.C. 1395dd) sets forth the federally-mandated responsibilities of Medicare-participating hospitals to individuals with potential emergency medical conditions.

- Under the anti-dumping statute, a hospital must provide to any person who comes seeking emergency services an appropriate medical screening examination sufficient to determine whether he or she has an emergency medical condition, as defined by statute. When medically appropriate, ancillary services routinely available at the hospital must be provided as part of the medical screening examination.

- If the person is determined to have an emergency medical condition,

  –The hospital is required to stabilize the medical condition of the individual, within the capabilities of the staff and facilities available at the hospital, prior to discharge or transfer; or

  –If the patient's medical condition cannot be stabilized before a transfer requested by the patient (or responsible medical personnel determine that the medical benefits of a transfer outweigh the risks), the hospital is required to follow very specific statutory requirements designed to facilitate a safe transfer to another facility.

- A hospital may not delay the provision of an appropriate medical screening examination or further medical examination and stabilizing medical treatment in order to inquire about the individual's method of payment or insurance status.

- Regulations implementing these statutory obligations are found at 42 CFR part 489. The anti-dumping statute is enforced jointly by the Health Care Financing Administration (HCFA) and the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS).

- Sanctions that may be imposed by HHS for violations of the anti-dumping statute include the termination of the hospital's provider agreement, and the imposition of civil money penalties against both the hospital and the physician (including on-call physicians) responsible for examination, treatment, or transfer of an individual. In addition, the anti-dumping statute provides for the exclusion of such physician if the violation is gross and flagrant or repeated.

Why is there a Special Concern About the Provision of Emergency Services to Enrollees of Managed Care Plans?

Many managed care plans require their members to seek prior authorization for some medical services, including emergency services. (As explained below, a Medicare or Medicaid contracting Managed Care Organization is prohibited from requiring its members to seek prior authorization for emergency medical services.) However, as noted above, the anti-dumping statute prohibits a hospital's inquiry about a patient's method of payment or insurance status, or use of such information, from delaying a screening examination or stabilizing medical treatment. It has come to our attention that some hospitals routinely seek prior authorization from a patient's primary care physician or from the plan when a managed care patient requests emergency services, since the failure to obtain authorization may result in the plan refusing to pay for the emergency services. In such circumstances, the patient may be personally liable for the costs.

A reasonable argument can be made that patients (other than those arriving in dire condition) should be informed when they request emergency services of their potential financial liability for services. Some would go further and argue that the hospital itself should seek prior approval from the patient's health plan for emergency services to preserve the patient's right to seek coverage for such services. However, our concern is that such an inquiry may improperly or unduly influence patients to leave the hospital without receiving an appropriate medical screening examination. This result would be inconsistent with the goals of the anti-dumping statute and could leave the hospital exposed to liability under the statute.

Investigations of allegations of the anti-dumping statute violations across the country have persuaded the OIG and HCFA that managed care patients may be at risk of being discharged or transferred without receiving a medical screening examination, largely because of the problems inherent in seeking "prior authorization." Hospitals sometimes are caught between the legal obligations imposed under the anti-dumping statute and the terms of agreements which they have with managed care plans. For example, some managed care organizations, as a condition of contracting with hospitals to provide services to their enrollees, have attempted to require such hospitals to obtain prior authorization from the plan before

screening or treating an enrollee in order to be eligible for reimbursement for services provided.

The OIG's and HCFA's view of the legal requirements of the anti-dumping statute in this situation is as follows. Notwithstanding the terms of any managed care agreements between plans and hospitals, the anti-dumping statute continues to govern the obligations of hospitals to screen and provide stabilizing medical treatment to individuals who come to the hospital seeking emergency services regardless of the individual's ability to pay. While managed care plans have a financial interest in controlling the kinds of services for which they will pay, and while they may have a legitimate interest in deterring their enrollees from over-utilizing emergency services, no contract between a hospital and a managed care plan can excuse the hospital from its anti-dumping statute obligations. Once a managed care enrollee comes to a hospital that offers emergency services, the hospital must provide the services required under the anti-dumping statute without regard for the patient's insurance status or any prior authorization requirement of such insurance.[1]

What About Arrangements Between Hospitals and Managed Care Plans for "Dual Staffing" of Emergency Departments?

Some managed care organizations (MCOs) and hospitals have entered into, or are considering entering into, arrangements whereby the hospital permits the MCO to station its own physicians in the hospital's emergency department, separate from the hospital's own emergency physician staff, for the purpose of screening and treating MCO patients who request emergency services. This kind of arrangement is known as "dual staffing."

Such arrangements can exist only where they do not violate current law. Regardless of any contractual arrangement a hospital enters into to staff its emergency department, the hospital remains responsible under EMTALA to provide an appropriate medical screening examination to determine whether or not an emergency medical condition (EMC) exists. If an EMC exists, EMTALA further provides that the hospital must treat and stabilize the medical condition, unless the patient is transferred in accordance with the specific requirements of the statute.

Also, section 1867(h) of the Act provides that a participating hospital, in providing emergency medical care, "may not delay provision of an appropriate medical screening

[1] Separate and apart from the anti-dumping statute, in accordance with sections 1857(g), 1876(i)(6), 1903(m)(5) and 1932(e) of the Social Security Act, the OIG (acting on behalf of the Secretary) has the authority to impose intermediate sanctions against Medicare and Medicaid contracting managed care plans that fail to provide medically necessary services, including emergency services, to enrollees where the failure adversely affects (or has a substantial likelihood of adversely affecting) the enrollee. Medicare and Medicaid managed care plans that fail to comply with the above provision are subject to civil money penalties of up to $25,000 for each denial of medically necessary services.

examination * * * or further medical examination and treatment * * * in order to inquire about the individual's method of payment or insurance status." A dual staffing system, based on method of payment or insurance status, which creates delays in screening or stabilization violates this prohibition. Also, the hospital remains responsible under the Medicare Conditions of Participation as well as any other relevant patient protections and quality safeguards. Further, the hospital is bound by provisions that protect whistle blowers who report violations of EMTALA in dual staffing situations.

Different points of view on dual staffing exist in the health care community. It is believed by some that dual staffing in emergency departments can facilitate the expeditious provision of services to MCO patients by physicians and other practitioners in their own health plans. MCO ability to care for their patients after stabilization, or after the absence of an EMC is determined, might be enhanced by dual staffing. However, some hospitals and emergency physicians have asked us to disallow dual staffing out of concern for logistical difficulties and the perception that separate cannot be equal in a bifurcated emergency department.

If a hospital constructs two equally good emergency service "tracks," each adequately staffed and each with equally good access to all of the medical capabilities of the hospital, such that both MCO and non-MCO patients receive equal access to screening and stabilizing medical treatment, then such an arrangement would seem to not violate the requirements of the anti-dumping statute.

Absent such equivalency, implementation of dual staffing raises concerns under EMTALA. The following are potential violations:

- Where the emergency department directs a hospital-owned and operated ambulance differently in field care or facility destination depending on which members of a dual staff (that is, either MCO or non-MCO physicians or practitioners) are either on the radio to emergency medical services (EMS) or are expected to see the patient.

- If the emergency department alert status affecting acceptance of EMS cases differs depending on which "side" (MCO or non-MCO) is expected to see the patient.

- If either the MCO or non-MCO track is understaffed or simply overcrowded, and a patient in a particular track is subjected to a delay in screening and stabilizing treatment, even though a physician in the alternative track was available to see the individual. Where there is no emergency department policy or procedure, or custom or practice, which requires cross-over coverage between the dual staffs as required for patient care. (Delays in screening or stabilization of patients on one track but not the other are delays in screening or stabilization based on the insurance status of the individual and thus represent potential violations of EMTALA.)

- If the hospital's emergency department quality oversight plan differs between the two "sides" (MCO and non-MCO) of the dually staffed ED.

- Where the protocols for transfer of unstable patients differ other than administratively, for example, (1) if the substance of stability determination criteria between the two staffs are different, or (2) when patients are unstable and are transferred routinely to different facilities that are not equivalent to each other in level of care or distance, and their destinations depend on their insurance status.

While we recognize that dual staffing will add to a hospital's burden to assure that it is not violating EMTALA, we do not believe the EMTALA statute makes dual staffing illegal *per se.* We expect that practical experience with dually staffed emergency departments will reveal whether or not they can be maintained without violating EMTALA.

What Are the Rules Governing Medicare and Medicaid Managed Care Plans With Respect to Prior Authorization Requirements and Payment for Emergency Services?

There are special requirements for managed care plans that contract with Medicare and Medicaid to provide services to beneficiaries of those programs. Congress has specified that Medicare and Medicaid managed care plans may not require prior authorization for emergency services, and must pay for such services, without regard to whether the hospital providing such services has a contractual relationship with the plan. Under statutory amendments recently enacted in the Balanced Budget Act (BBA) of 1997 (Public Law 105–33)[2], Medicare and Medicaid managed care plans are prohibited from requiring prior authorization for emergency services, including those that "are needed to evaluate or stabilize an emergency medical condition." Moreover, Medicare and Medicaid managed care plans are required to pay for emergency services provided to their enrollees. The obligation to pay for emergency services under Medicare managed care contracts is based on a "prudent layperson" standard, which means that the need for emergency services should be determined from a reasonable patient's perspective at the time of presentation of the symptoms.[3]

What Practices Will Promote Compliance With the Anti-Dumping Statute by Hospitals When Managed Care Enrollees Seek Emergency Services?

The OIG and HCFA are concerned that discussion by hospital personnel with a patient regarding the possible need for prior authorization, or his or her potential financial liability

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[2] See section 4001 of the BBA, which created section 1852(d) of the Act. Section 1852(d) covers emergency services and prior authorization for Medicare enrollees. Also, section 4704(a) of the BBA created section 1932(b) of the Act, which contains Medicaid provisions covering emergency services and prior authorization.

[3] With respect to Medicare, prior authorization requirements for Medicare MCO plans were already explicitly prohibited by regulations before the passage of the BBA for emergency services provided outside an HMO or competitive medical plan (42 CFR 417.414(c)(1)), and by implication for services provided within such a plan. Similarly, while the BBA clarified and codified the ''prudent layperson'' standard, a variation of this standard has always been part of the Medicare policy for managed care plans. Even prior to the BBA, Medicare and Medicaid managed care plans were required to reimburse for emergency services provided other than through the organization. See section 1876(c)(4)(B), 42 CFR 417.414(c)(1) for Medicare and section 1903(m)(2)(A)(vii), 42 CFR 434.30(b)(2) for Medicaid.

for medical services provided by a hospital that offers emergency services, could unduly influence patients to leave the emergency department without receiving an appropriate medical screening examination or any necessary stabilizing treatment. Without also informing the patient of his or her rights to a medical screening examination and to stabilizing medical treatment if the patient's condition warrants it and the medical risks of leaving, a discussion about insurance, ability to pay and seeking prior authorization may impede a hospital's compliance with its obligations under the anti-dumping statute. Discussions initiated by a hospital staff member with a patient regarding potential prior authorization requirements and their financial consequences that have the effect of delaying a medical screening are per se violations of the anti-dumping statute. Moreover, the OIG and HCFA believe that in the absence of an initial screening, the decision of a managed care plan regarding the need for treatment is likely to be ill-informed. Patients are entitled to receive a medical screening examination and stabilizing medical treatment under the anti-dumping statute regardless of a hospital's contract with a health plan that requires prior authorization. Accordingly, the OIG and HCFA suggest the following practices to minimize the likelihood that a hospital will violate the statute:

• *No Prior Authorization Before Screening or Commencing Stabilizing Treatment*

It is not appropriate for a hospital to seek, or direct a patient to seek, authorization to provide screening or stabilizing services to an individual from the individual's health plan or insurance company until after the hospital has provided (1) an appropriate medical screening examination to determine the presence or absence of an emergency medical condition, and (2) any further medical examination and treatment necessary to commence stabilization of an emergency medical condition. The hospital may seek authorization for payment for all services after providing a medical screening examination and once necessary stabilizing treatment is underway. (We recognize that this guidance differs in part from that provided in the *HCFA State Operations Manual on Provider Certification* (Transmittal No. 2, May 1988, Interpretive Guidelines— Responsibilities of Medicare Participating Hospitals in Emergency Cases, Data Tag No. A406, p. V–20), which states that "it is not appropriate for a hospital to request or a health plan to require prior authorization before a patient has received a medical screening exam to determine the presence or absence of an emergency medical condition or until an emergency medical condition has been stabilized." We will revise the *State Operations Manual* to ensure that it conforms to the guidance provided in this bulletin.) We wish to emphasize that an emergency physician is not precluded from contacting the patient's personal physician at any time to seek advice regarding the patient's medical history and needs that may be relevant to the medical screening and treatment of the patient, as long as this consultation does not inappropriately delay such screening and stabilization.[4]

[4] If, when contacted, a managed care physician requests that the patient be transferred, the hospital must still conclude the medical screening examination and provide any treatment necessary to stabilize the patient prior to transfer, or in the case of an unstable patient, provide an appropriate transfer. A hospital may only transfer an unstable patient at the request of the managed care physician when either a physician at the hospital certifies that the medical benefits of transfer outweigh the increased risk, or when the patient requests the transfer in writing after being informed of the hospital's obligations and the risks of transfer.

• *Use of Advance Beneficiary Notices and other Financial Responsibility Forms*

A hospital would violate the patient anti-dumping statute if it delayed a medical screening examination or necessary stabilizing treatment in order to prepare an ABN and obtain a beneficiary signature. The best practice would be for a hospital *not to give* financial responsibility forms or notices to an individual, or otherwise attempt to obtain the individual's agreement to pay for services before the individual is stabilized. This is because the circumstances surrounding the need for such services, and the individual's limited information about his or her medical condition, may not permit an individual to make a rational, informed consumer decision. It normally is permissible to ask for general registration information prior to performing an appropriate medical screening examination. The hospital may not, however, condition such a screening and further treatment upon the individual's completion of a financial responsibility form or provision of a co-payment for any services. Such a practice could unduly deter the individual from remaining at the hospital to receive care to which he or she is entitled and which the hospital is obligated to provide regardless of ability to pay, and could cause unnecessary delay. In accordance with the *HCFA State Operations Manual,* Interpretative Guidelines, V–27 (May 1998), a hospital may continue to follow reasonable registration processes for individuals presenting for evaluation and treatment of a medical condition. Reasonable registration processes may include asking whether an individual is insured and, if so, what that insurance is, as long as this inquiry does not delay screening or treatment. However, reasonable registration processes should not unduly discourage patients from remaining for further evaluation.

• *Qualified Medical Personnel Must Perform Medical Screening Examinations and Physicians Must Authorize Transfers*

A hospital should ensure that either a physician or other qualified medical personnel (that is, hospital staff approved by the hospital's governing body to perform certain medical functions) provides an appropriate medical screening examination to *all* individuals seeking emergency services. Depending upon the individual's presenting symptoms, this screening examination may range from a relatively simple examination to a complex one which requires substantial use of ancillary services available at the hospital and on-call physicians. If it is determined that the individual has an emergency medical condition and that the individual requires a transfer, only a physician (or, if a physician is not physically present in the emergency department at the time, a qualified medical person in consultation with a physician in accordance with regulations at 42 CFR 489.24(d)(1)(ii)(C)) may authorize such a transfer.

(continued)

• *When a Patient Inquires About Financial Liability for Emergency Services*

If a patient inquires about his or her obligation to pay for emergency services, such an inquiry should be answered by a staff member who has been well trained to provide information regarding potential financial liability. This staff member also should be knowledgeable about the hospital's anti-dumping statute obligations and should clearly inform the patient that, notwithstanding the patient's ability to pay, the hospital stands ready and willing to provide a medical screening examination and stabilizing treatment, if necessary. Hospital staff should encourage any patient who believes that he or she may have an emergency medical condition to remain for the medical screening examination and any necessary stabilizing treatment. Staff should also encourage the patient to defer further discussion of financial responsibility issues, if possible, until *after* the medical screening has been performed. If the patient chooses to withdraw his or her request for examination or treatment, a staff member with appropriate medical training should discuss the medical issues related to a "voluntary withdrawal."

• *Voluntary Withdrawal*

If an individual chooses to withdraw his or her request for examination or treatment at the presenting hospital, and if the hospital is aware that the individual intends to leave prior to the screening examination, a hospital should take the following steps: (1) Offer the individual further medical examination and treatment within the staff and facilities available at the hospital as may be required to identify and stabilize an emergency medical condition; (2) Inform the individual of the benefits of such examination and treatment, and of the risks of withdrawal prior to receiving such examination and treatment; and (3) Take all reasonable steps to secure the individual's written informed consent to refuse such examination and treatment. The medical record should contain a description of risks discussed and of the examination, treatment, or both, if applicable, that was refused. If an individual leaves without notifying hospital personnel, the hospital should, at a minimum, document the fact that the person had been there, what time the hospital discovered that the patient had left, and should retain all triage notes and additional records, if any. However, the burden rests with the hospital to show that it has taken appropriate steps to discourage an individual from leaving the hospital without evaluation.

Dated: November 4, 1999.
June Gibbs Brown, *Inspector General, Office of Inspector General.*

Dated: November 3, 1999.
Michael M. Hash, *Deputy Administrator, Health Care Financing Administration.*

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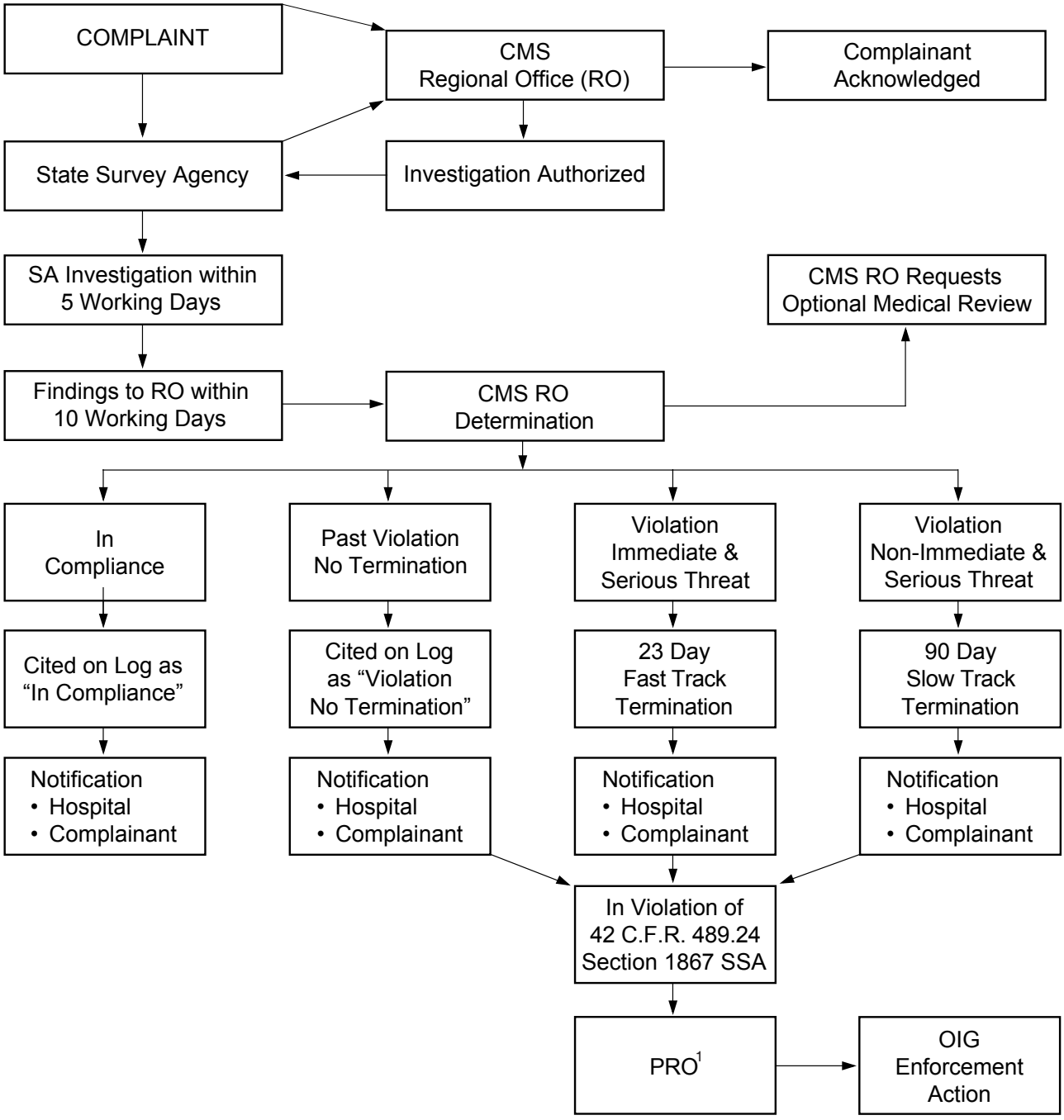
BILLING CODE 4150–04–P

EMTALA Enforcement Chart

Source: CMS Region IX
Date: January 9, 1998

COBRA "Anti-Dumping" Process



[1] **NOTE:** The Peer Review Organization (PRO) is now named the Quality Improvement Organization (QIO)

APPENDIX J

Hospital Records Subject to EMTALA Enforcement Survey

Source: **State Operations Manual, Appendix V, Interpretive Guidelines—Responsibilities of Medicare Participating Hospitals in Emergency Cases www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf**

Date: **Revised July 16, 2010**

- Dedicated emergency department patient log(s) for the past 6-12 months
- Dedicated emergency department policy and procedure manual(s)
- Consent forms for transfer of unstable patients
- Dedicated emergency department(s) committee meeting minutes for the past 12 months
- Dedicated emergency department staffing schedule (physicians for past 3 months and nursing staff for past 4 weeks)
- Medical staff bylaws/rules and regulations
- Medical staff meeting minutes for the past 6-12 months
- Current medical staff roster
- Physician on-call lists for the past 6 months
- Credentials files for emergency physicians and medical director (review of these documents is at the surveyor's option)
- Quality assessment and performance improvement (QAPI) plan
- QAPI minutes relating to EMTALA regulations
- List of contracted services (if the use of contracted services is questioned)
- Dedicated emergency department personnel records (review of these documents is at the surveyor's option)
- In-service training program records, schedules, reports, etc. (review of these documents is at the surveyor's option)
- Ambulance trip reports and memoranda of transfer
- Ambulance ownership information and applicable state/regional/community EMS protocols

APPENDIX K

Investigative Procedures for EMTALA Surveyors

Source: **CMS State Operations Manual, Appendix V—Responsibilities of Medicare Participating Hospitals in Emergency Cases—Part I—Investigative Procedures www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf**

Part I- Investigative Procedures

I. General Information
II. Principal Focus of Investigation
III. Task 1 - Entrance Conference
IV. Task 2 - Case Selection Methodology
V. Task 3- Record Review
VI. Task 4- Interviews
VII. Task 5-Exit Conference
VIII. Task 6- Professional Medical Review
IX. Task 7- Assessment of Compliance and Completion of the Deficiency Report
X. Additional Survey Report Documentation

Part I- Investigative Procedures

I. General Information

Medicare participating hospitals must meet the Emergency Medical Treatment and Labor Act (EMTALA) statute codified at §1867 of the Social Security Act, (the Act) the accompanying regulations in 42 CFR §489.24 and the related requirements at 42 CFR 489.20(l), (m), (q), and (r). EMTALA requires hospitals with emergency departments to provide a medical screening examination to any individual who comes to the emergency department and requests such an examination, and prohibits hospitals with emergency departments from refusing to examine or treat individuals with an emergency medical condition (EMC). The term "hospital" includes critical access hospitals. The provisions of EMTALA apply to all individuals (not just Medicare beneficiaries) who attempt to gain access to a hospital for emergency care. The regulations define "hospital with an emergency department" to mean a hospital with a dedicated emergency department (ED). In turn, the regulation defines "dedicated emergency department" as any department or facility of the hospital that either (1) is licensed by the state as an emergency department; (2) held out to the public as providing treatment for emergency medical conditions; or (3) on one-third of the visits to the department in the preceding calendar year actually provided treatment for emergency medical conditions on an urgent basis. These three requirements are discussed in greater detail at Tag A406.

The enforcement of EMTALA is a complaint driven process. The investigation of a hospital's policies/procedures and processes and any subsequent sanctions are initiated by a complaint. If the results of a complaint investigation indicate that a hospital violated one or more of the anti-dumping provisions of §1866 or 1867 (EMTALA), a hospital may be subject to termination of its provider agreement and/or the imposition of civil monetary penalties (CMPs). CMPs may be imposed against hospitals or individual physicians for EMTALA violations.

The RO evaluates and authorizes all complaints and refers cases to the SA that warrant investigation. The first step in determining if the hospital has an EMTALA obligation is for the surveyor verify whether the hospital in fact has a dedicated emergency department (ED). To do so, the surveyor must check whether the hospital meets one of the criteria that define whether the hospital has a dedicated emergency department.

As discussed above, a dedicated emergency department is defined as meeting one of the following criteria regardless of whether it is located on or off the main hospital campus: The entity: (1) is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; or (2) is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions (EMC) on an urgent basis without requiring a previously scheduled appointment; or (3) during the preceding calendar year, (i.e., the year immediately preceding the calendar year in which a determination under this section is being made), based on a representative sample of patient visits that occurred during the calendar year, it provides at least one-third of all of its visits for the treatment of EMCs on an urgent

basis without requiring a previously scheduled appointment. This includes individuals who may present as unscheduled ambulatory patients to units (such as labor and delivery or psychiatric units of hospitals) where patients are routinely evaluated and treated for emergency medical conditions.

Hospitals with dedicated emergency departments are required to take the following measures:

- Adopt and enforce policies and procedures to comply with the requirements of 42 CFR §489.24;
- Post signs in the dedicated ED specifying the rights of individuals with emergency medical conditions and women in labor who come to the dedicated ED for health care services, and indicate on the signs whether the hospital participates in the Medicaid program;
- Maintain medical and other records related to individuals transferred to and from the hospital for a period of five years from the date of the transfer;
- Maintain a list of physicians who are on-call to provide further evaluation and or treatment necessary to stabilize an individual with an emergency medical condition;
- Maintain a central log of individual's who come to the dedicated ED seeking treatment and indicate whether these individuals:
    - Refused treatment,
    - Were denied treatment,
    - Were treated, admitted, stabilized, and/or transferred or were discharged;
- Provide for an appropriate medical screening examination;
- Provide necessary stabilizing treatment for emergency medical conditions and labor within the hospital's capability and capacity;
- Provide an appropriate transfer of an unstabilized individual to another medical facility if:
    - The individual (or person acting on his or her behalf) after being informed of the risks and the hospital's obligations requests a transfer,

- A physician has signed the certification that the benefits of the transfer of the patient to another facility outweigh the risks or

- A qualified medical person (as determined by the hospital in its by-laws or rules and regulations) has signed the certification after a physician, in consultation with that qualified medical person, has made the determination that the benefits of the transfer outweigh the risks and the physician countersigns in a timely manner the certification. (This last criterion applies if the responsible physician is not physically present in the emergency department at the time the individual is transferred.

- Provide treatment to minimize the risks of transfer;

- Send all pertinent records to the receiving hospital;

- Obtain the consent of the receiving hospital to accept the transfer,

- Ensure that the transfer of an unstabilized individual is effected through qualified personnel and transportation equipment, including the use of medically appropriate life support measures;

- Medical screening examination and/or stabilizing treatment is not to be delayed in order to inquire about payment status;

- Accept appropriate transfer of individuals with an emergency medical condition if the hospital has specialized capabilities or facilities and has the capacity to treat those individuals; and

- Not penalize or take adverse action against a physician or a qualified medical person because the physician or qualified medical person refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee who reports a violation of these requirements.

If the hospital does not have a dedicated emergency department as defined in 42 CFR §489.24(b), apply 42 CFR §482.12(f) which requires the hospital's governing body to assure that the medical staff has written policies and procedures for appraisal of emergencies and the provision of initial treatment and referral (Form CMS-1537, "Medicare/Medicaid Hospital Survey Report").

Hospitals that violate the provisions in 42 CFR §489.24 or the related requirements in 42 CFR §489.20(l), (m), (q), and (r) are subject to civil monetary penalties or termination.

A hospital is required to report to CMS or the State survey agency promptly when it suspects it may have received an improperly transferred individual. Notification should occur within 72 hours of the occurrence. Failure to report improper transfers may subject the receiving hospital to termination of its provider agreement.

To assure that CMS is aware of all instances of improper transfer or potential violations of the other anti-dumping requirements, the State survey agencies must promptly report to the RO all complaints related to violations of 42 CFR §489.24 and the related requirements at 42 CFR §489.20(l), (m), (q), and (r). The RO will decide whether a complaint alleges a violation of these requirements and warrants an investigation.

Quality of care review performed either by the SA or other physicians must not delay processing of a substantiated EMTALA violation. If during the course of the investigation, you identify possible quality of care issues other than those related to the provisions of this regulation, obtain a copy of the patient's medical record and send the case to the RO for referral to the appropriate Quality Improvement Organization (QIO). Contact the RO if the hospital refuses to provide a copy of the medical record.

If you suspect emergency services are being denied based on diagnosis (e.g., AIDS), financial status, race, color, national origin, or handicap, refer the cases to the RO. The RO will forward the cases to the Office of Civil Rights (OCR) for investigation of discrimination.

A hospital must formally determine who is qualified to perform the initial medical screening examinations, i.e., qualified medical person. While it is permissible for a hospital to designate a non-physician practitioner as the qualified medical person, the designated non-physician practitioners must be set forth in a document that is approved by the governing body of the hospital. Those health practitioners designated to perform medical screening examinations are to be identified in the hospital by-laws or in the rules and regulations governing the medical staff following governing body approval. It is not acceptable for the hospital to allow the medical director of the emergency department to make what may be informal personnel appointments that could frequently change.

If it appears that a hospital with an dedicated ED does not have adequate staff and equipment to meet the needs of patients, consult the RO to determine whether or not to expand the survey for compliance with the requirements of 42 CFR §482.55 ("Condition of Participation: Emergency Services").

Look for evidence that the procedures and policies for emergency medical services (including triage of patients) are established, evaluated, and updated on an ongoing basis.

The hospital should have procedures, which assure integration with other hospital services (e.g., including laboratory, radiology, ICU, and operating room services) to ensue continuity of care.

II. Principal Focus of Investigation

Investigate for compliance with the regulations in 42 CFR §489.24 and the related requirements in 42 CFR §489.20(l), (m), (q), and (r). All investigations are to be unannounced. The investigation is based on an allegation of noncompliance. The purpose of the investigation is to ascertain whether a violation took place, to determine whether the violation constitutes an immediate and serious threat to patient health and safety, to identify any patterns of violations at the facility, and to assess whether the facility has policies and procedures to address the provisions of the EMTALA law. The investigation must be completed within 5 working days of the RO authorization.

The focus of the investigation is on the initial allegation of violation and the discovery of additional violations. If the allegation is not confirmed, the surveyors must still be assured that the hospital's policies and procedures, physician certifications of transfers, etc., are in compliance with the requirements of 42 CFR §489.24 and the related requirements at 42 CFR §489.20(l), (m), (q), and (r). If the allegation(s) is confirmed, the investigation would continue, but with an emphasis on the hospital's compliance within the last 6 months.

Ensure that the case(s), if substantiated, is (are) fully documented on Form CMS-2567, Statement of Deficiencies and Plan of Correction. The investigation paperwork should be completed within ten working days following completion of the onsite survey if it appears there may be a violation of §§1866 and 1867 of the Act (**the paperwork is to be in the RO possession by the 20th working day or less following completion of the onsite survey. This includes the 5 days allowed to complete the onsite investigation**). If there appears not to be a violation, and the responsibilities of Medicare participating hospitals in emergency cases appear to be met, the time frame to complete the paperwork and return to the RO may be extended to 15 working days (**the paperwork is to be in the RO possession by the 25th working day or less following completion of the onsite survey. This includes the 5 days allowed to complete the onsite investigation**).

Once the investigation is complete the RO is strongly encouraged to share as much information with the hospital as possible in accordance with the Privacy Act and the Health Insurance Portability and Accountability Act (HIPAA) regarding the complaint and investigation. The RO may also include any facts about the violation, a copy of any medical reviews (the identity of the reviewer must be deleted), and the identity of the patient involved (not the identity of the complainant or source of the complaint). CMS will determine if the violation constitutes immediate jeopardy to patient health and safety.

The hospital has the opportunity to present evidence to CMS that it believes demonstrates its compliance and the opportunity to comment on evidence CMS believes demonstrates

the hospital's noncompliance. CMS' regional offices retain delegated enforcement authority and final enforcement decisions are made there**.**

III. Task 1 - Entrance Conference

A brief entrance conference must be held with the CEO/president of the hospital (or his or her designee) and any other staff the CEO considers appropriate to explain the nature of the allegation, the purpose of the investigation, and the requirements against which the complaint will be investigated. The identity of the complainant and patient must always be kept confidential unless written consent is obtained. Ask the CEO to have the staff provide you with the following information (as appropriate):

- Dedicated ED logs for the past 6-12 months;
- The dedicated ED policy/procedures manual (review triage and assessment of patients presenting to the ED with emergency medical conditions, assessment of labor, transfers of individuals with emergency medical conditions, etc.);
- Consent forms for transfers of unstable individuals;
- Dedicated ED committee meeting minutes for the past 12 months;
- Dedicated ED staffing schedule (physicians for the past 3 months and nurses for the last 4 weeks) or as appropriate;
- Bylaws/rules and regulations of the medical staff;
- Minutes from medical staff meetings for the past 6-12 months;
- Current medical staff roster;
- Physician on-call lists for the past 6 months;
- Credential files (to be selected by you) include the director of the emergency department and emergency department physicians. Review of credentials files is optional. However, if there has been a turnover in significant personnel (e.g., the ED director) or an unusual turnover of ED physicians, or a problem is identified during record review of a particular physician's screening or treatment in the ER, credentials files should be obtained and reviewed;
- Quality Assessment and Performance Improvement (QAPI) Plan (formally known as Quality Assurance);
- QAPI minutes (request the portion of the quality improvement minutes and plan, which specifically relates to EMTALA regulations. If a problem is identified that

would require a more thorough review, additional portions of the quality improvement plan and minutes may be requested for review);

- List of contracted services (request this list if a potential violation of §1866 and 1867 of the Act is noted during the investigation and the use of contracted services is questioned);

- Dedicated ED personnel records (optional);

- In-service training program records, schedules, reports, etc. (optional review if questions arise through interview and record review regarding the staff's knowledge of 42 CFR §489.24);

- Ambulance trip reports and memoranda of transfer, if available (to be selected by you if the cases you are reviewing concern transfers); and

- Ambulance ownership information and applicable State/regional/community EMS protocols.

In addition, if the case you are investigating occurred prior to the time frames mentioned, examine the above records for a three-month period surrounding the date of the alleged violation.

Inform the CEO that you will be selecting a sample of cases (medical records) for review from the ED log and that you will require those records in a timely fashion.

IV. Task 2 - Case Selection Methodology

Even though a single occurrence is considered a violation a sample is done to identify additional violations and/or patterns of violations.

A. **Sample Size**. Select 20-50 records to review in depth, using the selection criteria described below. The sample is not intended to be a statistically valid sample and the sample selection should be focused on potential problem areas. The sample size should be expanded as necessary in order to adequately investigate possible violations or patterns of violations.

B. **Sample Selection**. The type of records sampled will vary based on the nature of the complaint and the types of patients requesting emergency services. Do not allow the facility staff to select the sample. Use the emergency department log and other appropriate information, such as patient charts, to identify:

- Individuals transferred to other facilities;

- Gaps, return cases, or nonsequential entries in the log;

- Refusals of examination, treatment, or transfer;
- Patients leaving against medical advice or left without being seen (LWBS); and
- Patients returning to the emergency department within 48 hours.

Sample selection requires that:

1. You identify the number of emergency cases seen per month for each of the 6 months preceding the survey. Place this information on Form CMS-1541B, "Responsibilities of Medicare Participating Hospitals in Emergency Cases Investigation Report," (Exhibit 137).

2. You identify the number of transfers of emergency patients to other acute care hospitals per month for each of the preceding 6 months. Review in-depth, transfers of patients where it appears that the transferring hospital could have provided continuing medical care. Place this information on Form CMS-1541B.

3. You include the complaint case (s) in the sample, regardless of how long ago it occurred. Select other cases at the time of the complaint in order to identify patterns of hospital behavior and to help protect the identity of the patient.

4. If the complaint case did not involve an inappropriate transfer (e.g., the complaint was for failure to provide an adequate screening examination, or a hospital with specialized capabilities refused an appropriate transfer), identify similar cases and review them.

5. If you identify additional violations, determine, if possible, whether there is a pattern related to:

    - Diagnosis (e.g., labor, AIDS, psych);
    - Race;
    - Color;
    - Type of health insurance (Medicaid, uninsured, under-insured, or managed care);
    - Nationality; or
    - Disability.

Representative Sample Size for the dedicated emergency department if applicable:

The SA surveyor should consult with the RO prior to conducting the representative sample of patient visits for a hospital department to determine whether the department meets the criteria of being a dedicated emergency department.

To determine if a hospital department is a dedicated emergency department because it meets the "one-third requirement" described above (i.e., the hospital, in the preceding year, had at least one-third of all of its visits for the treatment of EMCs on an urgent basis without requiring a previously scheduled appointment) the surveyor is to select a representative sample of patient visits that occurred the previous calendar year in the area of the hospital to be evaluated for status as a dedicated emergency department. This includes individuals who may present as unscheduled ambulatory patients to units (such as labor and delivery or psychiatric units of hospitals) where patients are routinely admitted for evaluation and treatment. The surveyors will review the facility log, appointment roster and other appropriate information to identify patients seen in the area or facility in question. Surveyors are to review 20 - 50 records of patients with diagnoses or presenting complaints, which may be associated with an emergency medical condition (e.g., cardiac, respiratory, pediatric patients (high fever, lethargic), loss of consciousness, etc.). Surveyors have the discretion (in consultation with the regional office) to expand the sample size as necessary in order to adequately investigate possible violations or patterns of violations. Do not allow the facility staff to select the sample. Review the selected cases to determine if patients had an emergency medical condition and received stabilizing treatment. If at least one-third of the sample cases reviewed were for the treatment of EMCs on an urgent basis without requiring a previously scheduled appointment, the area being evaluated is a dedicated emergency department, and therefore, the hospital has an EMTALA obligation. Hospitals that may meet this one-third criterion may be specialty hospitals (such as psychiatric hospitals), hospitals without "traditional" emergency departments, and urgent care centers. In addition, it is not relevant if the entity that meets the definition of a dedicated ED is not located on the campus of the main hospital.

Guidelines to determine if a department of a hospital meets the one-third criteria of being a dedicated emergency department:

For each case, the surveyors should answer three questions.

1. Was the individual an outpatient?

   Y N If not, what was his or her status (e.g., inpatient, visitor or other)?

2. Was the individual a walk-in (unscheduled appointment)?

   Y N

3. Did the individual have an EMC, and received stabilizing treatment?

   Y N

   (**NOTE**- an affirmative yes must be present for both parts of this question for the case to be counted toward the one-third criterion to be met. If **no** is answered for any part of this question, the criterion was **not met**, and select no for the overall answer).

All questions must have an answer of yes to confirm that the case is included as part of the percentage (one-third) to determine if the hospital has a dedicated emergency department. If one-third of the total cases being reviewed receive answers of "yes" to the three questions above, then the hospital has an EMTALA obligation.

Document information concerning your sample selection on a blank sheet of paper or SA worksheet and label it "Summary Listing of Sampled Cases." Include the dates the individuals requested services, any identifier codes used to protect the individual's confidentiality, and the reasons for your decision to include these individuals in your sample.

V. Task 3- Record Review

While surveyors may make preliminary findings during the course of the investigation, a physician must usually determine the appropriateness of the MSE, stabilizing treatment, and transfer. Because expert medical review is usually necessary, obtain copies of the medical and other record(s) of the alleged violation case (both hospitals if an individual sought care at two hospitals or were transferred) and any other violation cases identified in the course of the investigation.

Also, review documents pertaining to QAPI activities in the emergency department and remedial actions taken in response to a violation of these regulations. Document hospital corrective actions taken prior to the survey and take such corrective action into account when developing your recommendation to the RO.

In an accredited hospital, if it appears that CoPs are not met, contact the RO for authorization to extend the investigation. If you are conducting the investigation in a non-accredited hospital, you may expand the investigation to include other conditions without contacting the RO first. When there is insufficient information documented on the emergency record regarding a request for emergency care, it may be helpful to interview hospital staff, physicians, witnesses, ambulance personnel, the individual, or the individual's family. Ask for RO guidance if you are still unable to obtain a consistent and reliable account of what happened.

Any time delivery of a baby occurs during transfer, obtain a copy of all available records and refer the case for review to the QIO physician reviewer.

If you are unsure whether qualified personnel and or transportation equipment were used to effectuate a transfer, review the hospital's transfer policies, and obtain a copy of the medical record and transfer records.

In cases where treatment is rendered to stabilize an EMC, the medical records should reflect the medically indicated treatment necessary to stabilize it, the medications, treatments, surgeries and services rendered, and the effect of treatment on the individual's emergency condition or on the woman's labor and the unborn child.

The medical records should contain documentation such as: medically indicated screenings, tests, mental status evaluation, impressions, and diagnoses (supported by a history and physical examination, laboratory, and other test results) as appropriate.

For pregnant women, the medical records should show evidence that the screening examination included ongoing evaluation of fetal heart tones, regularity and duration of uterine contractions, fetal position and station, cervical dilation, and status of the membranes, i.e., ruptured, leaking, intact.

For individuals with psychiatric symptoms, the medical records should indicate an assessment of suicide or homicide attempt or risk, orientation, or assaultive behavior that indicates danger to self or others.

In cases where an individual (or person acting in the individual's behalf) withdrew the initial request for a medical screening examination (MSE) and/or treatment for an EMC and demanded his or her transfer, or demanded to leave the hospital, look for a signed informed refusal of examination and treatment form by either the individual or a person acting on the individual's behalf. Hospital personnel must inform the individual (or person acting on his or her behalf) of the risks and benefits associated with the transfer or the patient's refusal to seek further care. If the individual (or person acting in the individual's behalf) refused to sign the consent form, look for documentation by the hospital personnel that states that the individual refused to sign the form. The fact that an individual has not signed the form is not, however, automatically a violation of the

screening requirement. Hospitals must, under the regulations, use their best efforts to obtain a signature from an individual refusing further care.

Examine the ambulance trip reports in questionable transfer cases (if available). These records can answer questions concerning the appropriateness of a transfer and the stability of the individual during the transfer.

Appropriate record review should also be conducted at the receiving (or recipient) hospital if the alleged case and any other suspicious transfer cases involve the transfer or movement of the individual to another hospital.

Document all significant record review findings in the complaint investigation narrative.

VI. Task 4- Interviews

To obtain a clear picture of the circumstances surrounding a suspected violation of the special responsibilities of Medicare hospitals in emergency cases, it is necessary to interview facility staff. For example, you may be able to gather a great deal of information from the admitting clerk in the emergency department, the nurses on shift at the time the individual sought treatment, and the Director of Quality Improvement in the hospital to name a few. You may also need to interview witnesses, the patient, and/or the patient's family. The physician(s) involved in the incident should be interviewed. Document each interview you conduct on a blank sheet of paper or SA worksheet and label it "Summary of Interviews." Include the following information, as appropriate, in your notes for each interview:

- The individual's job title and assignment at the time of the incident;
- Relationship to the patient and/or reason for the interview; and
- Summary of the information obtained.

Appropriate interviews should also be conducted at the receiving hospital in cases of transfer or movement of the individual to another hospital.

VII. Task 5-Exit Conference

The purpose of the exit conference is to inform the hospital of the scope of the investigation, including the nature of the complaint, investigation tasks, and requirements investigated, and any hospital CoPs surveyed. Explain to the hospital staff the consequences of a violation of the requirements in 42 CFR §489.24 or the related requirements in 42 CFR §489.20(l), (m), (q), and (r) and the time frames that will be followed if a violation is found. Do not tell the hospital whether or not a violation was identified since it is the responsibility of the RO to make that determination. Inform the CEO (or his or her designee) that the RO will make the determination of compliance

based on the information collected during this investigation and any additional information acquired from physician review of the case. Do not leave a draft of the deficiencies of Form CMS-2567 with the hospital. Inform the hospital that the RO will send that information to the hospital once it is complete.

VIII. Task 6- Professional Medical Review

The purpose of a professional medical review (physician review) is to provide peer review using information available to the hospital at the time the alleged violation took place. Physician review is required prior to the imposition of CMPs or the termination of a hospital's provider agreement to determine if:

- The screening examination was appropriate. Under EMTALA, the term "appropriate" does not mean "correct", in the sense that the treating emergency physician is not required to correctly diagnose the individual's medical condition. The fact that a physician may have been negligent in his screening of an individual is not necessarily an EMTALA violation. When used in the context of EMTALA, "appropriate" means that the screening examination was suitable for the symptoms presented and conducted in a non-disparate fashion. Physician review is not necessary when the hospital did not screen the individual;

- The individual had an emergency medical condition. The physician should identify what the condition was and why it was an emergency (e.g., what could have happened to the patient if the treatment was delayed);

- In the case of a pregnant woman, there was inadequate time to affect a safe transfer to another hospital before delivery, or the transfer posed a threat to the health and safety of the woman or the unborn child;

- The stabilizing treatment was appropriate within a hospital's capability (**NOTE** that the clinical outcome of an individual's medical condition is not the basis for determining whether an appropriate screening was provided or whether the person transferred was stabilized);

- The transfer was effected through qualified personnel and transportation equipment, including the use of medically appropriate life support measures;

- If applicable, the on-call physician's response time was reasonable; and

- The transfer was appropriate for the individual because the individual; requested the transfer or because the medical benefits of the transfer outweighed the risk.

If you recommend a medical review of the case, indicate on Form CMS-1541B that you recommend such a review.

IX. Task 7- Assessment of Compliance and Completion of the Deficiency Report

A. **Analysis**. Analyze your findings relative to each provision of the regulations for the frequency of occurrence, dates of occurrence, and patterns in terms of race, color, diagnosis, nationality, handicap, and financial status. A single occurrence constitutes a violation and is sufficient for an adverse recommendation. Older cases where the hospital implemented corrective actions with no repeat violations may require consultation with the RO concerning appropriate recommendations.

If a team conducted the investigation, the team should meet to discuss the findings. Consider information provided by the hospital. Ask the hospital for additional information or clarification about particular findings, if necessary.

Review each regulation tag number sequentially in this Appendix, and come to a consensus as to whether or not the hospital complies with each stated requirement. The following outline may be helpful in this review. For each requirement recommended as not met, record all salient findings on the Form CMS-2567.

Outline of Data Tags Used for Citing Violations of Responsibilities of Medicare Participating Hospitals in Emergency Cases

Deficiency Tags	Requirements
A400	(§489.20) Policies and Procedures Which Address Anti-Dumping Provisions
A401	(§489.20(m)) Receiving Hospitals Must Report Suspected Incidences of IndividualsWith An Emergency Medical Condition Transferred in Violation of §489.24(e)
A402	(§489.20(q)) Sign Posting
A403	(§489.24(r)) Maintain Transfer Records for Five Years
A404	(§489.20(r)(2); §489.24(j)) On-Call Physicians
A405	(§489.20(r)(3)) Logs

Deficiency Tags	Requirements
A406	(§489.24(a); §489.24(c)) Appropriate Medical Screening Examination
A407	(§489.24(d)(3)) Stabilizing Treatment (§489.24(d)(4))
A408	(§489.24(d)(4) and (5)) No Delay in Examination or Treatment in Order to Inquire About Payment Status
A409	(§489.24 (e)(1) and (2)) Appropriate Transfer
A410	(§489.24(e)(3)) Whistleblower Protections
A411	(§489.24(f)) Recipient Hospital Responsibilities (Nondiscrimination)

B. **Composing the Statement of Deficiencies (Form CMS-2567)**. Support all deficiency citations by documenting evidence obtained from your interviews and record reviews on Form CMS-2567, "Statement of Deficiencies and Plan of Correction." Deficiencies related to the Conditions of Participation should also be documented on Form CMS-2567. Indicate whether your findings show that the deficiency constitutes an immediate jeopardy to patient health and safety (e.g., a situation that prevents individuals from getting medical screening examinations and/or a lack of treatment reflecting both the capacity and capability of the hospital's full resources, as guaranteed under §1867 of the Act). Some examples include stabilizing treatment not provided when required; failure of an on-call physician to respond appropriately, improper transfer; or evidence that there was a denial of medical screening examinations and/or treatment to persons with emergency medical conditions as a direct result of requesting payment information before assessment of the individual's medical condition. Examples of noncompliance, which usually does not pose an immediate jeopardy, include the following scenarios:

1. A transfer which was appropriate, but the physician certification was not signed or dated by the physician;

2. An appropriate, functioning central log that on one particular day in not fully completed; and

3. A written hospital policy that is missing, but nonetheless being implemented.

Do not make a medical judgment, but focus on the processes of the facility "beyond the paper." Identify whether single incidents of patient dumping, which do not represent a hospital's customary practice, are nonetheless serious and capable of being repeated.

Immediate jeopardy violations require a 23-day termination track. Non-immediate jeopardy violations require a 90-day termination track.

Write the deficiency statement in terms specific enough to allow a reasonably knowledgeable person to understand the aspect(s) of the requirement(s) that is (are) not met. **Do not prescribe an acceptable remedy**. Indicate the data prefix tag and regulatory citation, followed by a summary of the deficiency and supporting findings. When it is necessary to use specific examples, use individual identifier codes, not individual names.

The emergency services condition, or any other condition, is not automatically found out of compliance based on a violation of 42 CFR §489.20 and/or 42 CFR §489.24. A determination of noncompliance must be based on the regulatory requirements for the individual condition.

X. Additional Survey Report Documentation

Upon completion of each investigation, the team leader assures that the following additional documentation has been prepared for submission, along with Forms CMS-1541B, CMS-562, CMS-2567, and a copy of the medical record(s) to the RO:

A. **Summary Listing of Sample Cases and Description of Sample Selection (See Task 2).** At a minimum, identify:

- The name of each individual chosen to be a part of the sample and the date of their request for emergency services;
- Any individual identifier codes used as a reference to protect the individual's confidentiality;
- The reason for including the individual in the sample (e.g., unstabilized transfer, lack of screening, lack of treatment, failure to stabilize, diagnosis, race, color, financial status, handicap, nationality); and
- Include a copy of the medical record(s) for all individuals where the hospital violated the provisions in 42 CFR §489.24.

Also identify:

- How the sample was selected;
- The number of individuals in the sample; and
- Any overall characteristics of the individuals in the sample, such as race, color, nationality, handicap, financial status, and diagnosis.

B. **Summary of Interviews (See Task 4)**. Document interviews conducted with patients, families, staff, physicians, administrators, managers, and others. At a minimum, include the individual's job title and/or assignment at the time of the incident, the relationship to the patient and/or reason for the interview, and a summary of the information obtained in each interview.

C. **Complaint Investigation Narrative (See Task 3)**. Summarize significant findings in the medical records, meeting minutes, hospital policies and procedures, staffing schedules, quality assurance plans, hospital by-laws, rules and regulations, training programs, credential files, personnel files, and contracted services reviewed in the course of the investigation. Briefly summarize your findings in the investigation and the rationale used for the course of action recommended to the RO.

APPENDIX L

Sample Survey Tools for Patient Transfers and Medical Screening Examinations

QUALITY ASSESSMENT & IMPROVEMENT

<SAMPLE>

Emergency Services Transfer Forms – Documentation

Indicator: Transfer forms will be completed on all patient transfers.

Physician Assessment & Certification		Totals				Comments
		+	-	θ	%	
I.	Diagnosis Listed.					
II.	Section 1: Patient Condition.					
	A. Condition, appropriate box selected.					
	B. Reason for transfer listed.					
	C. Risks & Benefits transfer completed.					
III.	Section 2: Transfer Requirements.					
	A. Name of receiving facility.					
	B. Receiving facility contact listed.					
	C. Time.					
	D. Receiving physician listed.					
	E. Time.					
IV.	Section 2: Transportation/Level of Care.					
	A. Transportation type checked.					
	B. Personnel listed.					
V.	Section 3: Physician Certification.					
	A. Updated patient status.					
	B. Time.					
	C. Legible signature.					

Physician Assessment & Certification	Totals				Comments
	+	-	θ	%	
VI. Section 4: Discharge/Transfer.					
A. Vitals noted.					
B. Medical records sent.					
C. Patient belongings.					
D. Time.					
E. Legible signature and title.					
VII. Patient Consent.					
A. The patient (or legal representative) has checked the desired item and initialed.					
B. The patient (or legal representative) has signed the form.					
C. Notation that the patient (or legal representative) was unable/unwilling to sign. N =					
D. The form is dated and timed.					
E. A witness has signed the form.					

% = Percent compliant

QUALITY ASSESSMENT & IMPROVEMENT

<SAMPLE INDICATORS>

Indicator #1

For unstable patients, did the medical benefits of receiving treatment at another facility outweigh the risks of the transfer to the patient (or if pregnant, unborn children)?

Indicator #2

For stabilized patients, within medical probability, did the transfer create a medical hazard to the patient?

Indicator #3

For the unstable patient being transferred to a higher level of care, were the appropriate resources available for a safe transport?

Indicator #4

For patients at risk requiring emergency intubation during transfer, were appropriate resources for transport selected?

QUALITY ASSESSMENT & IMPROVEMENT

<SAMPLE>

Initial Medical Screening Exam Documentation

Indicator: An appropriate medical screening examination and disposition will be completed on all patients and documented in the medical record.

Are the following pieces of information completed?	Totals				Comments
	+	-	θ	%	
1. Adequate identification (name, address, phone).					
2. Time of arrival.					
3. Mode of arrival.					
4. Signature of individual for permission to treat.					
5. List of allergies, as indicated/per procedure.					
6. Medication history, as indicated/per procedure.					
7. Appropriate vital signs.					
8. Statement of chief complaint.					
9. Physical assessment which is appropriate based on the C/C.					
10. An evaluation of the individual's condition which lists the acuity and the disposition.					
11. If a physician is a consult, the name of the physician must be documented.					
12. A plan for the individual is recorded.					
13. Legible signature and title of staff completing initial assessment.					
14. The disposition of the individual has been recorded.					

Are the following pieces of information completed?	**Totals**				**Comments**
	+	-	θ	%	
15A. If the individual is referred N =					
The name of the nurse accepting the individual is documented, if appropriate.					
Note documented stating the individual's needs are non-urgent.					
The discharge box is checked.					
15B. If the individual is referred to a clinic: N =					
The time and date of the appointment.					
The provider's name and location.					
Note documented stated the individual's needs are non-emergent.					
A note is made as to where the individual went, with whom, and by what means of transportation.					
Discharge box is checked.					
15C. If the individual is discharged to home: N =					
The discharge box is checked.					
The individual has signed the form noting his/her understanding of the instructions.					
Note documented stating the individual's needs are non-emergent.					
A note is made as to where the individual went, with whom, and by what means of transportation.					
16. If the patient left the department prior to or during the Medical Screening Examination, and/or prior to treatment, AMA or Patient Refusal form signed.					

APPENDIX M

An Explanation of the Scope of RN Practice Including Standardized Procedures

Source: **Board of Registered Nursing**
www.rn.ca.gov/pdfs/regulations/npr-b-03.pdf

Date: **Revised January 2011**

(Continued on reverse)

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AN EXPLANATION OF THE SCOPE OF RN PRACTICE INCLUDING STANDARDIZED PROCEDURES

The Legislature, in its 1973-74 session, amended Section 2725 of the Nursing Practice Act (NPA), amplifying the role of the registered nurse and outlining activities which comprise the practice of nursing.

LEGISLATIVE INTENT

The Legislature recognized that nursing is a dynamic field, continually evolving to include more sophisticated patient care activities. It declared its intent to recognize the existence of **overlapping functions** between physicians and registered nurses and to permit **additional such sharing** and to provide **clear legal authority** for those functions and procedures which have common acceptance and usage. Prior to this, nurses had been educated to assume advanced roles, and demonstration projects had proven their ability to do this safely and effectively. Thus, legal amplification of the role paralleled the readiness of nurses to assume the role and recognized that many were already functioning in an expanded role.

SCOPES OF PRACTICE

A knowledge of the respective scopes of practice of registered nurses and physicians is important in determining **which activities overlap** medical practice and therefore require standardized procedures. Failure to distinguish nursing practice from medical practice may result in the limitation of the registered nurse's practice and the development of unnecessary standardized procedures. Registered nurses are cautioned not to confuse nursing policies and procedures with standardized procedures.

1. Scope of Registered Nursing Practice

The activities comprising the practice of nursing are outlined in the Nursing Practice Act, Business and Professions Code Section 2725. A broad, all inclusive definition states that the practice of nursing means those functions, including basic health care, which help people cope with difficulties in daily living which are associated with their actual or potential health or illness problems, or the treatment thereof, which require a substantial amount of scientific knowledge or technical skill.

In Section 2725(a), the Legislature expressly declared its intent to provide clear legal authority for functions and procedures which have common acceptance and usage. Registered nurses must recognize that the application of nursing process functions is common nursing practice which **does not** require a standardized procedure. Nursing practice is divided into three types of functions, which are described below.

A. Independent Functions

Subsection (b)(1) of Section 2725, authorizes direct and indirect patient care services that insure the safety, comfort, personal hygiene and protection of patients, and the performance of disease prevention and restorative measures. Indirect services include delegation and supervision of patient care activities performed by subordinates.

Subsection (b)(3) of Section 2725, specifies that the performance of skin tests, immunization techniques and withdrawal of human blood from veins and arteries is included in the practice of nursing.

Subsection (b)(4) of Section 2725, authorizes observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition and determination of whether these exhibit abnormal characteristics; and based on this determination, the implementation of appropriate reporting or referral, or the initiation of emergency procedures. These independent nursing functions have long been an important focus of nursing education, and an implied responsibility of the registered nurse.

B. Dependent Functions
Subsection (b)(2) of Section 2725, authorizes direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist or clinical psychologist.

C. Interdependent Functions
Subsection (b)(4) of Section 2725, authorizes the nurse to implement appropriate standardized procedures or changes in treatment regimen in accordance with standardized procedures after observing signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and determining that these exhibit abnormal characteristics. These activities overlap the practice of medicine and may require adherence to a standardized procedure when it is the nurse who determines that they are to be undertaken.

2. Scope of Medical Practice
The Medical Practice Act authorizes physicians **to diagnose** mental and physical conditions, **to use drugs in or** upon human beings, **to sever or penetrate the tissues** of human beings and **to use other methods** in the treatment of diseases, injuries, deformities or other physical or mental conditions. As a general guide, the performance of any of these by a registered nurse requires a standardized procedure; however, activities within each of these categories have already become common nursing practice and therefore do not require standardized procedures; for example, the administration of medication by injection requires penetration of human tissue, and registered nurses have performed this function through the years.

In Section 2725(a), the Legislature referred to the dynamic quality of the nursing profession. This means, among other things, that some functions which today are considered medical practice will become common nursing practice and no longer require standardized procedures. Examples of medical functions which have evolved into common nursing functions are the measurement of cardiac output pressures, and the insertion of PICC lines.

STANDARDIZED PROCEDURES FOR MEDICAL FUNCTIONS
The means designated to authorize performance of a medical function by a registered nurse is a standardized procedure developed through collaboration among registered nurses, physicians and administrators in the **organized health care system** in which it is to be used. Because of this interdisciplinary collaboration, there is accountability on several levels for the activities to be performed by the registered nurse. Section 2725(a) defines "organized health care systems" to include, but are not limited to, licensed health facilities, clinics, home health agencies, physicians' offices, and public or community health services.

GUIDELINES FOR DEVELOPING STANDARDIZED PROCEDURES
Standardized procedures are **not subject to prior approval** by the boards that regulate nursing and medicine; however, they must be developed according to the following guidelines which were jointly promulgated by the Board of Registered Nursing and the Medical Board of California. (Board of Registered Nursing, Title 16, California Code of Regulations (CCR) section 1474; Medical Board of California, Title 16, CCR Section 1379.)

(a) Standardized procedures shall include a written description of the method used in developing and approving them and any revision thereof.

(b) Each standardized procedure shall:

(1) **Be in writing, dated and signed by the organized health care system** personnel authorized to approve it.

(2) Specify **which standardized procedure functions** registered nurses may perform and under what circumstances.

(3) State any specific **requirements which are to be followed** by registered nurses in performing particular standardized procedure functions.

(4) Specify any **experience, training and/or education** requirements for performance of standardized procedure functions.

(5) Establish a method for initial and continuing **evaluation** of the competence of those registered nurses authorized to perform standardized procedure functions.

(6) Provide for a method of maintaining a written record of those **persons authorized to perform** standardized procedure functions.

(7) Specify the scope of **supervision** required for performance of standardized procedure functions, for example, telephone contact with the physician.

(8) Set forth any specialized circumstances under which the registered nurse is to immediately **communicate with a patient's physician** concerning the patient's condition.

(9) State the limitations on **settings**, if any, in which standardized procedure functions may be performed.

(10) Specify patient **record-keeping** requirements.

(11) Provide for a method of **periodic review** of the standardized procedures.

An additional safeguard for the consumer is provided by steps four and five of the guidelines which, together, form a **requirement that the nurse be currently capable** to perform the procedure. The registered nurse who undertakes a procedure without the competence to do so is grossly negligent and subject to discipline by the Board of Registered Nursing.

SUMMARY OF RN FUNCTIONS UNDER STANDARDIZED PROCEDURES
Registered nursing functions under standardized procedures may be summarized as follows:

WHO: the registered nurse

WHAT: may perform a medical function beyond the usual scope of RN practice

HOW: in accord with a written standardized procedure developed by nursing, medicine and administration

WHERE: in an organized health care system

WHEN: after the RN has been evaluated and approved as having met the education and experience requirements specified in the procedure

WHY: because the standardized procedure authorizes the RN to exceed the usual scope of RN practice

TO DETERMINE IF A STANDARDIZED PROCEDURE IS REQUIRED

Ask each question below in the order presented. Continue only until your answer points to "S.P. required," or to "S.P. not required."

1. Is the function commonly recognized as nursing practice?

   NO ⇓ YES ⇒ S.P. not required

2. Is it the standard of practice in the community that RNs perform this function in the clinical area for which it is being considered?

   NO ⇓ YES ⇒ S.P. not required

3. Does the function require the nurse to:
   Diagnose disease,
   Prescribe medicine or treatment, or
   Penetrate or sever tissue?

   NO ⇓ YES ⇒ S.P. required

4. Does safe performance of the function require judgment based on medical knowledge beyond that usually possessed by the competent RN in the area for which it is being considered?

   NO ⇓ YES ⇒ S.P. required

S.P. not required

WHO DEVELOPS STANDARDIZED PROCEDURES?

1. Organized Health Care Systems →
   - Health Facilities licensed by Dept. of Public Health
   - Health Facilities not licensed (CCR 1470): Clinics, Home Health Agencies, Physicians Offices, Public or Community Health Services

2. Collaborating:

   Administrators, and Health Care Professionals, including →
   - REGISTERED NURSES
   - PHYSICIANS

APPENDIX N

Policies Recommended for EMTALA Compliance

Source: Steve Lipton (with assistance from Susan Harris, RN, BSN, MPA)
February 2004

The EMTALA statute and regulations require hospitals to adopt policies and procedures to ensure compliance with the requirements of EMTALA.

Hospital Board and Medical Staff Policies

It is recommended that the following policies be adopted by the hospital board and the medical staff as evidence of the hospital's commitment to comply with EMTALA:

- The hospital board should adopt a policy expressing its commitment to comply with the requirements of EMTALA and directing each department or service responsible for meeting the EMTALA obligations to adopt policies and procedures, in-service education and a quality management program to ensure compliance with EMTALA. A Model Hospital Policy on Compliance with EMTALA is included as *Appendix O*.
- The medical staff bylaws and rules and regulations should (i) reflect compliance with the requirements of EMTALA; (ii) establish requirements for on-call coverage for emergency services; and (iii) designate physicians and other categories of health care professionals who are authorized to perform medical screening examinations. The designations should be listed for each department that performs medical screening examinations, and include any limitations that are determined appropriate by the medical staff. *Appendix M* describes the process in California for certification of health care professionals to perform medical screening examinations.

Specific Policies and Procedures

The following types of policies should be incorporated in policies and procedures adopted by the hospital and/or, as applicable, by individual departments and services responsible for compliance with EMTALA. These policies may be adopted as stand-alone policies or combined into a series of policies. The policies should be supplemented by forms as determined appropriate by the hospital.

Medical Screening Examinations

- Triage and role of the triage nurse.
- Scope of an emergency medical screening exam.
- Standardized procedures for nonphysicians performing medical screening examinations.
- Role of a managed care plan in the screening process.
- Directing patients to a hospital-owned facility outside of the emergency department including what type of patients will be directed.

- Handling of telephone orders to the emergency department by members of the attending staff.
- Documentation of medical screening examinations.

Labor and Delivery Policies

- Performance of medical screening examinations.
- Standardized procedures for nonphysicians performing medical screening examinations.
- Documentation of medical screening examinations.
- Transfer/discharge of labor patients.
- Requirements for certifying and discharging a patient with false labor.

Psychiatric Patients

- Performance of medical screening examinations (including a psychiatric assessment).
- Transfer of psychiatric patients.
- Procedures for monitoring psychiatric patients on a custodial hold.
- Role of crisis teams or other outside personnel who may evaluate the patient, write an involuntary hold and assist in the placement of the patient in a regional psychiatric evaluation and treatment facility.

Other Dedicated Emergency Departments (On-Campus and Off-Campus)

- Performance of medical screening examinations.
- Transfer requirements.
- Requirements for hospital-based off-campus services are not routinely staffed by physicians and nurses (e.g., physical therapy center).

Hospital Property (Outside of the Dedicated Emergency Department)

- Description of hospital property.
- Description of response to emergency situations in the main facility building(s).
- Description of response to emergency situations in other facility buildings on the hospital campus.
- Description of response to emergency situations in parking lots, sidewalks and other public areas.
- Contact with 9-1-1 for emergency patient management and transport of an emergency patient.

- Documentation of emergency services provided to individual on hospital property who has a potential emergency condition.
- Documentation of refusal to accept emergency services by an individual on hospital property who has a potential emergency condition.

Off-Campus Hospital Departments (that are not Dedicated Emergency Departments)

- Appraisal of individuals who may have emergency medical conditions.
- Referrals of individuals who may have emergency medical conditions.
- Documentation of emergency services provided to individuals who present with potential emergency medical conditions.

Financial Considerations; Managed Care

- Registration process.
- Contacts with managed care plans for prior authorization.
- Resolution of disputes between the hospital and a managed care physician.
- Contacts with health plans (if required) for patient medical records.
- Collection of copayments.
- Issuance of advance beneficiary notices (ABNs).
- Discussions with emergency patients of hospital charges, insurance status and payment terms.

Transfer/Discharge of Emergency Patients

- Transfer of emergency patients with unstabilized emergency medical conditions.
- Transfer of emergency patients with stabilized emergency medical conditions.
- Patient request for a transfer.
- Requirements for physician certification for transfer.
- Transferring a patient by nonphysician qualified personnel.
- Procedures for an appropriate transfer including selection of receiving hospital, obtaining consent from receiving hospital and physician, sending medical records and selecting an appropriate mode, equipment and personnel for the transfer.
- Patient reassessment at the time of transfer or discharge.
- Transferring a patient in police custody.
- Transfer of a patient for off-site tests.
- Discharge of stable patients (follow-up instructions).
- Provider and referral agreements.

Patient Refusal of Treatment or Transfer

- Patient refusal of the medical screening examination.

- Patient refusal of further examination and treatment.
- Patient refusal of a transfer.
- Patient elopement.
- Patient departure for financial reasons.
- Patient departure for other stated reasons.

Acceptance of Patient Transfers

- Policies and procedures for accepting patient transfers from other hospitals.
- Defining hospital capacity and capability including reserved beds.

Central Logs

- Content of central logs.
- Maintenance of the central log(s).

Signage

- Location of signs.
- Content of signs.

Physician On-Call Responsibilities

- Establishment and maintenance of the on-call roster.
- Requirements for physician specialty coverage (including determination of part-time coverage when permitted by law).
- Requirements for when a physician is on-call.
- Physician on-call response time.
- Physician obligation to accept a transfer.
- Requirements for on-call physician with simultaneous coverage responsibilities.
- Requirements for on-call physicians performing elective surgery when on-call.
- Resolution of disputes between treating and on-call physicians.
- Hospital/medical staff chain of command in the event of an on-call crisis or dispute.
- Refusal or failure of an on-call physician to accept a patient or to come to the hospital.

Reporting Patient Dumping Violations

- Reporting an EMTALA violation.
- Non-retaliation policy for employees and physicians who report violations.
- Resolution of internal disputes regarding patient transfers and other EMTALA compliance concerns.

Maintenance and Retention of Emergency Records

- Retention of medical records.
- Retention of central logs.
- Retention of transfer records and other emergency records.
- Retention of on-call rosters.

Quality Improvement and Risk Management

- Quality improvement and risk management activities.
- In-service education.
- EMTALA activities conducted as part of the organization's internal compliance program activities.

APPENDIX O

Model Hospital Policy on Compliance with EMTALA

Source: **M. Steven Lipton, Davis Wright Tremaine LLP**
Revised 11/17

Compliance with Emergency Medical Treatment and Active Labor Act (EMTALA)

I. Purpose

To describe and comply with EMTALA and to define policies and procedures for compliance with the EMTALA obligations.

II. Policy

A. **Compliance**. It is the policy of the Hospital to comply with the EMTALA obligations. These policies are mandated by Section 1867 of the Social Security Act, as amended, and regulations adopted by the Centers for Medicare & Medicaid Services (CMS), and applicable state laws governing the provision of emergency services and care.

B. **Non-Discrimination**. The Hospital will provide emergency services and care without regard to an individual's race, ethnicity, national origin, citizenship, age, sex, sexual orientation, preexisting medical condition, physical or mental disability, insurance status, economic status, ability to pay for medical services, or any other characteristic listed in the Unruh Civil Rights Act, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental disability is medically significant to the provision of appropriate medical care to the patient.

C. **Enforcement**. CMS and the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services are responsible for the enforcement of EMTALA. Violations of EMTALA may be reported to other federal and state agencies and to the Joint Commission.

D. **Sanctions**. Failure to comply with EMTALA may result in termination by CMS of the Hospital's participation in the Medicare and Medicaid programs, as well as civil monetary penalties imposed by the OIG for both the Hospital and physicians of up to $50,000 and possible exclusion from Medicare/Medicaid. Failure to comply with state laws on emergency services is subject to a licensing enforcement action. A violation of EMTALA is also subject to civil lawsuits for damages.

III. Definitions

A. **Appropriate Transfer** means a transfer of an individual with an emergency medical condition that is implemented in accordance with EMTALA standards (see VIII below).

B. **Campus** means the buildings, structures and public areas of the Hospital that are located on Hospital property (see III.L below). **Off-Campus** means the buildings, structure and public areas of the Hospital that are located off-site of the Hospital property.

C. **Capability** means the physical space, equipment, staff, supplies and services (e.g., surgery, intensive care, pediatrics, obstetrics and psychiatry), including ancillary services available at the Hospital.

D. **Capacity** means the ability of the Hospital to accommodate an individual requesting or needing examination or the treatment of a transferred individual. Capacity encompasses the number and availability of qualified staff, beds, equipment and the Hospital's past practices of accommodating additional individuals in excess of its occupancy limits.

E. **Central Log** means a log maintained by the Hospital on each individual who comes to its dedicated emergency department(s) or any location on the Hospital property seeking emergency assistance and the disposition of each individual.

F. **Comes to the Emergency Department** means an individual who—

(1) Presents at the Hospital's dedicated emergency department and requests or has a request made on his/her behalf for examination or treatment for a medical condition, or a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs examination or treatment for a medical condition;

(2) Presents on Hospital property other than a dedicated emergency department, and requests or has a request made on his/her behalf for examination or treatment for what may be an emergency medical condition, or a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs emergency examination or treatment;

(3) Is in a ground or air ambulance owned and operated by the Hospital for the purposes of examination or treatment for a medical condition at the Hospital's dedicated emergency department, unless the ambulance is operated (i) under communitywide EMS protocols that direct the ambulance to transport the individual to another facility

(e.g., the closest available facility); or (ii) at the direction of a physician is not employed or affiliated with the Hospital; or

(4) Is in a non-Hospital owned ground or air ambulance that is on Hospital property for presentation for examination or treatment for a medical condition at the Hospital's dedicated emergency department.

G. **Dedicated Emergency Department** means any department of the Hospital, (whether located on Hospital property or off-campus) that meets at least one of the following requirements:

(1) It is licensed under applicable state law as an emergency room or emergency department; or

(2) It is held out to the public (by name, posted signs, advertising or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or

(3) During the immediately preceding calendar year, it provided (based on a representative sample) at least one-third of all its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

H. **Department of the Hospital** means a Hospital facility or department that provides services under the name, ownership, provider number and financial and administrative control of the Hospital. For purposes of EMTALA, a department of the Hospital does not include a skilled nursing facility, home health agency, rural health clinic, free-standing ambulatory surgery center, private physician office or any other provider or entity that participates in the Medicare program under a separate provider number.

I. **EMTALA** means the Emergency Medical Treatment and Active Labor Act codified in §§1866 and 1867 of the Social Security Act (42 U.S.C. §1395dd), and the regulations and interpretive guidelines adopted by CMS thereunder. EMTALA is also referred to as the "patient anti-dumping" law.

J. **Emergency Medical Condition** means:

(1) A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) 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

(2) With respect to a pregnant woman who is having contractions:

i. When there is inadequate time to effect a safe transfer to another hospital before delivery; or

ii. The transfer may pose a threat to the health or safety of the woman or the unborn child.

K. **Hospital** means a Hospital that has entered into a Medicare provider agreement, including a critical access or rural primary care hospital.

L. **Hospital Property** means the entire main Hospital campus, including areas and structures that are located within 250 yards of the main buildings, and any other areas determined on an individual case basis by the CMS regional office, to be part of the main Hospital's campus. Hospital property includes the parking lots, sidewalks, and driveways on the main Hospital campus.

M. **Inpatient** means an individual who is admitted to the Hospital for bed occupancy for purposes of receiving inpatient services with the expectation that he/she will remain at least overnight and occupy a bed, even though the individual may be later discharged or transferred to another facility and does not actually use a Hospital bed overnight.

N. **Labor** means the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman is in true labor unless a physician, certified nurse-midwife or another qualified person acting within the scope of his/her practice (and the Medical Staff Bylaws), certifies that, after a reasonable period of observation, the woman is in false labor.

O. **Medical Screening Examination** means the process required to reach within reasonable clinical confidence, the point at which it can be determined whether or not an emergency medical condition exists or a woman is in labor. The medical screening examination is an ongoing process, including monitoring of the individual, until the individual is either stabilized or transferred.

P. **On-Call List** means the list of physicians who are "on-call" after the initial medical screening examination to provide further evaluation and/or treatment necessary to stabilize an individual with an emergency medical condition.

Q. **Outpatient** means an individual who has begun to receive outpatient services as part of an encounter, other than an encounter that triggers the EMTALA obligations. An "encounter" is a direct personal contact between an outpatient and a physician or qualified medical person who is authorized by state law to order or furnish Hospital services for the diagnosis or treatment of the outpatient.

R. **Physician** means: (i) a doctor of medicine or osteopathy; (ii) a doctor of dental surgery or dental medicine; (iii) a doctor of podiatric medicine; or (iv) a doctor of optometry, each acting within the scope of his/her respective licensure and clinical privileges.

S. **Physician Certification** means the written certification by the treating physician ordering a transfer and setting forth, based on the information available at the time of transfer, that the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of a woman in labor, to the unborn child, from effecting the transfer.

T. **Qualified Medical Person** means an individual other than a licensed physician who (i) is licensed or certified by the state in which the Hospital is located; (ii) practices in a category of health professionals that has been designated by the Hospital and the medical staff bylaws, rules and regulations, to perform medical screening examinations within the scope of his/her designation; (iii) has demonstrated current competence in the performance of medical screening examinations within his/her health profession; and (iv) as applicable, performs the medical screening examination in accordance with protocols, standardized procedures or other policies as may be required by law or Hospital policy. A qualified medical person may include registered nurses, nurse practitioners, nurse-midwives, psychiatric social workers, psychologists and physician assistants.

U. **Signage** means the signs posted by the Hospital in its dedicated emergency department(s) and in a place or places likely to be noticed by all individuals entering the dedicated emergency department(s) (including waiting room, admitting area, entrance and treatment areas), that inform individuals of their rights under EMTALA.

V. **Stabilized** means, with respect to an emergency medical condition, that no material deterioration of the condition is likely within reasonable medical probability, to result from or occur during the transfer of the individual from the Hospital or in the case of a woman in labor, that the woman delivered

the child and the placenta. An individual will be deemed stabilized if the treating physician has determined, within reasonable clinical confidence, that the emergency medical condition has been resolved.

W. **To Stabilize** means, with respect to an emergency medical condition, to either provide such medical treatment of the condition as may be 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 from the Hospital or, in the case of a woman in labor, that the woman has delivered the child and the placenta.

X. **Transfer** means the movement (including the discharge) of an individual outside the Hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the Hospital, but does not include such a movement of an individual who has been declared dead or who leaves the Hospital against medical advice or without being seen.

Y. **Triage** means a process to determine the order in which individuals will be provided a medical screening examination by a physician or qualified medical person. Triage is not the equivalent of a medical screening examination and does not determine the presence or absence of an emergency medical condition.

IV. Scope of EMTALA

A. **Application to the Hospital**. EMTALA is applicable to any individual who comes to the emergency department (see definition in III.F above).

B. **Where EMTALA Does Not Apply**. EMTALA does not apply to the following:

(1) An outpatient during the course of his/her encounter (even if the outpatient develops an emergency medical condition while receiving outpatient services and is taken to the dedicated emergency department for further examination and treatment);

(2) An inpatient (including inpatients who are "boarded" in the dedicated emergency department waiting for an available bed);

(3) An individual who presents to any off-campus department of the Hospital that is not a dedicated emergency department;

(4) An individual who presents to a rural health clinic, skilled nursing facility or home health agency owned or operated by the Hospital, whether located on-campus or off-campus, or a private physician's

office or other ambulatory care clinic that participates separately from the Hospital in the Medicare program;

(5) Restaurants, private residences, shops or other nonmedical facilities that are not part of the Hospital.

C. **Application to Physicians**. EMTALA is applicable to any physician who is responsible for the examination, treatment or transfer of an individual to whom EMTALA applies, including an on-call physician and other members of the medical staff who provide for the care of such an individual.

D. **Dedicated Emergency Departments**. The Hospital has determined that the following departments of the Hospital are dedicated emergency departments:

(1) Emergency Department

(2) Labor & Delivery

(3) Psychiatric Service

(4) Urgent Care Center

(5) [modify above list and/or insert other applicable departments]

V. General Policies

A. **Signage**. The Hospital will post signage conspicuously in lobbies, waiting rooms, admitting areas and treatment rooms where examination and treatment occurs in the form required by CMS that specifies the rights of individuals to examination and treatment for emergency medical conditions and whether the Hospital participates in the Medicaid program. Signage will be posted in each dedicated emergency department.

B. **Central Log**. Each dedicated emergency department of the Hospital will maintain a central log recording the names of individuals who come to the emergency department. The central log will record the name of each person who presents for emergency services and whether the person refused treatment, was refused treatment by the Hospital or whether the individual was transferred, admitted and treated, stabilized and transferred or discharged. Each dedicated emergency department will establish its own central log policy and procedure.

C. **On-Call Coverage**. The Hospital will maintain a list of physicians who are on-call to come to the Hospital to consult or provide treatment necessary to stabilize an individual with an emergency medical condition. The on-call list will be maintained in a manner that best meets the needs of the individuals who are receiving emergency services in accordance with the resources available to the Hospital, including the availability of on-call

physicians. On-call physician responsibilities to respond, examine and treat emergency patients will be defined in the medical staff bylaws, rules and regulations. Each dedicated emergency department will be prospectively aware of the physicians who are on-call to the department. The notification of an on-call physician will be documented in the medical record and any failure or refusal of an on-call physician to respond to call will be reported to the medical staff.

D. **Maintenance of Records**. Medical and other records (such as transfer logs, on-call lists and changes to the on-call list and central logs) will be maintained in accordance with Hospital record retention policies, but not less than five years.

E. **Disputes**. In the event of any concern over emergency services to an individual, or a dispute with another facility regarding a transfer or a concern about the Hospital's compliance with EMTALA, Hospital staff or physicians will refer the dispute to the department or person designated by the Hospital.

F. **Reporting EMTALA Violations**. The Hospital will report to CMS or the state survey agency if it has a reason to believe that it has received an individual who has been transferred in an unstabilized emergency medical condition from another facility. All Hospital personnel who believe that an EMTALA violation has occurred will report the violation to the department or person designated by the Hospital.

G. **Retaliation**. The Hospital will not retaliate, penalize or take adverse action against any physician or qualified medical person for refusing to transfer an individual with an emergency medical condition that has not been stabilized, or against any Hospital employee for reporting a violation of EMTALA or state laws to a governmental enforcement agency.

VI. Medical Screening Examination

A. **Policy Statement**. A medical screening examination will be offered to any individual who comes to the emergency department. The medical screening examination must be provided within the capability of the dedicated emergency department, including ancillary services routinely available to the dedicated emergency department (including the availability of on-call physicians). The medical screening examination must be the same appropriate examination that the Hospital would perform on any individual with similar signs and symptoms, regardless of the individual's ability to pay for medical care.

B. **Scope**. The scope of the medical screening examination must be tailored to the presenting complaint and the medical history of the individual. The

process may range from a simple examination (such as a brief history and physical) to a complex examination that may include laboratory tests, MRI or diagnostic imaging, lumbar punctures, other diagnostic tests and procedures and the use of on-call physicians.

C. **Comparison with Triage**. Triage is not equivalent to a medical screening examination. Triage merely determines the "order" in which individuals will be seen, not the presence or absence of an emergency medical condition.

D. **Continuous Monitoring**. The medical screening examination is a continuous process reflecting ongoing monitoring in accordance with an individual's needs. Monitoring will continue until the individual is stabilized or appropriately transferred. Reevaluation of the individual must occur prior to discharge or transfer.

E. **Personnel Qualified to Perform Medical Screening Examinations**. The categories of qualified medical persons qualified to perform medical screening examinations in the dedicated emergency department(s) and other departments of the Hospital will be defined in the medical staff rules and regulations.

F. **Department Policies**. Each Hospital department will adopt policies and procedures that describe the conduct of the medical screening examination in its dedicated emergency department(s) and other departments of the Hospital. The policies will also describe the documentation of patient records, on-going in-service training of Hospital personnel and quality management review of medical screening examinations.

VII. Patient Registration

A. **Policy**. The Hospital will provide a medical screening examination, and, as clinically indicated, initiate necessary stabilizing treatment, without first inquiring about an individual's method of payment or insurance status.

B. **Patient Registration**. The Hospital may follow reasonable registration processes for individuals for whom examination or treatment is required under EMTALA.

C. **Prior Authorization**. The Hospital may not seek, or direct an individual to seek, authorization from the individual's insurance company or health plan for the medical screening examination or stabilizing treatment until the hospital has provided the medical screening examination and initiated any further examination and treatment that may be required to stabilize the emergency medical condition.

VIII. Transfer of Individuals with an Emergency Medical Condition

A. **Policy Statement**. The Hospital will not transfer an individual with an unstabilized emergency medical condition unless (i) the individual makes an informed request for the transfer; or (ii) a physician certifies that the medical benefits reasonably expected from the provision of treatment at the receiving facility outweigh the risks to the individual from the transfer. The Hospital must provide additional examination and treatment within its capacity as may be required to stabilize the emergency medical condition until the individual leaves the Hospital.

B. **Requirements for an Appropriate Transfer**. An individual with an unstabilized emergency medical condition may be transferred only if the Hospital complies with ***all*** of the following standards:

(1) The Hospital provides medical treatment within its capacity to minimize the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child; the medical record will reflect the vital signs and condition of the individual at the time of the transfer;

(2) The receiving facility has available space and qualified personnel for treatment of the individual; and the receiving facility and receiving physician have agreed to accept the individual and to provide appropriate medical treatment;

(3) The Hospital sends to the receiving facility all medical records (or copies thereof) available at the time of transfer related to the emergency medical condition of the individual, including (i) records related to the individual's emergency condition; (ii) the individual's informed written consent to transfer or the physician certification (or copy thereof); and (iii) the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment; and

(4) The transfer is effected using proper personnel and equipment, as well as necessary and medically appropriate life-support measures.

C. **Transfers for Off-Site Tests**. If an individual who has or may have an emergency medical condition is transferred to another facility for a test with the intention of the individual returning to the Hospital after the test, the Hospital will effect an appropriate transfer.

D. **Department Policies**. Each dedicated emergency department and other departments of the Hospital that transfer individuals with emergency medical conditions will adopt policies and procedures that describe the procedures for the transfer of individuals and documentation of the transfer,

and conduct ongoing, in-service training of dedicated emergency department personnel.

E. **Disputes**. The treating physician is responsible to determine whether an individual is stabilized and the mode of transportation for the transfer.

IX. Refusal of Emergency Services or Transfer

A. **Policy**. An individual retains the right to refuse necessary stabilizing treatment and further medical examination, as well as a transfer to another facility.

B. **Refusal of Medical Screening Examination**. If an individual leaves the Hospital before receiving a medical screening examination, either with or without notice to staff of his/her departure, staff should document the circumstances and reasons (if known) for the individual's departure and the time of departure.

C. **Refusal of Further Examination or Stabilizing Treatment**. If an individual who has received a medical screening examination refuses to consent to further examination or stabilizing treatment, the Hospital must offer the examination and treatment to the individual, inform the individual of the risks and benefits of the examination and treatment and request that the individual sign a form that he/she has refused further examination or treatment.

D. **Refusal of a Transfer**. An individual offered a transfer by the Hospital to another medical facility in accordance with the EMTALA requirements and the Hospital has informed the individual (or his/her representative) of the risks and benefits to the individual of the transfer, the individual (or his/her representative) may refuse the transfer. The Hospital must take all reasonable steps to secure the individual's (or his/her representative's) written informed consent to the refusal of the transfer.

X. Acceptance of Transfers

A. **Policy Statement**. The Hospital has the obligation to accept an appropriate transfer of an individual with an unstabilized emergency medical condition who requires specialized capabilities or facilities if the Hospital has the capacity to treat the individual.

B. **Policies and Documentation**. Each department of the Hospital that is contacted to accept emergency patient transfers will have policies and procedures for receiving inquiries from other facilities, including documentation of calls, the names (if known) and conditions of individuals, the outcomes of the calls and the reasons if the Hospital refuses to accept the transfer.

C. **Disputes**. The treating physician is responsible to determine whether an individual is stabilized and the mode of transportation for the transfer.

XI. Quality Improvement

Monitoring EMTALA compliance is a responsibility of Hospital administration, the medical staff, department heads, performance improvement and risk management. The Hospital and medical staff will adopt a monitoring program to evaluate the conduct of the medical screening examinations, transfers, on-call coverage and other areas for which the Hospital determines the need for oversight in order to maintain compliance with the EMTALA obligations.

APPENDIX P

CHA Transfer Forms and Model Signage

Source: **California Hospital Association**
Consent Manual

Forms:
Refusal to Permit Medical Treatment, CHA Form 5-1

Patient Refusal of Transfer, CHA Form 9-1

Consent to Transfer for Medical Treatment, CHA Form 9-3

Physician Certification, CHA Form 9-4

Physician Authorization for Transfer, CHA Form 9-5

Patient Refusal of Further Medical Treatment, CHA Form 9-6

Patient Transfer Acknowledgement, CHA Form 9-7

Patient Request for Transfer for Discharge, CHA Form 9-8

Notice for Emergency Room, CHA Form 9-9

Detention of Patient with Psychiatric Emergency in a Nondesignated Health Facility, CHA Form 12-12

Sign: Obstetrical Care Notice (Appendix 10-C)

FORM 5-1

Refusal to Permit Medical Treatment

My doctor *(physician name)* _____,

has advised the following medical treatment: _____

_____

My doctor has informed me of the following:

1. The nature and advisability of this medical treatment.
2. The risks and complications of this medical treatment.
3. The expected benefits of this medical treatment.
4. The alternatives to this medical treatment and their risks and benefits.
5. The probable consequences of not receiving this medical treatment.

I understand that the doctor named above and other doctors who provide services to me are not employees or agents of the hospital. They are independent medical practitioners.

Notwithstanding the recommendation of my doctor, I hereby request that this medical treatment not be administered to me during my stay at *(name of hospital)* _____ .

I hereby release the hospital, its personnel, my doctor, and any other persons participating in my care from any responsibility whatsoever for any injury or unfavorable consequences which may occur as a result of my refusal to permit this medical treatment.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(legal representative)

NOTE: This form should include taglines as required by the Affordable Care Act. *(See www.calhospital.org/taglines, for detailed information.)*

FORM 5-1S

NEGATIVA A PERMITIR TRATAMIENTO MÉDICO

Mi médico *(nombre del médico)* _____ ha aconsejado el siguiente tratamiento médico: _____

_____

Mi médico me ha informado lo siguiente:

1. La naturaleza y la conveniencia de este tratamiento médico.
2. Los riesgos y las complicaciones de este tratamiento médico.
3. Los beneficios que se esperan de este tratamiento médico.
4. Las alternativas a este tratamiento médico y sus riesgos y beneficios.
5. Las consecuencias probables de no recibir este tratamiento médico.

Entiendo que el médico antes nombrado y otros médicos que me prestan servicios no son empleados ni agentes del hospital, son médicos independientes.

Sin perjuicio de la recomendación de mi médico, por la presente, solicito que no se me administre este tratamiento médico durante mi permanencia en el *(nombre del hospital)* _____ .

Por la presente eximo al hospital, a su personal, a mi médico y a otras personas que participen en mi atención de toda responsabilidad, sea cual fuere, por cualquier lesión o consecuencia adversa que se pueda producir debido a mi negativa a permitir este tratamiento médico.

Fecha: _____ Hora: _____
AM / PM

Firma: _____
(paciente/representante legal)

En caso de que lo firmase una persona que no sea el paciente, indique la relación: _____

Nombre en letra de imprenta: _____
(representante legal)

NOTE: This form should include taglines as required by the Affordable Care Act.
(See www.calhospital.org/taglines, for detailed information.)

FORM 9-1

Patient Refusal of Transfer

I acknowledge that I have been offered a transfer to another medical facility for medical treatment and that I refuse this transfer. I have been informed of the risks and consequences potentially involved in this refusal, the possible benefits of transfer to another medical facility, and any alternatives to my decision to refuse the transfer.

I refuse this transfer because _____

_____

_____

I hereby release the attending physician, any other physicians involved in my care, the hospital, and its agents and employees, from all responsibility for any ill effects which may result from my refusal of further medical examination and treatment.

I understand that the physicians involved in my care are not employees or agents of the hospital. They are independent medical practitioners.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(legal representative)

COPY MUST BE GIVEN TO PATIENT.

NOTE: This form should include taglines as required by the Affordable Care Act.
(See www.calhospital.org/taglines, for detailed information.)

Reference: 42 U.S.C. Section 1395dd(b)(2)

FORM 9-1S

Rechazo de Traslado de Parte del Paciente

Reconozco que se me ha ofrecido ser trasladado a otra institución médica para recibir tratamiento médico y que yo rechazo dicho traslado. Se me ha informado acerca de los riesgos y consecuencias que pueden estar implícitas en este rechazo, de los posibles beneficios de ser trasladado a otra institución médica y de cualquier alternativa a mi decisión de rechazar dicho traslado.

Yo rechazo dicho traslado porque _____

_____

_____

Por medio de la presente exonero al médico de mi caso, a cualquier otro médico involucrado en mi atención médica al hospital y a sus agentes y empleados, de toda responsabilidad por cualquier efecto adverso que pueda resultar de mi rechazo de un exámen y tratamiento médico adicional.

Entiendo que el médico que me atiende y otros médicos que me brindan servicios no son empleados ni agentes del hospital. Son médicos facultativos independientes.

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(paciente o representante legal)

Si no lo firma el paciente, indique la relación con éste: _____

Nombre en letra de imprenta: _____
(representante legal)

COPY MUST BE GIVEN TO PATIENT.

NOTE: This form should include taglines as required by the Affordable Care Act.
(See www.calhospital.org/taglines, for detailed information.)

Reference: 42 U.S.C. Section 1395dd(b)(2)

FORM 9-3

Consent to Transfer for Medical Treatment

Patient's Name: _____

My attending physician is Dr. *(physician name)* _____.

My physician has recommended that I should be transferred to *(name of receiving facility)* _____ _____ where the following procedure(s) will be performed *(name of procedure)* _____ _____ by or under the supervision of Dr. *(name of receiving physician)* _____ . I have separately given my consent for the performance of this procedure(s).

Upon my consent, arrangements will be made to transfer me from this hospital to the facility named above. Before I give consent, I have the right to be informed of any risks or complications which may result from the transfer.

My physician has recommended the following method of transportation *(specify method of transportation)* _____ and, except in those cases in which an employee of the hospital accompanies me during the transfer, the hospital does not assume any responsibility for my care during the transfer or during my absence from the hospital.

Temporary Absence Release for Transfer to Another Facility

Having given my permission to the attending physician(s) and obtained his/her permission to be absent from the hospital for the performance of a medical procedure(s) at *(name of receiving facility)* _____ from *(time)* _____, *(date)* _____ to *(approximately) (time)* _____, *(date)* _____, I assume all responsibility for myself during the temporary absence. I hereby release *(name of transferring hospital)* _____, its employees and all attending physician(s) from all responsibility during my absence and for my condition as a result.

(over)

My signature below constitutes my acknowledgment (1) that I have read and agree to the foregoing; (2) that the plans for my transfer and the procedure(s) to be performed following the transfer have been adequately explained to me by my physician; (3) that I have received all of the information I desire concerning such plans and procedure(s); and (4) that I consent to the transfer to the facility named above for the performance of the medical procedure.

The physicians involved in your care are not employees or agents of the hospital. They are independent medical practitioners.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(legal representative)

NOTE: This form should include taglines as required by the Affordable Care Act.
(See www.calhospital.org/taglines, for detailed information.)

FORM 9-3S

Consentimiento de Traslado Para Recibir Tratamiento Médico

Nombre del/de la paciente: _____

El médico que me atiende es el/la Dr./Dra. *(nombre del médico)* _____.

Mi médico recomendó que me trasladaran a *(nombre del establecimiento que lo/la recibe)* _____ _____ en donde me realizarán los siguientes procedimientos *(nombre de los procedimientos)* _____ _____ con la supervisión del/de la Dr./Dra. *(nombre del médico que lo/la recibe)* _____. He dado mi consentimiento por separado para la realización de estos procedimientos.

Con mi consentimiento, se harán todos los arreglos necesarios para que me trasladen de este hospital al establecimiento mencionado anteriormente. Antes de dar mi consentimiento, tengo derecho a recibir información sobre cualquier riesgo o complicación que pueda surgir del traslado.

Mi médico ha recomendado el siguiente método de transporte *(especifique el método de transporte)* _____ y, salvo en los casos en los cuales un empleado del hospital me acompañe durante el traslado, el hospital no asume ninguna responsabilidad sobre mi atención durante el traslado o durante mi ausencia en el hospital.

Eximición de Responsabilidad por Ausencia Temporal Para Traslado a Otro Establecimiento

Después de haberle dado mi permiso al médico que me atiende y después de haber obtenido su permiso para ausentarme del hospital para que me realicen un procedimiento médico en *(nombre del establecimiento que lo/la recibe)* _____ desde *(hora)* _____ _____, *(fecha)* _____ hasta *(aproximadamente) (hora)* _____, *(fecha)* _____, asumo toda responsabilidad sobre mi persona durante mi ausencia temporaria. Por medio de la presente, eximo a *(nombre del hospital desde donde se hace el traslado)* _____, sus empleados y a todos los médicos que me atendieron de toda responsabilidad durante mi ausencia y de mi estado de salud como resultado del traslado.

(sobre)

Mi firma a continuación confirma que (1) he leído y estoy de acuerdo con lo que se menciona anteriormente; (2) mi médico me ha explicado de manera adecuada los planes para mi traslado y los procedimientos que se me realizarán después de este traslado; (3) he recibido toda la información relacionada con dichos planes y procedimientos; y (4) doy mi consentimiento para trasladarme al establecimiento que se menciona anteriormente para que se me realicen los procedimientos médicos.

Los médicos que lo/la atienden no son empleados o agentes del hospital. Son médicos independientes.

Fecha: _____ Hora: _____
AM / PM

Firma: _____
(paciente/representante legal)

Si no lo firma el paciente, indique la relación con éste: _____

Nombre en letra de imprenta: _____
(representante legal)

NOTE: This form should include taglines as required by the Affordable Care Act. *(See www.calhospital.org/taglines, for detailed information.)*

FORM 9-4

Physician Certification

I, *(physician name)* _____, the undersigned physician, have examined and evaluated *(patient name)* _____.

Check box A or B as Applicable

☐ A. Patient's Condition is Not Stabilized

Based on my examination, the information available to me at this time, and my assessment of the reasonable risks and benefits to the patient, I have concluded for the reasons that follow that, as of the time of transfer, the benefits reasonably expected from the provision of continued medical and/or psychiatric treatment at another facility outweigh the increased risks, if any, to the patient and, if pregnant, to the patient's unborn child, from effecting the transfer.

☐ B. Patient's Condition is Stabilized

I believe, within reasonable medical probability, that the transfer will not result in a material deterioration in, or jeopardy to, the medical or psychiatric condition or expected chances for recovery of the patient or, if pregnant, of the patient's unborn child.

Reasons for transfer, including summary of risks and benefits: _____

_____

_____

Updated status of patient's condition: _____

_____

_____

Date: _____ Time: _____ AM / PM

Signature: _____
(physician)

Print name: _____
(physician)

(over)

NOTE: If the physician is not physically present in the emergency department (or in labor and delivery, if applicable) at the time the patient is transferred, a qualified medical person (QMP) may sign the certification after a physician, in consultation with the qualified medical person, has made the necessary determination. The physician must countersign the certification later.

Date: _____ Time: _____ AM / PM

Signature: _____
(qualified medical professional)

Print name: _____
(qualified medical professional)

Date: _____ Time: _____ AM / PM

Counter signature if above signed by a QMP: _____
(physician)

Print name: _____
(physician)

COPY MUST BE SENT WITH PATIENT.

Reference: 42 U.S.C. Section 1395dd(c)(1)(A)(ii)
Health and Safety Code Section 1317.2(b)

FORM 9-5

Physician Authorization for Transfer

Patient Name: _____

Section 1

Check One of the Following

- ❑ A. The patient's emergency medical condition has been stabilized such that within reasonable medical probability, no material deterioration in the condition or expected chances for recovery of the patient are likely to result from or occur during transfer. (With regard to a woman in labor, the patient has already delivered, including the placenta.)
- ❑ B. The patient's emergency medical condition has not been stabilized.

Section 2

Complete only if Section 1(B) above has been checked. If 1(B) has not been checked, proceed to Section 3.

Check One of the Following

- ❑ A. The patient requests transfer. *(Complete "Patient Request for Transfer or Discharge," CHA Form 9-8.)*
- ❑ B. A legally responsible person acting on the patient's behalf requests transfer. *(Complete "Patient Request for Transfer or Discharge," CHA Form 9-8.)*

  Name of person requesting transfer: _____

  Relationship to patient: _____
- ❑ C. Based on the reasonable risks and benefits to the patient, and based upon the information available at the time of the patient's examination, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks, if any, to the patient and, if pregnant, to the patient's unborn child from effecting the transfer. *(Complete "Physician Certification," CHA Form 9-4.)*

Section 3

Check Below as Appropriate

NOTE: The patient may not be transferred unless each of the following requirements is met:

- ❑ A. The receiving facility has available space and qualified personnel for the treatment of the patient.

  Name of facility: _____

❑ B. The receiving facility has agreed to accept transfer and to provide appropriate medical treatment.

Name of person accepting transfer: _____

Position: _____

❑ C. The receiving facility will be provided with appropriate medical records related to the emergency condition of the patient.

❑ D. The patient will be transferred by qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures *(see Section 6 below)*.

Section 4

Transfer is Refused, Check (A) or (B) Below

❑ A. The patient was offered transfer, but refused. *(Complete "Patient Refusal of Transfer," CHA Form 9-1.)*

❑ B. Transfer was offered, but refused by a legally responsible person acting on the patient's behalf. *(Complete "Patient Refusal of Transfer," CHA Form 9-1.)*

Section 5

Completed by Transferring Physician

Time: _____

Updated status of patient's condition: _____

_____

I certify that I have answered the above questions, based upon the information available to me at the time of the patient's examination.

Date: _____ Time: _____ AM / PM

Signature: _____
(physician authorizing transfer)

Print name: _____
(physician authorizing transfer)

Section 6

Mode of Transport: Report of Patient's Status During Transport Attached

❑ Paramedic unit

❑ EMT unit

❑ Air transport

❑ Personnel (e.g., physician, MICN, and/or respiratory therapist): _____

FORM 9-6

Patient Refusal of Further Medical Treatment

I acknowledge that I have been examined and that I have been offered further examination and treatment at *(hospital name)* _____. However, I refuse further medical examination and treatment. I have been informed of the risks and consequences potentially involved in this refusal, the possible benefits of continuing medical treatment at this hospital, and any alternatives to my decision to refuse further examination and treatment.

I hereby release the attending physician, any other physicians involved in my care, the hospital, and its agents and employees, from all responsibility for any ill effects which may result from my refusal of further medical examination and treatment.

I understand that the physicians involved in my care are not employees or agents of the hospital. They are independent medical practitioners.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(legal representative)

COPY MUST BE GIVEN TO PATIENT.

NOTE: This form should include taglines as required by the Affordable Care Act. *(See www.calhospital.org/taglines, for detailed information.)*

Reference: 42 U.S.C. Section 1395dd(b)(3)

FORM 9-6S

Rechazo por Parte del Paciente de Tratamiento Medico Adicional

Reconozco que he sido examinado y que me han ofrecido un examen y tratamiento adicionales en este hospital *(nombre de hospital)* _____ . Sin embargo, rehúso dicho examen y tratamiento médico adicionales. Se me ha informado acerca de los riesgos y posibles consecuencias de mi rechazo, de los posibles beneficios de continuar el tratamiento médico en este hospital y cualquier alternativa a mi decisión de rechazar el examen y tratamiento adicionales.

Por medio del presente exonero al médico del caso, a cualquier otro médico involucrado en mi atención médica, al hospital y a sus agentes y empleados, de toda responsabilidad por cualquier efecto adverso que pueda resultar de mi rechazo de un examen y tratamiento médico adicionales.

Entiendo que el médico que me atiende y otros médicos que me brindan servicios no son empleados ni agentes del hospital. Son médicos facultativos independientes.

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(paciente o representante legal)

Si no lo firma el paciente, indique la relación con éste: _____

Nombre en letra de imprenta: _____
(representante legal)

COPY MUST BE GIVEN TO PATIENT.

NOTE: This form should include taglines as required by the Affordable Care Act.
(See www.calhospital.org/taglines, for detailed information.)

Reference: 42 U.S.C. Section 1395dd(b)(3)

FORM 9-7

Patient Transfer Acknowledgment

Re: Transfer of _____
(patient name)

I understand that I have a right to receive medical screening, examination, and evaluation by a physician (or other appropriate personnel), without regard to my ability to pay, prior to any transfer from this hospital. I also have a right to be informed of the reasons for any transfer. I acknowledge that I have received medical screening, examination, and evaluation by a physician (or other appropriate personnel), and that I have been informed of the reasons for my transfer.

I understand that the physicians involved in my care are not employees or agents of the hospital. They are independent medical practitioners.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(legal representative)

Should you have any complaints concerning the services you have received from this hospital, you may contact:

Department of Public Health, Licensing and Certification

_____ *District Office

_____

_____

COPY MUST BE SENT WITH PATIENT.

**Fill in the name, address and telephone number of the appropriate CDPH district office.*

NOTE: This form should include taglines as required by the Affordable Care Act.
(See www.calhospital.org/taglines, for detailed information.)

Reference: Health and Safety Code Section 1317.3(d)

FORM 9-7S

Reconocimiento de Traslado por Parte del Paciente

Asunto: Traslado de _____
(nombre del paciente)

Entiendo que tengo el derecho a recibir un diagnóstico inicial, examen y evaluación médica de parte de un médico u otro miembro capacitado del personal, independientemente de mi habilidad de pagar, antes de ser trasladado de este hospital y que tengo el derecho a que se me informe de los motivos de cualquier traslado. También tengo el derecho de que se me informen los motivos de todo traslado. Reconozco que he recibido un diagnóstico inicial, examen y evaluación médicos de parte de un médico u otro miembro capacitado del personal y que se me ha informado de las razones de mi traslado.

Entiendo que el médico que me atiende y otros médicos que me brindan servicios no son empleados ni agentes del hospital. Son médicos facultativos independientes.

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(paciente o representante legal)

Si no lo firma el paciente, indique la relación con éste: _____

Nombre en letra de imprenta: _____
(representante legal)

Si tiene usted cualquier queja respecto a los servicios que ha recibido de este hospital, puede ponerse en contacto con:

Departamento de Salud Pública de California, Certificación y Licencias

_____ *Oficina de Destrito

_____

_____

COPY MUST BE SENT WITH PATIENT.

**Fill in the name, address and telephone number of the appropriate CDPH district office.*

NOTE: This form should include taglines as required by the Affordable Care Act.
(See www.calhospital.org/taglines, for detailed information.)

Reference: Health and Safety Code Section 1317.3(d)

FORM 9-8

Patient Request for Transfer or Discharge

This is to certify that I, *(patient name)* _____,
a patient who has received services at *(hospital name)* _____
_____, am being transferred or discharged at my or my legal representative's request.

I acknowledge that I have been informed of the hospital's obligations under the Emergency Medical Treatment and Active Labor Act to provide me a medical screening exam to determine whether I have an emergency medical condition, and if I do, to provide me the medical treatment needed to stabilize my condition.

I have been informed of the risks and consequences potentially involved in the transfer discharge, which are _____

_____

and the possible benefits of continuing treatment at this hospital, which are _____

_____

and the alternatives, if any, to the transfer or discharge I am requesting, and the obligation of this hospital to provide further examination and treatment, within its available staff and facilities, as required to stabilize my medical condition.

I request this transfer or discharge because _____

_____

I hereby release the attending physician, any other physicians involved in my care, the hospital, and its agents and employees, from all responsibility for any ill effects which may result from the transfer or delay involved in the transfer.

I understand that the physicians involved in my care are not employees or agents of the hospital. They are independent medical practitioners.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(legal representative)

COPY MUST BE SENT WITH PATIENT.

NOTE: This form should include taglines as required by the Affordable Care Act.
(See www.calhospital.org/taglines, for detailed information.)

Reference: 42 U.S.C. Section 1395dd(c)(1)(A)(i)
Health and Safety Code Section 1317.2(j)

FORM 9-8S

Solictud de Traslado o Para ser Dado se Alta se Parte sel Paciente

La presente es para certificar que yo *(nombre del paciente)*_____, un paciente que ha recibido servicios en este hospital *(nombre de hospital)* _____, está siendo trasladado o dado de alta a petición mia o la de mi representante legal.

Reconozco que he recibido información acerca de las obligaciones del hospital en virtud de la Ley de Tratamiento Médico de Emergencia y Trabajo Activo de proporcionarme un examen médico para determinar si presento un cuadro clínico de emergencia, y de ser así, de proporcionarme el tratamiento médico necesario para estabilizar mi afección. He recibido información acerca de los riesgos y consecuencias que posiblemente involucre el alta de traslado, que son _____

_____

y de los posibles beneficios de continuar mi tratamiento en este hospital, que son _____

_____

y las alternativas, en su caso, al traslado o dada de alta que estoy solicitando, así como la obligación de este hospital de proveer dicho examen y tratamiento adicional dentro de las posibilidades de su personal e instalaciones, según se requieran para estabilizar la condición médica del paciente.

Solicito este traslado o dada de alta por los siguientes motivos _____

_____

Por la presente exonero al médico del caso a cualquier otro médico relacionado con mi atención médica, al hospital y a sus representantes y empleados de toda responsabilidad por cualquier efecto adverso que pueda resultar del traslado.

Entiendo que el médico que me atiende y otros médicos que me brindan servicios no son empleados ni agentes del hospital. Son médicos facultativos independientes.

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(paciente o representante legal)

Si no lo firma el paciente, indique la relación con éste: _____

Nombre en letra de imprenta: _____
(representante legal)

COPY MUST BE SENT WITH PATIENT.

NOTE: This form should include taglines as required by the Affordable Care Act. *(See www.calhospital.org/taglines, for detailed information.)*

Reference: 42 U.S.C. Section 1395dd(c)(1)(A)(i)
Health and Safety Code Section 1317.2(j)

FORM 9-9

Notice for Emergency Room

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;
- Necessary stabilizing treatment (including treatment for an unborn child);
- And, if necessary, an appropriate transfer to another facility even if you cannot pay, you do not have medical insurance or you are not entitled to Medicare or Medicaid.

This hospital [does/does not] participate in the Medi-Cal program.

If you have any questions concerning this hospital's emergency services policy, please ask the admitting nurse or contact (title of other contact person at hospital) _____.

If you have any complaints concerning the services you have received from this hospital, you may contact:

California Department of Public Health, Licensing and Certification

_____ *District Office

_____

_____

** Fill in the name, address and telephone number of the appropriate CDPH district office.*

NOTE: This sign must be large enough to be clearly readable by patients from a distance of 20 feet or the expected vantage point of the patients.

Reference: 42 U.S.C. Section 1395cc(a)(1)(N)(iii) and (iv); 42 C.F.R. Section 489.20(q);
42 C.F.R. Section 489.20(q)
Health and Safety Code Section 1317.3(d)

FORM 9-9S

Aviso Para la Sala de Emergencias

¡La ley lo exige!

Si tiene una emergencia médica o está en trabajo de parto

Tiene derecho a recibir, dentro de las posibilidades del personal y las instalaciones de este hospital:

- Un examen médico de evaluación adecuado;
- La atención necesaria para estabilizarlo/a (incluida la atención de un niño por nacer);
- Si fuera necesario, el traslado a otro establecimiento adecuado, aunque usted no pueda pagar, no tenga seguro médico o no tenga derecho a recibir los servicios de Medicare o Medicaid.

Este hospital [sí/no] participa en el programa Medi-Cal.

Si usted tiene cualquier pregunta respecto a las normas relativas a servicios de emergencia de este hospital, favor de preguntar a la enfermera de admisiones o póngase en contacto con (puesto e alguna otra persona representante del hospital) _____.

Si usted tiene cualquier queja relacionada con los servicios que ha recibido de este hospital, puede ponerse en contacto con:

Departamento de Salud Pública, Certificación y Licencias

_____*Oficina de Destrito

_____

_____

** Fill in the name, address and telephone number of the appropriate DPH district office.*

NOTE: This sign must be large enough to be clearly readable by patients from a distance of 20 feet or the expected vantage point of the patients.

Reference: 42 U.S.C. Section 1395cc(a)(1)(N)(iii) and (iv); 42 C.F.R. Section 489.20(q);
42 C.F.R. Section 489.20(q)
Health and Safety Code Section 1317.3(d)

FORM 12-12

Detention of Patient with Psychiatric Emergency in a Nondesignated Health Facility

(Health and Safety Code Section 1799.111)

A licensed general acute care or psychiatric hospital (that is not a county-designated facility pursuant to Section 5150 of the Welfare and Institutions Code), licensed professional staff of those hospitals, and physicians, providing emergency medical services in any department of those hospitals will not be held civilly or criminally liable for detaining a patient if all of the following conditions exist during the detention.

Name of Patient: _____

1. The law requires probable cause for detaining the patient/believing the patient is, as a result of a mental disorder, a danger to self or others or gravely disabled. Describe the patient's behavior and/or statements, and circumstances under which the patient was detained (use direct quotes from the patient, law enforcement officers, and/or others when appropriate).

   _____

   _____

   _____

2. Based upon the above information, I believe that the patient named above cannot be safely released from the hospital because he or she is, as a result of a mental disorder, one or more of the following:

   ☐ A danger to self

   ☐ A danger to others

   ☐ Gravely disabled (for purposes of a detention under Health and Safety Code Section 1799.111, **"gravely disabled"** means an inability of the patient to provide for his or her basic personal needs for food, clothing, or shelter)

Signature of treating physician and surgeon (or clinical psychologist with the medical staff privileges, clinical privileges, or professional responsibilities provided in Health and Safety Code Section 1316.5*)

Name: _____

Signature: _____

Date: _____ Time: _____ AM / PM

(over)

The hospital staff, treating physician and surgeon, or appropriate licensed mental health professional must make and document repeated unsuccessful efforts to find appropriate mental health treatment for the detained patient. Required telephone calls or other contacts must commence at the earliest possible time when the treating physician and surgeon has determined the time at which the patient will be medically stable for transfer. The hospital may not wait until after the time when the patient becomes medically stable for transfer to start making these contacts. Document efforts to find appropriate mental heath treatment for the patient:

Date/Time	Person/Facility Contacted	Results of Contact:

The patient may not be detained beyond 24 hours. Date and time patient first detained: _____

If the patient is detained beyond eight hours, but less than 24 hours, both of the following additional conditions must be met:

1. A discharge or transfer for appropriate evaluation or treatment for the patient has been delayed because of the need for continuous and ongoing care, observation, or treatment that the hospital is providing.

   Describe the care, observation, or treatment the hospital is providing in the lines below or in the medical record.

   _____

   _____

2. The patient named above continues to be, as a result of a mental disorder, one or more of the following:

   ☐ A danger to self

   ☐ A danger to others

   ☐ Gravely disabled (for purposes of a detention under Health and Safety Code Section 1799.111, "gravely disabled" means an inability of the patient to provide for his or her basic personal needs for food, clothing, or shelter)

Signature of treating physician and surgeon (or clinical psychologist with the medical staff privileges, clinical privileges, or professional responsibilities provided in Health and Safety Code Section 1316.5*)

Name: _____

Signature: _____

Date: _____ Time: _____ AM / PM

To receive immunity from civil or criminal liability for any actions of the patient after release, all of the following conditions must exist during the detention:

1. The patient was not been admitted to a licensed general acute care hospital or a licensed acute psychiatric hospital for evaluation and treatment pursuant to Section 5150 of the Welfare and Institutions Code.
2. The release from the hospital is authorized by a physician and surgeon or a clinical psychologist with the medical staff privileges or professional responsibilities provided for in Section 1316.5, who determines, based on a face-to-face examination of the patient detained, that the patient does not present a danger to himself or herself or others and is not gravely disabled, as defined in paragraph (1) of subdivision (a). In order for this paragraph to apply to a clinical psychologist, the clinical psychologist must have a collaborative treatment relationship with the physician and surgeon. The clinical psychologist may authorize the release of the patient from the detention, but only after he or she has consulted with the physician and surgeon. In the event of a clinical or professional disagreement regarding the release of a patient subject to the detention, the detention must be maintained unless the hospital's medical director overrules the decision of the physician and surgeon opposing the release. Both the physician and surgeon and the clinical psychologist must enter their findings, concerns, or objections in the patient's medical record.

NOTE: A patient detained under this law must be credited for the time detained, up to 24 hours, in the event he or she is placed on a subsequent 72-hour hold pursuant to Section 5150 of the Welfare and Institutions Code in a designated facility.

*Health and Safety Code Section 1316.5 states that state owned and operated health facilities that offer services within the scope of practice of a psychologist must establish rules and procedures for consideration of an application for medical staff membership and clinical privileges submitted by a clinical psychologist. Private health facilities may enable the appointment of clinical psychologists on such terms and conditions as the facility may establish. If a particular service is offered by a health facility which permits clinical psychologists on its medical staff which both physicians and clinical psychologists are authorized by law to perform, such service may be performed by either, without discrimination.

Reference: Health and Safety Code Sections 1316.5 and 1799.111

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CALIFORNIA HOSPITAL ASSOCIATION
1215 K Street, Suite 800, Sacramento, CA 95814 (916) 443-7401

APPENDIX Q

Requirements for Off-Campus Emergency Departments

Source: **Centers for Medicare & Medicaid Services**

Memo: **Requirements for Provider-based Off-campus Emergency Departments and Hospitals that Specialize in the Provision of Emergency Services, S&C-08-08, Jan. 11, 2008**

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-08-08

DATE: **January 11, 2008**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Requirements for Provider-based Off-campus Emergency Departments and Hospitals that Specialize in the Provision of Emergency Services

Memorandum Summary

- Growth in the demand for hospital emergency services has resulted in a number of hospitals seeking to expand their emergency department (ED) services to off-site locations.
- Provider-based off-site hospital EDs are permitted, and must demonstrate compliance with the hospital Conditions of Participation (CoPs). They must also be in compliance with the provider-based regulations at 42 CFR 413.65.
- In rare cases, new providers are seeking certification as a hospital specializing in the provision of emergency services. Such providers have the burden of proof to demonstrate that they meet the statutory definition of a hospital for Medicare purposes, and their applications require detailed, case-specific analysis. Regional Offices (ROs) are to consult with Centers for Medicare & Medicaid Services (CMS) Central Office survey and certification staff before processing such applications.

Background

CMS is encountering increasing interest in so-called "freestanding[1]" emergency departments (EDs) from providers and communities around the country, who point to the continued growth over the past decade in the demand for ED services and crowding in existing EDs.

[1] We are using the term "freestanding" in a colloquial sense here, and not as the term is used in the definition of a free-standing facility found at 42 CFR 413.65(a)(2).

Page 2 – State Survey Agency Directors

A variety of arrangements have been proposed under the rubric of a "freestanding" ED. In most cases, the ED would be owned and operated by a Medicare-participating hospital as a provider-based ED. In rare cases, the provider seeks to participate in Medicare as a stand-alone hospital, with its own provider agreement, and specializing in the provision of emergency services. In terms of operations, some EDs would be open 24 hours/day, 7 days/week, while others would operate only part-time. This memorandum contains guidance on the applicable regulatory standards that govern the circumstances under which provider-based EDs and so-called "emergency services hospitals" meet the CMS CoPs that qualify them to participate in Medicare as a hospital or part of a hospital.

Hospital Provider-based ED

The most common scenario occurs when a Medicare-participating hospital that offers emergency services seeks to establish an ED located away from the main campus and to have that ED operate as a provider-based department of the hospital. Services of the provider-based ED would be included under the hospital's Medicare Provider Agreement. Such arrangements are acceptable, so long as the off-campus ED complies with:

- Hospital CoPs found in 42 CFR 482.1 through 482.45. The expectation here is the same as for any department on the hospital's campus. This includes, but is not limited to, the following requirements:

  - Medical staff practicing at the off-campus ED must be part of the hospital's single organized medical staff as required by the Medical Staff CoP at 42 CFR 482.22.
  - The responsibilities of the hospital's Governing Body, as specified in the Governing Body CoP at 42 CFR 482.12, apply to the services and activities of the off-campus ED.
  - Nursing personnel at the off-campus ED must be part of the hospital's single organized nursing service and all nursing services must be provided in accordance with the Nursing CoP at 42 CFR 482.23.
  - Emergency laboratory services must be available to the off-campus ED during all of its operating hours, in accordance with the Laboratory Services CoP at 42 CFR 482.27(b)(1).
  - The off-campus ED must be integrated into the hospital's quality assessment/performance improvement (QAPI) program, as specified under the QAPI CoP at 42 CFR 482.21.
  - The medical records of patients seen at the off-campus ED must be part of the hospital's single medical record system and must satisfy the standards for the Medical Records Services CoP at 42 CFR 482.24.
  - Infection control practices at the off-campus ED must meet the requirements of the Infection Control CoP at 42 CFR 482.42.

Page 3 – State Survey Agency Directors

- Requirements pertaining to the Hospital CoP governing emergency services found at 42 CFR 482.55. In particular:

  – The provider must demonstrate how the off-campus ED meets the emergency needs of its patients in accordance with accepted standards of practice for hospital emergency departments.

    + Neither the hospital CoP for emergency services nor the EMTALA definition of a dedicated emergency department (noted below) specifically addresses part-time versus full-time operation of an ED. Medicare payment rules include codes for both full- and part-time EDs.
    + All hospital EDs, including off-campus EDs, must comply with all applicable State requirements, including any requirements related to hours of operation.
    + Providers operating part-time provider-based EDs as permitted under State law are expected by CMS to document how the needs of patients will be addressed when they present at the off-site ED during hours when it is not in operation.

  – The provider must demonstrate how the off-campus ED satisfies the requirement at 42 CFR 482.55(a)(2) for its services to be integrated with the other departments of the hospital. This includes documenting how inpatient admissions and intra-hospital transport of patients from the off-site ED to the main campus would be handled in a manner that is also consistent with the requirement at 42 CFR 482.13(c)(2) for patients to receive care in a safe setting.

  – The organization and direction of the emergency services at the off-campus location must be by a qualified member of the hospital's medical staff. In view of the provider-based requirement (see below) for integration of services between the off-campus ED and the main campus, CMS expects the hospital's main and off-campus EDs to be under the same overall medical staff direction.

  – The policies and procedures governing medical care provided at the off-campus location must be established by, and remain an ongoing responsibility of the hospital's medical staff. In view of the provider-based requirement (see below) for integration of services between the off-campus ED and the main campus, CMS expects the off-campus ED to operate under the same general policies and procedures as the ED at the hospital's main campus, taking into account pertinent differences in the scope of their operations.

- Hospital CoPs found in 42 CFR 482.51 through 42 CFR 482.57 governing other optional services the hospital chooses to offer at the off-campus location. If any of these optional services, such as surgery, anesthesia, rehabilitation, or respiratory services, is offered at the off-campus ED location, that service must be provided in accordance with the applicable CoP. For example, if respiratory services are offered, those services must comply with the requirements of the Respiratory Services CoP at 42 CFR 482.57.

Page 4 – State Survey Agency Directors

- EMTALA requirements at 42 CFR 489.20 and 489.24. The off-campus ED would be considered a "dedicated emergency department," as defined at 42 CFR 489.24(b):

  > "Dedicated emergency department means any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements:
  >
  > 1. It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department;
  > 2. It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or
  > 3. During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment."

  The EMTALA-related provisions include the requirement at 42 CFR 489.24(d) to provide individuals determined to have an emergency medical condition with either stabilizing treatment or an appropriate transfer to another hospital. In the case of an investigation of an EMTALA complaint alleging failure to provide a medical screening examination, stabilizing treatment, or an appropriate transfer from the off-campus ED, SAs and ROs should consider the capabilities and capacity of the hospital's main campus, not just the off-campus ED, when determining whether there has been an EMTALA violation.

- Requirements found in 42 CFR 413.65 for a provider-based off-campus department of the main hospital. SAs do not survey for compliance with the provider-based requirements per se, but the hospital would be expected to document its compliance. Among the clinical services requirements at 42 CFR 413.65(d)(2) are the following:

  - Professional staff of the off-campus ED have clinical privileges at the main campus of the hospital.
  - The hospital maintains the same monitoring and oversight of the off-campus ED as it does for any other of its departments.
  - The medical director of the off-campus ED maintains a reporting relationship to the hospital's chief medical officer (or similar position) that is similar to that of a department medical director.
  - Medical staff committees of the hospital are responsible for medical activities in the off-campus ED.
  - Medical records are integrated into a unified retrieval system.
  - The services of the off-campus ED are integrated into those of the hospital's main campus, and patients of the off-campus ED who require further care have access to all services of the main campus.

Page 5 – State Survey Agency Directors

CMS encourages hospitals with off-campus EDs to educate communities and EMS agencies in their service area about the operating hours and capabilities available at the off-campus ED, as well as the hospital's capabilities for rapid transport of patients from the off-campus ED to the main campus for further treatment. This is particularly desirable in the case of off-site EDs that are closer to another hospital than to their own main campus, as a way to facilitate informed decision-making by patients choosing where to seek emergency medical care and by EMS providers transporting patients in need of emergency medical care.

Each request for provider-based status for an off-campus ED submitted to a Regional Office (RO) must be reviewed by RO survey and certification staff in addition to the standard review of provider-based requests.

SAs must tailor surveys of a hospital facility that includes an off-campus ED to the nature of all the services provided at the site.

Hospitals Specializing in Emergency Services

CMS has occasionally encountered interest from providers who seek participation in Medicare as a hospital that specializes in emergency services. However, "emergency services hospital" is not a recognized separate category of Medicare-participating hospital. Such an applicant must demonstrate that it satisfies the statutory definition of a hospital at Section 1861(e) of the Social Security Act, including the requirement that the provider is primarily engaged in the provision of services to inpatients. In the case of an applicant specializing in emergency services, CMS would pay particular attention to the size of the applicant's ED compared to its inpatient capacity. A detailed analysis of the facts of the applicant's operations would be required.

We interpret the statutory requirement that a hospital be primarily engaged in the provision of inpatient services to mean that the provider devotes 51% or more of its beds to inpatient care. In the absence of other clearly persuasive data, CMS renders a determination regarding hospital status based on the proportion of inpatient beds to all other beds. At the request of the applicant CMS may examine other factors in addition to bed ratio. The agency recognizes that the "51%" test may not be dispositive in all cases. However, we consider the burden of proof (to demonstrate that inpatient care is the primary health care service) to reside with the applicant, and consider the burden to increase substantially as the ratio of inpatient to other beds decreases.

Regional Offices that receive applications from facilities seeking first-time participation in Medicare as a hospital specializing in emergency services must consult with the Central Office Survey and Certification Group, Division of Acute Care Services on the review of the application.

If you have additional questions or concerns, please contact David Eddinger at 410-786-3429 or via email at david.eddinger@cms.hhs.gov .

Page 6 – State Survey Agency Directors

Effective Date: Immediately. Please ensure that all appropriate staff are fully informed within 30 days of the date of this memorandum.

Training: The information contained in this letter should be shared with all survey and certification staff, their managers, and the State/RO training coordinators.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management

APPENDIX R

EMTALA Options in a Disaster

Source: **Centers for Medicare & Medicaid Services**

Memo: **Emergency Medical Treatment and Active Labor Act (EMTALA) Requirements and Options for Hospitals in a Disaster, S&C-09-52, Aug. 14, 2009**

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Service
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-09-52

DATE: **August 14, 2009**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: **Emergency Medical Treatment and Labor Act (EMTALA) Requirements and Options for Hospitals in a Disaster**

Memorandum Summary

- **Planning for Surge in Emergency Department Services:** A brief summary of EMTALA requirements and options for hospitals experiencing an extraordinary surge in demand for ED services has been developed to assist hospitals and their communities in planning for a potential surge in ED volume this fall related to H1N1 influenza.
- **Waiver Description:** Rules governing EMTALA waivers are also described.
- **Availability and Distribution of Summary Sheet:** State Survey Agencies (SAs) are requested to distribute this summary sheet widely to hospital and emergency response planning officials.

In anticipation of a possible significant increase in demand for emergency services due to H1N1 influenza resurgence this fall several Federal agencies, State health departments, and hospitals have expressed significant concerns about compliance with EMTALA requirements during an outbreak. Many stakeholders perceive that EMTALA imposes significant restrictions on hospitals' ability to provide adequate care when EDs experience extraordinary surges in demand. The attached fact sheet clarifies options that are permissible under EMTALA and should reassure the provider community and public health officials that there is existing flexibility under EMTALA. Among other things, the fact sheet notes that an EMTALA-mandated medical screening examination (MSE) does not need to be an extensive work-up in every case, and that the MSE may take place outside the ED, at other sites on the hospital's campus.

The fact sheet also summarizes the provisions governing EMTALA waivers. Surveyors and managers responsible for EMTALA enforcement are expected to be aware of the flexibilities hospitals are currently afforded under EMTALA and to assess incoming EMTALA complaints accordingly in determining whether an on-site investigation is required. They are also expected to keep these flexibilities in mind when assessing hospital compliance with EMTALA during a survey.

Page 2 – State Survey Agency Directors

To help dispel misconceptions among the provider community concerning EMTALA requirements, SAs are requested to distribute the attached fact sheet widely to the provider community in their State, as well as to State and local public health officials responsible for emergency preparedness.

Questions about this document should be addressed to CDR Frances Jensen, M.D., at frances.jensen@cms.hhs.gov.

Training: The information contained in this letter should be shared with all survey and certification staff, their managers, and the State/RO training coordinators immediately

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Service
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

FACT SHEET

Emergency Medical Treatment and Labor Act (EMTALA) &
Surges in Demand for Emergency Department (ED) Services During a Pandemic

I. What is EMTALA?

- EMTALA is a Federal law that requires all Medicare-participating hospitals with dedicated EDs to perform the following for **all** individuals who come to their EDs, regardless of their ability to pay:
  - An *appropriate* medical screening exam (MSE) to determine if the individual has an Emergency Medical Condition (EMC). If there is no EMC, the hospital's EMTALA obligations end.
  - If there is an EMC, the hospital must:
    + Treat and stabilize the EMC within its capability (including inpatient admission when necessary); ***OR***
    + Transfer the individual to a hospital that has the capability and capacity to stabilize the EMC.
- Hospitals with specialized capabilities (with or without an ED) may not refuse an appropriate transfer under EMTALA if they have the capacity to treat the transferred individual.
- EMTALA ensures access to hospital emergency services; it need not be a barrier to providing care in a disaster.

II. Options for Managing Extraordinary ED Surges Under Existing EMTALA Requirements (No Waiver Required)

A. Hospitals may set up alternative screening sites on campus

- The MSE does not have to take place in the ED. A hospital may set up alternative sites on its campus to perform MSEs.
  - Individuals may be redirected to these sites after being logged in. The redirection and logging can even take place outside the entrance to the ED.
  - The person doing the directing should be qualified (e.g., an RN) to recognize individuals who are obviously in need of immediate treatment in the ED.
- The content of the MSE varies according to the individual's presenting signs and symptoms. It can be as simple or as complex, as needed, to determine if an EMC exists.
- MSEs must be conducted by qualified personnel, which may include physicians, nurse practitioners, physician's assistants, or RNs trained to perform MSEs and acting within the scope of their State Practice Act.
- The hospital must provide stabilizing treatment (or appropriate transfer) to individuals found to have an EMC, including moving them as needed from the alternative site to another on-campus department.

B. Hospitals may set up screening at off-campus, hospital-controlled sites.

- Hospitals and community officials may encourage the public to go to these sites instead of the hospital for screening for influenza-like illness (ILI). *However, a hospital may not tell individuals who have already come to its ED to go to the off-site location for the MSE.*

- Unless the off-campus site is already a dedicated ED (DED) of the hospital, as defined under EMTALA regulations, EMTALA requirements do not apply.
- The hospital should not hold the site out to the public as a place that provides care for EMCs in general on an urgent, unscheduled basis. They can hold it out as an ILI screening center.
- The off-campus site should be staffed with medical personnel trained to evaluate individuals with ILIs.
- If an individual needs additional medical attention on an emergent basis, the hospital is required, under the Medicare Conditions of Participation, to arrange referral/transfer. Prior coordination with local emergency medical services (EMS) is advised to develop transport arrangements.

C. Communities may set up screening clinics at sites not under the control of a hospital

- There is no EMTALA obligation at these sites.
- Hospitals and community officials may encourage the public to go to these sites instead of the hospital for screening for ILI. *However, a hospital may not tell individuals who have already come to its ED to go to the off-site location for the MSE.*
- Communities are encouraged to staff the sites with medical personnel trained to evaluate individuals with ILIs.
- In preparation for a pandemic, the community, its local hospitals and EMS are encouraged to plan for referral and transport of individuals needing additional medical attention on an emergent basis.

III. EMTALA Waivers

- An EMTALA waiver allows hospitals to:
  - Direct or relocate individuals who come to the ED to an alternative off-campus site, in accordance with a State emergency or pandemic preparedness plan, for the MSE.
  - Effect transfers normally prohibited under EMTALA of individuals with unstable EMCs, so long as the transfer is necessitated by the circumstances of the declared emergency.
- By law, the EMTALA MSE and stabilization requirements can be waived for a hospital **only if**:
  - The President has declared an emergency or disaster under the Stafford Act or the National Emergencies Act ; ***and***
  - The Secretary of HHS has declared a Public Health Emergency; ***and***
  - The Secretary invokes her/his waiver authority (which may be retroactive), including notifying Congress at least 48 hours in advance; ***and***
  - The waiver includes waiver of EMTALA requirements and the hospital is covered by the waiver.
- CMS will provide notice of an EMTALA waiver to covered hospitals through its Regional Offices and/or State Survey Agencies.
- Duration of an EMTALA waiver:
  - In the case of a public health emergency involving pandemic infectious disease, until the termination of the declaration of the public health emergency; ***otherwise***
  - In all other cases, 72 hours after the hospital has activated its disaster plan
  - In no case does an EMTALA waiver start before the waiver's effective date, which is usually the effective date of the public health emergency declaration.

APPENDIX S

Sample Transfer Agreement

TRANSFER AGREEMENT

This Transfer Agreement ("**Agreement**") is entered into as of _____, 20__ ("**Effective Date**"), between _____ ("___"), a ____[insert type of entity] ("___") and _____ Hospital, a _____[insert type of entity] ("___").

RECITALS

A. Each Party operates a licensed general acute care hospital that at times has patients, including emergency patients and inpatients, who may need a transfer to another hospital for specialized care that the Party does not have the capacity or capability, including resources that are temporarily unavailable, or for alignment with the patient's managed care plan or other responsible payor for services or for other reasons.

B. The Parties hereto desire to enter into an agreement for the transfer of patients in order to facilitate continuity of care and the timely transfer of patients and records to each other, and to specify the rights and obligations of Parties to this Agreement.

DEFINITIONS

1. "**Transferring Hospital**" is the hospital from which the patient is being transferred.

2. "**Receiving Hospital**" is the hospital to which the patient is being transferred.

3. "**Transferring Physician**" is the physician initiating and responsible for the patient's transfer at Transferring Hospital.

4. "**Receiving Physician**" is the physician who accepts responsibility for the care of the patient at Receiving Hospital.

5. "**Stabilize**" and "**Emergency Medical Condition**" have the same meanings as these terms are defined in the EMTALA regulations (42 C.F.R. §489.24) setting forth the responsibilities of hospitals in emergency cases.

NOW, THEREFORE, the Parties agree as follows:

AGREEMENT

1. **Duties of Transferring Hospital**. The Transferring Hospital or Transferring Physician, as indicated, shall have the following duties and obligations in connection with a patient's transfer under this Agreement:

(a) **Authorization to Transfer**. The Transferring Physician shall authorize the transfer of the patient to the Receiving Hospital, including documenting in the patient medical record the medical necessity or other reason for the transfer of the patient to the Receiving Hospital and the medical condition of the patient at the time of transfer. The Transferring Hospital and Transferring Physician shall determine that the patient is appropriate for transfer in accordance with all applicable federal or state laws and regulations regarding patient transfers as well as with applicable requirements of the Transferring Hospital's transfer policies and EMS transfer guidelines.

(b) **Obtaining Consent for the Transfer**. The Transferring Hospital or Transferring Physician shall obtain the consent of the Receiving Hospital and a Receiving Physician for the transfer.

(1) The consent of the Receiving Hospital shall be obtained by telephone, facsimile or other electronic means, by contacting the Receiving Hospital in accordance with procedures set forth in **Exhibit A**, or if none, by contacting the [*insert designated person or department*] at the Receiving Hospital.

(2) The Transferring Hospital/Physician will use best efforts to provide clear, accurate communication of patient data and clinical status, including assigning clinical personnel, as appropriate and feasible, to provide (or be immediately available to provide) information regarding a patient who has a complex or unstabilized condition or requires a higher level of care.

(3) At the time of initial contact, the Transferring Hospital will provide the following information to the Receiving Hospital --

- The patient's name and date of birth (gender as applicable);
- Whether patient is an emergency patient or an inpatient;
- The patient's diagnosis and description of the patient's clinical condition;
- The patient's clinical status, including whether the patient has an Emergency Medical Condition, and if so, whether the condition is Stabilized;
- The reason for the transfer (i.e., higher level of care, lack of required specialty services, lack of beds, inadequate staffing, patient request, etc.); and
- The estimated time of arrival of the patient.

(4) As necessary for the Receiving Hospital and Receiving Physician to evaluate the clinical needs of the patient and their respective capability and capacity to meet those needs, the Transferring Hospital or Transferring Physician will provide (orally or electronically) pertinent clinical information to the Receiving Hospital and Receiving Physician, so long as the Transferring Physician determines that any delay in providing the information will not result in a material deterioration in the patient's medical condition.

(5) If the Receiving Hospital confirms that it has capacity and capability to accept the patient, the Transferring Hospital or Transferring Physician will obtain the consent of the Receiving Physician. The Receiving Hospital will assist the Transferring Hospital or Transferring Physician in contacting a qualified Receiving Physician who may be available to accept the patient.

(6) The Transferring Hospital and Transferring Physician will document in the patient record the consent of the Receiving Hospital and Receiving Physician, including the time and date and the names of the Receiving Physician and Receiving Hospital representative who have respectively consented to the transfer.

(c) **Insurance Information**.

(1) If the transfer involves a patient with an Emergency Medical Condition that is ***not*** Stabilized, the Transferring Hospital will not provide the Receiving Hospital or Receiving Physician any insurance or financial information until the Receiving Hospital and Receiving Physician have accepted the patient.

(2) If the Transferring Hospital/Physician advises the Receiving Hospital that the patient is an inpatient or the patient's condition is Stabilized, the Transferring Hospital will provide the Receiving Hospital the patient's insurance information (including the name and telephone number of the patient's health plan, patient ID # or member #).

(d) **Patient Transportation**. The Transferring Hospital and Transferring Physician are responsible to arrange appropriate and safe transportation that is appropriate for the patient's medical condition, including designation of (i) appropriate equipment for the transfer, (ii) treatment orders during transport, and (iii) the level of professional personnel (including physicians and hospital personnel, when appropriate) who should accompany the patient during transfer.

(1) If there is a delay in the transfer process that will result in the patient's arrival at the Receiving Hospital by more than one (1) hour beyond the estimated time of arrival, or the ambulance or other patient transport is re-directed enroute to another hospital, the Transferring Hospital (if aware of the delay or diversion) will immediately notify the Receiving Hospital.

(2) Except as otherwise agreed by the Parties with respect to a specific transfer, the Transferring Facility shall remain responsible for the patient until he/she arrives at the Receiving Facility, at which time the responsibility for the patient's care will shift to the Receiving Facility.

(e) **Transfer of Patient Records**. The Transferring Hospital will forward (with the patient or by electronic means) copies of those portions of the patient's medical record that are relevant to the transfer and continued care of the patient, including copies of records related to the patient's condition, observations of signs or symptoms, preliminary diagnosis, treatment provided and results of tests and procedures.

(1) If a patient has an Emergency Medical Condition that has ***not*** been Stabilized, the records will include (i) a copy of the patient's informed consent to the transfer or the physician's certification that the medical benefits of the transfer outweigh the risks of transfer; and (ii) if an on-call physician at the Transferring Hospital failed or refused to examine or treat the patient within a reasonable time, the name and address of the on-call physician.

(2) If all necessary and relevant medical records are not available at the time the patient is transferred, the records will be forwarded by the Transferring Hospital within four (4) hours of the transfer.

(f) **Patient Notice and Consent**. The Transferring Facility will comply with patient notice and consent requirements applicable to the transfer. The Transferring Hospital will recognize the right of the patient to make an informed refusal of consent to treatment or transfer in accordance with applicable law.

(g) **Transfers for Tests/Procedures**. If a transfer is for the purposes of a specific procedure or test and the patient will return to the Transferring Hospital, the Transferring Hospital will comply with the procedures set forth in the Addendum to this Agreement.

(h) **Personal Property**. Unless the patient is being transferred for a specific procedure or test and will return to the Transferring Hospital, the Transferring Facility will transfer the patient's personal property (such as money and valuables) and information related to these items, or make other appropriate disposition of personal property, in accordance with its policy and procedure for the inventory and safekeeping of patient valuables.

(i) **Patient Rights/Preference**. If the patient is an emergency patient whose condition is Stabilized or is an inpatient, the Transferring Hospital will (i) comply with applicable contractual, statutory and regulatory obligations that might exist between the patient and his/her health plan or designated provider; and (ii) recognize the right of the patient to transfer to the hospital and/or physician of his/her choice.

2. **Responsibilities of the Receiving Hospital**. The Receiving Hospital shall have the following duties and obligations in connection with a patient transfer under this Agreement:

(a) **Conditions for Patient Acceptance**. The Receiving Hospital will accept a patient transferred in accordance with this Agreement and provide or arrange for the provision of medical services to the patient, provided –

(1) The Receiving Hospital has appropriate beds, equipment, staff and service capacity to meet the expected needs of the patient;

(2) A Receiving Physician on the Receiving Hospital's medical staff has accepted the patient; and

(3) The patient meets the Receiving Hospital's admission criteria applicable to the patient.

(b) **Response Time**. If the transfer involves a patient with an Emergency Medical Condition that is ***not*** Stabilized, the Receiving Hospital will exercise reasonable efforts to respond to the Transferring Hospital within thirty (30) minutes after receiving the request to transfer the patient.

(c) **Admissions Process**. The Receiving Hospital will be responsible for the admissions and/or registration process for each patient accepted by the Receiving Physician, as follows:

(1) The admission requirements of the Receiving Hospital will be completed prior to the transfer except if the patient has an Emergency Medical Condition that is not Stabilized at the time of the transfer.

(2) Except for the transfer of a patient who has an Emergency Medical Condition that is not Stabilized at the time of the transfer –

- The admission process will include provision by the Transferring Hospital of patient insurance information relating to coverage of medical services (such as Medicare, Medicaid, HMO, etc.) and pertinent medical and demographic information regarding the patient; and
- The Transferring Hospital will obtain prior authorization from the patient's payor or other person for the transfer and the admission or other medical services to be provided by the Receiving Hospital if (i) obtaining prior authorization is required by the payor prior to the transfer and/or admission; and (ii) requesting such authorization is otherwise permitted by law.

(d) **Transfers for Tests/Procedures**. If the transfer is for the purpose of a specific procedure or test, Receiving Hospital will comply with procedures set forth in the Addendum of this Agreement.

(e) **Transportation**. When appropriate and within its capabilities, or upon request by the Transferring Hospital, the Receiving Hospital or Receiving Physician will consult with the Transferring Hospital or Transferring Physician as to the transport of the patient.

(f) **Patient Valuables**. The Receiving Hospital will maintain policies for the acknowledgment and inventory of any patient valuables transported with the patient.

3. **Return Transfers**.

(a) When a patient transferred under this Agreement no longer requires the specialized services of the Receiving Facility and is stable for transfer back to the Transferring Facility, consistent with all applicable requirements under federal and state law (including patient notice and consent requirements), the Transferring Facility shall accept the transfer back of the patient if it has the capability to provide continuing care to the patient, and shall make best efforts to accomplish the transfer within a maximum of forty-eight (48) hours, including, without limitation --

(1) Reserving a bed and giving the patient priority over non-emergency admissions in order to ensure prompt placement of the patient;

(2) Identifying a physician at the Transferring Facility who will be responsible for the patient; and

(3) Providing appropriate personnel, equipment and services to assist the Receiving Facility with the return transfer of the patient.

(b) In the event the Transferring Facility is unable to accept the transfer back of the patient within forty-eight (48) hours of the request by Receiving Facility, the Chief Executive Officer (or designee) of the Transferring Facility will promptly confer with the Chief Executive Officer (or designee) of the Receiving Facility about the reasons for such inability, and they shall develop a plan to expedite the transfer back of the patient as promptly as possible.

(c) In order to facilitate return transfers, each Party shall establish policies and procedures to (i) identify bed availability for returning patients; and (ii) communicate with the Transferring Hospital in a timely manner in order to provide information necessary for assuring bed availability for a returning patient

4. **Disputes**.

(a) If a dispute arises between the Parties during the course of a pending transfer relating to the clinical status and needs of the patient or the method of transportation, the judgment of the Transferring Physician shall take precedence solely for purposes of facilitating a timely decision on the transfer. If a dispute between the Parties arises or continues after a final decision has been made by the Receiving Hospital and Receiving Physician on the acceptance of a transfer, the judgment of the Transferring Physician shall not be dispositive in the resolution of the dispute.

(b) To the extent permitted by law, the Parties will cooperate in the mutual review of a transfer that the Receiving Hospital identifies as implemented in a manner that is a possible violation of state or federal law, or this Agreement.

(c) All patient transfers will be done on an equitable basis, without regard to financial or diagnostic desirability.

5. **Disaster/Emergency Situation**. In the event of an area-wide disaster or national, state or local emergency situation that requires the evacuation of patients, each Party agrees to admit evacuated patients from the other Party, to the extent there is physical capacity to do so, and when consistent with local disaster evacuation orders and protocols.

6. **Independent Contractor**.

(a) The Parties are at all times independent contractors with respect to their relationship with one another, the purpose of which is to promote continuity of patient care consistent with applicable laws and regulations. Nothing in this Agreement shall create nor be construed as creating any agency, partnership, joint venture or other corporate relationship between Parties.

(b) The governing body of each Party shall have the exclusive control over its policies, management, assets and affairs. Neither Party shall assume any liability by virtue of this Agreement for any debts or obligations of either a financial or a legal nature incurred by the other Party to the Agreement. Nothing in this Agreement shall affect or interfere with the (i) bylaws, rules and regulations of a Party as they relate to medical staff membership and the clinical privileges of the members of each Party's medical staff; or (ii) the services and admission policies of each Party.

7. **Charges for Services**.

(a) Charges for services performed by either Party shall be billed and collected by the Party rendering the services directly from the patient, third party payer or other source legally responsible for payment (including, if applicable, pursuant to Paragraph 7(b) below). Except as set forth in paragraph 7(b) below, neither Party shall have any liability to the other for such charges unless mutually agreed to in writing in advance.

(b) If a Party has a legal obligation (whether imposed by statute or by contract) to provide or pay for care for a patient who is transferred under this Agreement, the Party having the responsibility shall be liable for the reasonable charges of the other Party for providing medically necessary services and care.

8. **Non-Exclusive**. This Agreement shall be non-exclusive between the Parties. Nothing in this Agreement shall be construed as limiting the rights of either Party to contract with any other health facility on a limited or general basis.

9. **Compliance with Law**. The Parties shall comply with all applicable federal, state and local laws, regulations and ordinances, including applicable standards of the Joint Commission and any other applicable accrediting bodies, and reasonable policies and procedures of the parties.

(a) To the extent that any provision of this Agreement conflicts with EMTALA or state licensing laws for the provision of emergency services and care, as such laws may be amended, the provisions of EMTALA or the state licensing laws, as applicable, shall take precedence over and/or automatically supersede any inconsistent provisions of this Agreement.

(b) Each Party shall at all times be licensed by the State Department of Public Health, and certified by the Medicare and Medicaid programs.

10. **Term**. This Agreement shall be effective on the Effective Date and shall continue unless and until terminated as follows:

(a) By either Party without cause, upon sixty (60) days prior written notice to the other Party; or

(b) Upon material breach of this Agreement, the non-breaching Party may terminate this Agreement on twenty (20) days written notice of the termination to the beaching Party. The notice shall state the acts or omissions that constitute the material breach. Material breach of this Agreement shall include, without limitation, violation of any federal, state or local statutes or regulations related

to patient transfers. Remedy of the alleged material breach to the satisfaction of the Party giving notice within fifteen (15) days of the notice shall reinstate the Agreement.

11. **Amendments**. This Agreement may be amended at any time by a written agreement signed by the Parties hereto. Nothing in this Agreement shall prevent the Parties from entering a separate agreement, or otherwise modifying the terms of this Agreement, for a specific patient transfer between the Parties.

12. **Miscellaneous**.

(a) **Notice**. Any notice required or permitted by this Agreement shall be effective and shall be deemed delivered upon placing in the mail, by certified or registered mail, postage prepaid, or upon personal delivery as follows:

To _____	To _____
_____	_____
_____	_____
_____	_____
Attn: Chief Executive Officer	Attn: Chief Executive Officer

(b) **Invalid Provision**. In the event that any portion of this Agreement shall be determined to be invalid or unenforceable, the remainder of this Agreement shall be deemed to continue to be binding upon the Parties hereto in the same manner as if the invalid or unenforceable provision were not part of this Agreement.

(c) **Maintenance of Records**. Each Party shall maintain all documentation relating to transfers under this Agreement, including transfer requests, acceptances and denials, for a minimum period of five (5) years from the date of the request for a transfer.

(d) **Name Use**. Neither Party shall use the name of the other Party in any promotional or advertising material without the express written consent of the other Party. This Agreement shall not constitute an endorsement by either Party of the other Party, and it shall not be so used.

(e) **Governing Law**. This Agreement shall be construed in accordance with the laws of the State of _____. Venue for disputes under this Agreement shall be the County of _____.

(f) **Liability Insurance**. Each Party shall maintain general and professional liability insurance with coverage limits in amounts which are usual and customary for similar health facilities in _____ in size, complexity and scope of services. Each Party shall give the other Party at least 30 days prior written notice of any proposed reduction or cancellation of such insurance coverage, and shall provide to the other Party evidence of the above described insurance policy or policies upon request.

(g) **Indemnification**. Each Party agrees to indemnify, defend, and hold harmless the other Party, its directors, officers, employees and agents from any and all liabilities, claims, damages, losses, reasonable attorney's fees, and other reasonable costs of defense (including costs incurred prior to commencement of a lawsuit) resulting solely from or attributable solely to acts or omissions of the indemnifying Party or any of its agents in the performance of this Agreement.

(h) **Assignment and Delegation**. Neither Party hereto shall assign or transfer this Agreement, in whole or in part, or any of its rights, duties, or obligations under this Agreement, without the prior written consent of the other Party hereto.

(i) **Entire Agreement**. This Agreement contains the entire understanding of the Parties with respect to the subject matter hereof and supersedes all prior agreements, oral or written, and all other communications between the Parties relating to such subject matter.

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the Effective Date.

_____	_____
By: _____	By: _____

ADDENDUM FOR TRANSFERS FOR SPECIFIC TEST(s) OR PROCEDURE(S) WHERE THE PATIENT WILL RETURN TO THE TRANSFERRING HOSPITAL

1. **Responsibilities of Transferring Hospital**. In the event of a transfer for a specific test(s) or procedure(s) and the patient will return thereafter to the Transferring Hospital --

(a) The Transferring Physician shall (i) obtain the patient's consent for the transfer as well as for the test(s) and procedure(s), including documenting the consents in writing when required; and (ii) determine the mode of transport, equipment and personnel for the transfer.

(b) The Transferring Hospital shall comply with all applicable laws relating to the transfer of the patient and agree to accept the return of the patient upon completion of the test(s) and procedure(s) at the Receiving Hospital.

(c) The Transferring Hospital shall be financially responsible, including billing, for the transport of the patient to and from the Receiving Hospital. The Receiving Hospital shall not pay for the cost of transportation unless the Receiving Hospital is legally obligated to do so.

(d) Except for the transfer of a patient with an Unstabilized Emergency Medical Condition, the Transferring Hospital shall obtain prior authorization from the patient's payor or other person for the transfer and the test(s)/procedure(s) if (i) prior authorization is required by the payor prior to the transfer and/or procedure; and (ii) requesting such authorization is otherwise permitted by law.

2. **Responsibilities of the Receiving Hospital**. In the event the transfer is for a specific test(s) or procedure(s) and the patient will return thereafter to the Transferring Hospital --

(a) The Receiving Hospital shall be responsible for assuring that the requested test(s) and procedure(s) are performed promptly and that, as soon as possible, the patient is returned to Transferring Hospital.

(b) Before returning the patient, the Receiving Physician shall determine that the patient's condition is Stabilized for transfer to the Transferring Hospital. If the patient's condition is not Stabilized for the transfer, the Receiving Hospital will arrange for an appropriate physician to care for the patient until such time as the patient's condition is Stabilized for the transfer. When the patient's condition is Stabilized, the Receiving Hospital agrees to return the patient in an expeditious manner, subject to the patient's (and, if applicable, payor's) consent.

(c) The Receiving Hospital shall forward a copy of all pertinent medical records with the patient. The medical records should reflect the patient's condition while at Receiving Hospital, the procedures and services performed on the patient at Receiving Hospital, including the results. Records that are not available at the time of the return transfer shall be forwarded as soon as they become available.

(d) Except as arranged by the Transferring Hospital, the Receiving Hospital shall be responsible for coordinating for the patient's return to Transferring Hospital, including the responsibility for selecting an appropriate mode of transportation and appropriate personnel, including physicians and hospital personnel, when appropriate, to accompany the patient.

EXHIBIT A

PROCEDURE FOR OBTAINING RECEIVING HOSPITAL'S CONSENT FOR PATIENT TRANSFER

Hospital 1:

Hospital 2:

APPENDIX T

Sample Transfer Checklist and Script for Accepting Emergency Patients

PART 1 — COLLECT BASIC INFORMATION	
INQUIRIES/DOCUMENTATION	**COMMENTS**
❑ Date and time of the call ❑ Name of transferring hospital ❑ Name of the caller (position if known) ❑ Telephone number of caller ❑ Name of staff member receiving the call ❑ Patient's name ❑ Patient's age (gender optional) ❑ Name of transferring physician ❑ Other basic information	Do not ask for any insurance or financial information prior to determination whether the request is for an EMTALA or non-EMTALA patient transfer. If an EMTALA transfer, do not ask for any insurance or financial information before final decision to accept or decline the transfer.

PART 2 — DETERMINE WHETHER THE REQUEST IS FOR AN EMTALA OR NON-EMTALA TRANSFER	
INQUIRIES/DOCUMENTATION	**COMMENTS**
1. **"Is the patient in an emergency department (or labor & delivery)?"** • If an inpatient — no EMTALA obligation to accept the patient (refer to Transfer Policy for acceptance of non-EMTALA transfers). **Go to Part 5 if transfer declined.** • If an emergency patient — **go to question 2.**	Inpatients include patients admitted to the hospital who are boarded in the emergency department pending the availability of an inpatient bed or other treatment area.

PART 2 — DETERMINE WHETHER THE REQUEST IS FOR AN EMTALA OR NON-EMTALA TRANSFER (CONT.)	
INQUIRIES/DOCUMENTATION	**COMMENTS**
2. **"Has there been a determination that the patient has an 'emergency medical condition?'"** • If patient does not have an "emergency medical condition" — no EMTALA obligation to accept the patient (refer to Transfer Policy for acceptance of non-EMTALA transfers). **Go to Part 5 if transfer declined.** • If patient has an "emergency medical condition" — **go to question 3.**	**"Emergency medical condition"** is a medical condition (including severe pain, psychiatric disturbances or chemical dependency abuse) manifesting itself by acute symptoms of sufficient severity so that the absence of immediate medical attention could reasonably be expected to result in: (A)(i) Placing the health of the patient (or an unborn child) in serious jeopardy, or (ii) Serious impairment of bodily functions, or (iii) Serious dysfunction of any bodily organ or part; or (B) A pregnant woman having contractions if there is inadequate time for a safe transfer to another facility or the transfer will pose a threat to the health of the mother or the unborn child.
3. **"Has there been a determination as to whether the emergency medical condition is "stabilized" or "unstabilized?"** • If "stabilized," no EMTALA obligation to accept the patient (refer to Transfer Policy for acceptance of non-EMTALA transfers). **Go to Part 5 if transfer declined.** • If not stabilized, **go to question 4.**	**"Stabilized"** means when no material deterioration is likely, within reasonable medical probability, to result from or occur during the transfer of the patient to another medical facility (or woman having contractions has delivered the baby/placenta). The determination of whether the patient is stabilized is made by the transferring physician.

PART 2 — DETERMINE WHETHER THE REQUEST IS FOR AN EMTALA OR NON-EMTALA TRANSFER (CONT.)	
INQUIRIES/DOCUMENTATION	**COMMENTS**
4. **"What are the reasons for the transfer?"** • If the reasons are not to access "specialized services" that are required to stabilize the patient's emergency medical condition (for example, the reason given relates to insurance purposes, physician preference, etc.), there is no EMTALA obligation to accept the patient (refer to Admission Policy for acceptance of non-EMTALA transfers). • If the reasons are to access "specialized services" that are required to stabilize the patient's emergency medical condition, document the reasons: ❑ Specialized care (NICU, neurosurgery, catheterization, etc.) ❑ Lack of capacity at transferring hospital ❑ Diagnostic testing only (and return to transferring hospital) ❑ Patient request for transfer ❑ On-call physician is unavailable (in surgery or at another hospital). ❑ On-call physician failed or refused to respond ❑ No on-call physician on the schedule **Go to question 5.**	**NOTE:** The hospital may be required to accept a non-EMTALA transfer from another facility (e.g., the patient is insured by a plan that is aligned with the hospital, or under a county contract or transfer agreement). **"Specialized services"** are any services (including surgery) provided by the receiving hospital that are necessary to stabilize the patient's emergency medical condition that are a higher level of care at the time of the transfer than the level of care available at the transferring hospital at the time of the transfer. A patient request for a transfer must be an informed request (after receiving information regarding risks and benefits and alternatives) to the transfer. If an on-call physician failed or refused to respond, and the patient is accepted for transfer, report the on-call failure to [specify location for reporting on-call failures].
5. **"Does the transferring hospital have the present capability and capacity to provide those services?"** • If the transferring hospital has the present capability and capacity to provide the specialized services required for the patient, no EMTALA obligation to accept the patient (refer to Transfer Policy for acceptance of non-EMTALA transfers). • If the transferring hospital states that it does not have the present capability and capacity to provide the specialized services required for the patient, **go to Part 3.**	Document the name of the person who determined the presence of, or lack of, capability and capacity.

PART 3 — DETERMINE HOSPITAL CAPABILITY AND CAPACITY TO ACCEPT THE TRANSFER	
NOTE: In order to assess the clinical needs of the patient and the capability and capacity of the receiving hospital, the receiving hospital may ask for the patient's vital signs, test results and other clinical information that is pertinent to determining the receiving hospital's capability to meet the patient's needs	
INQUIRIES/DOCUMENTATION	**COMMENTS**
1. **Does the hospital have an appropriately staffed bed that is expected to be available at the time of patient's arrival (or later, if the patient will be routed to surgery or other treatment area)?** • If the patient requires an inpatient bed and an appropriately staffed bed is not expected to be available at the time of the transfer, there is no obligation to accept the patient. **Go to Part 5.** • If the patient requires an inpatient bed and an appropriately staffed bed is expected to be available at the time of the transfer, **go to Question 2.**	If the receiving hospital routinely boards inpatients in the ED or other overflow area, or holds an open bed for a later use, consult with [insert contact person] as to whether there is bed capacity to accept the patient.
2. **Is the ED expected to have capacity to examine, treat and monitor the patient pending assignment of the patient to an inpatient bed, treatment or discharge from the ED?** • If the patient requires the services of the ED and the ED is on diversion or saturation or otherwise does not have capacity to accept another emergency patient with an unstabilized emergency condition, there is no obligation to accept the patient. **Go to Part 5.** • If the patient does not require the services of the ED, **go to Question 3.** • If the patient requires the services of the ED and the ED has capacity to examine, treat and monitor the patient, **go to Question 3.**	

PART 3 — DETERMINE HOSPITAL CAPABILITY AND CAPACITY TO ACCEPT THE TRANSFER (CONT.)	
INQUIRIES/DOCUMENTATION	**COMMENTS**
3. **Does the hospital expect to have service capacity at the time of the patient's arrival (or within clinically required time frames) to provide the level of care required for the patient?** • If the patient requires an operating room, cardiac catheterization or other treatment area, and the treatment area and staff are not expected to be available at the time of the transfer (or within clinically required timeframes), there is no obligation to accept the patient. **Go to Part 5.** • If the special treatment area is expected to be available at the time of the transfer, **go to Question 4.**	
4. **Is there an appropriate medical staff physician who will accept the responsibility for the patient?** • If there is no appropriate medical staff physician who is available and willing to accept the patient, there is no obligation to accept the patient. **Go to Part 5.** • If there is an appropriate medical staff physician who is available and willing to accept the patient, **accept the patient transfer and proceed to Part 4.**	If an on-call physician is available to accept the patient, but is unwilling to do so, report the decision to _____.

PART 4 — DOCUMENTATION OF TRANSFER ACCEPTANCE	
INQUIRIES/DOCUMENTATION	**COMMENTS**
❑ Date and time of acceptance ❑ Name of accepting physician ❑ Bed unit assigned to the patient (or route to emergency department) ❑ Mode of transport (ALS, BLS, air, private vehicle, other) ❑ Other information	

PART 5 — DOCUMENTATION IF TRANSFER NOT ACCEPTED	
INQUIRIES/DOCUMENTATION	**COMMENTS**
❑ Not an emergency medical condition ❑ Emergency medical condition is stabilized ❑ Patient does not require specialized services at the hospital ❑ Hospital does not provide the specialized services required to stabilize the patient's emergency medical condition ❑ Hospital does not have bed, services or ED capacity (document the reasons) ❑ On-call physician is not available to accept the patient (document the reasons) ❑ Transfer is for insurance reasons ❑ Transfer is a lateral transfer (level of care available at transferring hospital at time of transfer) ❑ Other (document the reasons)	Additional information supporting the refusal should be documented

CDPH All-Facility Letter 12-17

(May 17, 2012)

State of California—Health and Human Services Agency
California Department of Public Health

RON CHAPMAN, MD, MPH
Director & State Health Officer

EDMUND G. BROWN, JR.
Governor

May 17, 2012 AFL 12-17

TO: General Acute Care Hospitals (GACH) and Acute Psychiatric Hospitals (APH)

SUBJECT: Care and Treatment of Psychiatric Emergency Medical Conditions

AUTHORITY: Health and Safety Code (HSC) Section 1317.1 and Code of Federal Regulations (CFR) Section 489.24

In response to questions regarding the applicability of the Emergency Medical Treatment and Labor Act (EMTALA) to the transfer of patients with psychiatric emergencies, this All Facilities Letter (AFL) serves as a reminder of pertinent state law and federal regulations.

On November 23, 2009, the California Department of Public Health (CDPH) issued AFL 09-42 notifying all APHs and GACHs of legislation that became effective January 1, 2010, related to the transfer of patients with psychiatric emergencies. In addition the Centers for Medicare and Medicaid Services (CMS) interpretive guidelines for EMTALA regulations specifically address the transfer of patients with psychiatric emergencies.

State law

HSC 1317.1 defines “psychiatric emergency medical condition” as a mental disorder that manifests itself by acute symptoms of sufficient severity to render the patient either an immediate danger to himself or others, or immediately unable to provide for, or utilize food, shelter, or clothing, due to the mental disorder. It is also explicit that GACHs and APHs must provide the care and treatment necessary to relieve or eliminate a psychiatric emergency medical condition within the capability of the facility, including, as necessary, admission or transfer to a psychiatric unit within a GACH or to an APH.

Federal regulations

CFR 489.24(b) includes “psychiatric disturbances and/or symptoms of substance abuse” in the definition of an emergency medical condition for which hospitals must provide medical examination and treatment, as required to stabilize the condition. CMS’

Licensing and Certification Program, MS 0512 ● P.O. Box 997377 ● Sacramento, CA 95899-7377
(916) 324-6630 ● (916) 324-4820 FAX
Internet Address: www.cdph.ca.gov

interpretive guidelines for the provisions of CFR Section 489.24 (as found in State Operations Manual (SOM) Appendix V Tag A-2407/C-2407), further clarify that an individual expressing suicidal or homicidal thoughts or gestures, who can be determined to be dangerous to self or others, would be considered to manifest an emergency medical condition. CMS guidance states that psychiatric patients are considered stable when they are protected and prevented from injuring or harming themselves or others.

Hospitals are required to comply with both state and federal requirements. CDPH's failure to expressly notify facilities of legislative or regulatory changes does not relieve them of this responsibility. Facilities should refer to the full texts of HSC 1317.1, CFR 489.24, and federal interpretative guidance regarding CFR 489.24 to ensure compliance.

If you have any questions, please contact your respective L&C District Office. For your convenience the list of all District Office addresses and contact information can be found using the following link:

http://www.cdph.ca.gov/certlic/facilities/Pages/LCDistrictOffices.aspx

Sincerely,

Original Signed by Debby Rogers

Debby Rogers, RN, MS, FAEN
Deputy Director
Center for Health Care Quality

APPENDIX V

CMS Letter Regarding Transfer of Patients to Crisis Stabilization Units

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations/Survey and Certification Group

November 12, 2009

Mr. Steve Lipton
Davis Wright Tremaine LLP
Suite 800
505 Montgomery Street
San Francisco, CA 94111-6533

COPY

Dear Mr. Lipton:

Your inquiry dated June 24, 2009 to the Centers for Medicare and Medicaid Services (CMS) Regional Office (RO) in San Francisco regarding the transfer of behavioral emergency patients to crisis stabilization units (CSUs) in California was forwarded to CMS Central Office for response. According to your letter, you are seeking guidance on the compliance of a hospital with EMTALA requirements if it transfers an individual who has come to that hospital's emergency department to a State of California-designated CSU for the continued provision of "evaluation and treatment for behavioral patients in crisis involving patients under an involuntary hold". You also indicated that such a transfer would only occur after these individuals had undergone a medical screening examination and been subsequently determined to have an unstabilized emergency medical condition, as defined by the EMTALA statute at Section 1867 of the Social Security Act ('the Act'). We appreciate the ongoing challenges hospitals and communities face in obtaining care for individuals with psychiatric emergencies and interest in assessing whether various arrangements would be consistent with EMTALA requirements. However, please be advised that CMS does not review hospital policies and render determinations on their compliance with the EMTALA regulations outside the context of the investigation of a specific EMTALA complaint. EMTALA compliance is very case/fact-sensitive.

For your information, CMS' official interpretation of the EMTALA regulatory requirements for hospitals concerning the stabilization and the appropriate transfer of individuals with emergency medical conditions (EMCs) is contained in the Interpretive Guidelines located in Appendix V of the State Operations Manual (http://www.cms.hhs.gov/manuals/downloads/som107ap_v_emerg.pdf.). This guidance affirms that, when evaluating whether a transfer of an individual protected under EMTALA is appropriate, we look at the relevant regulatory requirements including, but not limited to,: 1) did the transferring hospital provide the necessary stabilizing treatment within its capacity so as to minimize the risks of the transfer; and 2) whether a physician certified that the medical benefits reasonably expected from the provision of *appropriate medical treatment* [emphasis added] at another medical facility outweigh the increased risks from effecting the transfer. Thus, transfer

to a medical facility that lacked the capacity to stabilize the EMC would not be consistent with EMTALA. Your client might find it prudent as it develops transfer policies to assess the capabilities of CSUs to provide appropriate stabilizing treatment to individuals with psychiatric emergency medical conditions.

Once again, thank you for your inquiry.

Sincerely,

Marilyn Dahl

Marilyn Dahl
Director, Division of Acute Care Services

cc: Rufus Arther, CMS RO9

EMTALA Physician Review Worksheet

EXHIBIT 138

(Rev. 134, Issued: 02-20-15, Effective: 02-13-15, Implementation; 02-13-15)

EMTALA Physician Review Worksheet

☐ **5 - Day Review** ☐ **60 - Day Review**

***NOTE**: A separate Worksheet must be completed by the QIO Physician Reviewer for each medical record reviewed. To facilitate accurate completion, the CMS Regional Office (RO) will complete Section I for each medical record sent to the QIO along with the request for review. The RO must label each medical record with the unique patient identifier as found on the draft Form CMS 2567.*

SECTION I

Complaint Control Number:_____ Patient *Identifier Number on Draft 2567*:_____

Name of Patient: _____ DOB: _____

Name of Alleged Violating Hospital and/or Physician: _____

_____

City: _____ State: _____ CMS Certification Number: _____

Date and Time of Admission to Emergency Services: _____

Date and Time of Discharge from Emergency Services: _____

Name of Receiving Hospital (if applicable): _____

Receiving Hospital Location:

City: _____ State: _____ CMS Certification Number: _____

Date and Time of Admission to Receiving Hospital (if applicable):_____

Manner of Transport: _____

Receiving Hospital Distance from Sending Hospital (if applicable and known): _____

SECTION II

Note to Physician Reviewer: Please complete the following questions to address issues related to EMTALA. Please be sure to include your clinical rationale for your *findings*, and make any summary comments and comments on other aspects of the case in the summary section on the last page of this document. Please keep in mind that the purpose of your comments is to provide your clinical perspective on the care rendered, for the CMS 5-day EMTALA review or for the OIG 60-day EMTALA review.

Therefore, please refrain from making ANY statements about whether or not a violation of EMTALA has occurred, as that decision is the responsibility of CMS and the OIG only.

(Violations of EMTALA may also constitute negligence under state malpractice law. *However, determining negligence is not part of and should not be mentioned in your EMTALA review.*)

EXHIBIT 138

(Rev. 134, Issued: 02-20-15, Effective: 02-13-15, Implementation; 02-13-15)

EMTALA Physician Review Worksheet

MEDICAL SCREENING EXAMINATION

Note to Physician Reviewer: Depending upon an individual's presenting symptoms, an appropriate medical screening examination can range from a simple process involving only a brief history and physical examination to a complex process that also involves performing ancillary studies and procedures such as (but not limited to) lumbar puncture, clinical laboratory tests, CT scans and other diagnostic tests and procedures, *some of which may require the services of an on-call specialist to order, conduct or interpret.*

A hospital must provide appropriate screening services within the full capabilities of its staff and facilities, including access to specialists who are on call.

An **Emergency Medical Condition** is defined as **EITHER**: (1) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in: placing the individual's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or serious impairment to bodily functions; or serious dysfunction of any bodily organ or part; **OR** (2) with respect to a pregnant woman who is having contractions, that there is inadequate time to effect a safe transfer to another hospital before delivery, or that the transfer may pose a threat to the health or safety of the woman or the unborn child. *(See 42 CFR 489.24(b))*

1. Did the hospital provide a medical screening examination that was, *within reasonable clinical confidence, sufficient to determine whether or not an EMERGENCY MEDICAL CONDITION (as defined above) existed? More specifically:*

1a. *Was the medical screening examination appropriate given all of* the individual's medical complaints and signs and symptoms *at the time the individual presented*?

☐ **YES** ☐ **NO**

Please explain your clinical rationale: _____

_____

_____

1b. *Was the medical screening examination appropriate given the hospital's capabilities* - including ancillary services routinely available and consultations by on–call specialist physicians?

☐ **YES** ☐ **NO**

Please explain your clinical rationale: _____

_____

_____

_____

EXHIBIT 138

(Rev. 134, Issued: 02-20-15, Effective: 02-13-15, Implementation; 02-13-15)

EMTALA Physician Review Worksheet

1c. Is there any evidence that there was an inappropriately long delay, based on the individual's clinical presentation, between the individual's arrival and the provision of an appropriate medical screening examination?

☐ **YES** ☐ **NO**

Please explain your clinical rationale: _____

_____

_____

_____

EMERGENCY MEDICAL CONDITION

2. Did this individual have an EMERGENCY MEDICAL CONDITION as defined by Part (1) of the definition noted above? (Individual conditions meeting the definition in Part 2 above are addressed in subsequent questions.)

☐ **YES** ☐ **NO**

Please explain your clinical rationale:

_____

_____

_____

_____

3. Was this individual a pregnant woman who was having contractions?

☐ **YES** ☐ **NO**

Please explain your clinical rationale: _____

_____

_____

_____

(If "NO" is checked, skip questions #3a & #3b and proceed to #4)

EXHIBIT 138

(Rev. 134, Issued: 02-20-15, Effective: 02-13-15, Implementation; 02-13-15)

EMTALA Physician Review Worksheet

***3*a. If "YES" *is checked in #3* and the pregnant woman was transferred/discharged, at the time of transfer/discharge, could it be determined with reasonable medical certainty that there would be adequate time to effect a safe transfer to another hospital before delivery?**

☐ **YES** ☐ **NO** ☐ **N/A**

Please explain your clinical rationale: _____

_____

_____

_____

***3*b. If *"YES" is checked in #3 and* the pregnant woman with contractions was transferred/discharged, at the time of transfer/discharge could it be determined, with reasonable medical certainty, that the transfer/discharge would not pose a threat to the health or safety of the *pregnant woman* or the unborn child?**

☐ **YES** ☐ **NO** ☐ **N/A**

Please explain your clinical rationale: _____

_____

_____

_____

STABILIZING TREATMENT

Note to Physician Reviewer: Terms relating to "stabilization" are specifically defined under EMTALA. These terms DO NOT REFLECT the common usage in the medical profession, but instead focus on the medical risks associated with a particular transfer/discharge. Thus, when answering questions related to "stability" for EMTALA, please be very careful to refer to the definition provided below. In addition, the clinical outcome of an individual's condition is not a proper basis for determining whether a person transferred was stabilized. However, the individual's outcome may be a "red flag" indicating that a more thorough evaluation of the individual's condition at the time of transfer was needed.

*Under EMTALA, **to stabilize** means, with respect to part 1 of the definition of an "emergency medical condition," to provide such medical treatment of the condition necessary to assure,* within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer/discharge of the individual from the hospital, or in the case of *part 2 of the definition, concerning* a pregnant woman having contractions, that the pregnant woman has delivered the child and placenta.

EXHIBIT 138

(Rev. 134, Issued: 02-20-15, Effective: 02-13-15, Implementation; 02-13-15)

EMTALA Physician Review Worksheet

4. If *the individual had* an emergency medical condition (EMC), was the EMC "stabilized" *(as defined above) prior to the time of the individual's transfer or discharge?*

☐ **YES** ☐ **NO** ☐ **N/A**

Please explain your clinical rationale: _____

_____

_____

_____

Note to Physician Reviewer: *A hospital must provide appropriate stabilizing treatment services for an emergency medical condition within the full capabilities of its staff and facilities, including access to specialists who are on call.*

5a. Is there any evidence that the hospital was equipped with such staff, services, or equipment necessary to "stabilize" the individual's emergency medical condition??

☐ **YES** ☐ **NO** ☐ **N/A**

Please explain your clinical rationale: _____

_____

_____

_____

5b. If the hospital had the capability to stabilize the individual and the individual's *emergency medical condition* was not stabilized prior to transfer/discharge, is there any information available to indicate WHY the emergency medical condition was NOT "stabilized" prior to discharge/transfer?

☐ **YES** ☐ **NO** ☐ **N/A**

If yes, does this rationale have a sound clinical basis?: _____

_____

_____

_____

_____

EXHIBIT 138

(Rev. 134, Issued: 02-20-15, Effective: 02-13-15, Implementation; 02-13-15)

EMTALA Physician Review Worksheet

5c. Is there any evidence that there was an inappropriately long delay, based on the individual's clinical presentation, between the individual's arrival and the provision of appropriate stabilizing treatment for the individual's emergency medical condition?

☐ ***YES*** ☐ ***NO*** ☐ ***N/A***

Please explain your clinical rationale: _____

_____

_____

_____

_____

Note to Physician Reviewer: *A hospital is required to inform the individual or the individual's legal representative of the risks and benefits of further examination and treatment. If the individual/representative then refuses to consent to further examination or treatment, the medical record must contain a description of the examination or treatment, or both, which was refused, as well as documentation of the individual/representative having been informed of these risks/benefits.*

6. Does the medical record indicate the individual refused to consent to necessary stabilizing treatment?

☐ ***YES*** ☐ ***NO***

(If "NO" is checked, skip question #6a and proceed to #7)

6a. If "YES" is checked and if the medical record contains a description of the communication to the individual/legal representative of the risks and benefits and benefits of further examination or treatment, was this communication appropriate, based on the information available to the hospital at the time of the refusal?

☐ ***YES*** ☐ ***NO*** ☐ ***N/A***

Please explain: _____

_____

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_____

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EXHIBIT 138

(Rev. 134, Issued: 02-20-15, Effective: 02-13-15, Implementation; 02-13-15)

EMTALA Physician Review Worksheet

APPROPRIATE TRANSFERS

7a. If your response to question 5a was "NO" finding that the hospital was not capable of stabilizing the individual's emergency medical condition, **what were the required specialized capabilities that the hospital lacked?**

_____

_____

_____

_____

7b. **If the individual was transferred to another hospital, did the *sending* hospital provide further examination and stabilizing treatment, within its *capacity* (including ancillary services routinely available to it) to minimize the risks of transfer to the individual's health and, where relevant, the health of the unborn child?**

☐ **YES** ☐ **NO** ☐ **N/A**

Please explain your clinical rationale: _____

_____

_____

_____

_____

8. If the individual was transferred to another hospital, to minimize the risks of transfer, *were* qualified personnel and transportation equipment, including *medically appropriate* life support measures, *used to effect (i.e., accomplish) the transfer*?

☐ **YES** ☐ **NO** ☐ **N/A**

Please explain your clinical rationale: _____

_____

_____

_____

EXHIBIT 138

(Rev. 134, Issued: 02-20-15, Effective: 02-13-15, Implementation; 02-13-15)

EMTALA Physician Review Worksheet

9a. ***If this individual was transferred to another hospital for stabilizing treatment of an unstabilized emergency medical condition, do you find that, considering the individual's clinical condition at the time of transfer and any other pertinent information available at that point in time, the medical benefits reasonably expected from appropriate medical treatment at the other hospital outweighed the increased risk to the individual (or woman in labor or unborn child) from being transferred?***

☐ **YES** ☐ **NO** ☐ **N/A**

Please explain your clinical rationale: _____

_____

_____

Note to physician reviewer: *The physician certification required for an appropriate transfer must be in writing, must contain a summary of the specific risks and benefits pertaining to this individual's clinical situation, and must be placed in the individual's medical record.*

9b. ***Do you find that the summary of risks and benefits of transfer contained in the physician certification was appropriate, based on the information available to the hospital at the time of transfer about the individual's condition?***

☐ **YES** ☐ **NO** ☐ **N/A***

Please explain: _____

_____

_____

**Check N/A not only if this case does not involve a transfer, but also if there was no physician certification in the medical record*

9c. ***If the transfer was at the request of the individual or the individual's legal representative, rather than based on a physician's certification of the benefits outweighing the risks, and the medical record documents this, do you find that the likely risks of the transfer were identified for the individual/representative?***

☐ **YES** ☐ **NO**

Please explain your clinical rationale: _____

_____

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EXHIBIT 138

(Rev. 134, Issued: 02-20-15, Effective: 02-13-15, Implementation; 02-13-15)

EMTALA Physician Review Worksheet

10. **Does the documentation suggest that the transferring hospital sent to the receiving hospital all available and pertinent medical documentation related to the emergency medical condition?**

☐ **YES** ☐ **NO** ☐ **N/A**

Please explain: _____

_____

_____

RESPONSIBILITY OF HOSPITALS WITH SPECIALIZED DIAGNOSTIC OR TREATMENT CAPABILITIES OR FACILITIES

Note to Physician Reviewer: While "specialized capabilities or facilities" include such facilities as burn units, shock-trauma units, neonatal intensive care units or regional referral centers, it also includes *many more clinical characteristics*. Most simply, if an individual with an emergency medical condition needs services to stabilize that condition that cannot be made available in a clinically appropriate timeframe at the hospital where the individual presented, but which are available at another hospital, the hospital with these capabilities/services must accept a request for transfer, if it has the capacity to provide the needed *stabilizing treatment*.

11. **Is there any evidence that a Medicare-participating hospital that refused a transfer request has specialized capabilities or services (not available at the *sending* hospital) that the individual required?**

☐ **YES** ☐ **NO** ☐ **N/A**

Please explain: _____

_____

_____

(If "NO" or "N/A" is checked, skip question #11a and go to #12.)

11.a If "YES" is checked in #11, is there evidence that the hospital with specialized capabilities or services lacked the capacity to treat the individual requesting stabilizing treatment, at the time of the request?

Please explain: _____

_____

_____

_____

EXHIBIT 138

(Rev. 134, Issued: 02-20-15, Effective: 02-13-15, Implementation; 02-13-15)

EMTALA Physician Review Worksheet

QUALITY

12. **Do you have any specific concerns about the quality of care rendered to the individual that have not already been addressed fully above?**

☐ **YES** ☐ **NO**

If yes, please explain your clinical rationale: _____

_____

_____

_____

_____

SUMMARY OF FINDINGS:

13. Please summarize the key facts of the case below and any concerns or clarifications to your answers above with regard to this case. Remember, do not state an opinion regarding whether EMTALA was violated.

_____

_____

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EXHIBIT 138

(Rev. 134, Issued: 02-20-15, Effective: 02-13-15, Implementation; 02-13-15)

EMTALA Physician Review Worksheet

I agree to provide medical advice to the Centers for Medicare & Medicaid Services and/or the Office of Inspector General, as necessary, to properly adjudicate any issues and to testify as an expert witness on behalf of the Office of Inspector General, if necessary.

Physician Reviewer Name (printed): _____

Physician Reviewer Signature: _____

Specialty: _____ **Date:** _____

Case ID: _____

Time Required to Complete This Review: _____ ***hours*** _____ ***minutes***

APPENDIX X

EMTALA Requirements & Conflicting Payor Requirements or Collection Practices

CMS Survey and Certification Memorandum 14-06 (Dec. 13, 2013)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality /Survey & Certification Group

Ref: S&C: 14-06-Hospitals /CAHs

DATE: **December 13, 2013**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Emergency Medical Treatment and Labor Act (EMTALA) Requirements & Conflicting Payor Requirements or Collection Practices

Memorandum Summary

- ***EMTALA & Payor Requirements:*** Some proposed or existing payment policies of third party payors of hospital services have generated confusion among providers about their EMTALA obligations. The Centers for Medicare & Medicaid Services (CMS) is clarifying for Medicare-participating hospitals and critical access hospitals (CAH) that they are required to comply with EMTALA, regardless of any conflicting requirements of third-party payors, including when those payors are State Medicaid programs.

- ***Certain Hospital Collection Practices May Also Conflict with EMTALA:*** It is not acceptable for a hospital or CAH to request immediate payment, by cash or other methods, for services provided to an individual who is protected under EMTALA prior to the receipt of such services. A hospital may only request on-the-spot payment after it has conducted an appropriate medical screening examination (MSE) and, if applicable, stabilized an individual's emergency medical condition (EMC) or admitted the individual. Hospital patients are further protected under the patient's rights Condition of Participation at 42 CFR 482.13(c)(3), which protects patients from abuse or harassment.

- ***Provisions of the Affordable Care Act May Mitigate Future Problems:*** The Affordable Care Act contains provisions requiring certain insurance issuers to cover emergency services, including stabilization, without preauthorization.

Background

CMS has received questions from providers that suggest third-party health services payors may be proposing or establishing payment-related policies and procedures that could, if adhered to by Medicare-participating hospitals and CAHs, place those facilities and their physicians at risk for noncompliance with EMTALA. Providers submitting questions to CMS have expressed

confusion about whether a third party payor's policies might alter EMTALA compliance requirements, or have asked CMS to intervene where they believe a proposed Medicaid policy would create conflicts with EMTALA.

It is important for all parties to understand that, regardless of the individual's payment method and/or the ability to pay, a Medicare-participating hospital or CAH must provide the services required under EMTALA, in accordance with 42 CFR 489.20, subsections l, m, q, and r, and 42 CFR 489.24. Furthermore, in the case of Medicaid payor proposals, it is important to be aware that not every proposal under discussion in a State ends up being formally included as an amendment to its State Medicaid plan. Furthermore, CMS will only approve revisions to State Medicaid plans that adhere to applicable Federal regulations, including those governing provision of emergency services. When CMS becomes aware of existing or proposed State Medicaid policies or practices that would create conflict with Federal Medicaid or EMTALA requirements, it takes action to resolve the conflict.

Additional Protections Under The Affordable Care Act

Section 1001 of the Affordable Care Act created a new Section 2719A in the Public Health Service Act (PHSA) that provides for fair practices of private health insurance plans and generally states that if a health insurer offers benefits with respect to emergency services, the following are required:

- There may be no requirement for preauthorization of services even if the emergency services are provided on an out-of-network basis;

- There cannot be administrative requirements or limitations imposed on emergency services provided on an out-of-network basis that are stricter than those imposed on in-network emergency services; and

- The amount of cost sharing expressed as a co-payment amount or a co-insurance rate for out-of-network emergency services cannot exceed the amounts imposed on in-network emergency services.

Thus, the Affordable Care Act adopted protections for individuals to ensure that they receive appropriate emergency care without concerns of undue payment hardship. Note that the definitions of "emergency medical condition" and "emergency services" in Section 2719A(b)(2) of the PHSA specifically reference EMTALA provisions at Section 1867 of the Act.

These Affordable Care Act requirements apply to non-grandfathered employer group health plans (both insured and self-insured) and to non-grandfathered health insurance issuers in the group and individual markets. These requirements, however, do not apply to Medicare and Medicaid fee-for-service or managed care plans.

Page 3 – State Survey Agency Directors

Third Party Payor Policies or Practices Raised by Providers & Pertinent EMTALA Requirements

The following are examples of reported existing or proposed practices which, if the hospital or CAH were to adhere to them, could place them at risk of violating EMTALA. (Throughout this memo, when we use the term "hospital," it also includes CAHs for EMTALA purposes, unless expressly stated otherwise.):

1. Payors requiring prior authorization before a hospital initiates stabilizing treatment, or initiates or accepts an appropriate transfer of an individual protected under EMTALA who has been determined, on the basis of an appropriate MSE, to have an EMC requiring stabilization.

    - 42 CFR 489.24(d)(4) prohibits a hospital from seeking, or directing an individual to seek, insurer authorization for screening or stabilization services until after the hospital has provided the MSE and initiated stabilizing treatment. In light of the Affordable Care Act provisions (see above) that require many insurance issuers to cover emergency services without prior authorization, CMS expects there to be fewer cases in which a hospital may be asked to seek prior authorization.

      Further, in accordance with 42 CFR 489.24(f), a hospital with specialized capabilities required by an individual protected under EMTALA must accept an appropriate transfer of that individual, if it has the capacity to do so. Recipient hospitals may not first inquire into the individual's ability to pay or whether a third-party payor has authorized the transfer or admission.

    - It is important to note that under EMTALA the statutory definition of an individual's EMC being "stabilized" does not necessarily equate to an individual being clinically stable. As defined in the Social Security Act ("the Act") at §1867(e)(3)(B) (and the regulations at 42 CFR 489.24(b)), the term "stabilized" means, with respect to an EMC, "that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta)."

      The similarity of the terms "clinically stable" and "stabilized" appears to cause confusion among hospitals, practitioners and other hospital staff. It is not uncommon for practitioners to find that an individual has become "clinically stable," often understood to mean the normalization of the individual's vital signs, and then conclude that the hospital's EMTALA obligation has ended. However, if the EMC has not been stabilized, as that term is defined above, EMTALA continues to apply. For example, a patient diagnosed with appendicitis might have relatively normal vital signs, but is still in need of surgery, and therefore continues to have an EMC that has not been stabilized.

Page 4 – State Survey Agency Directors

- Furthermore, many practitioners and some third-party payors seem to assume that if an individual can withstand the risk of a transfer, then that means the individual has been stabilized and the hospital's EMTALA obligation has ended. This also is not necessarily the case. This mistaken assumption can be reflected in the commonly used term "stable for transfer." "Stable for transfer" is not a term used in EMTALA, and it is not necessarily equivalent to the term "stabilized," as defined for EMTALA purposes. Use of this term can, therefore, be very misleading.

  For example, an "appropriate transfer," as discussed at Section1867(c) of the Act and in the regulations at 42 CFR 489.24(e), assumes that the:

  - Individual has an EMC that has not been stabilized;
  - Hospital lacks the capability or capacity to provide stabilizing treatment; and
  - Benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks resulting from effecting the transfer.

  In such a case, although the individual may be "stable for transfer," he/she nevertheless has an unstabilized EMC, and remains protected under EMTALA before, during and after the transfer. Therefore, it would not be appropriate for a hospital to seek prior authorization for the transfer from a payor before initiating or agreeing to accept the transfer.

2. Payors requiring secondary evaluation and approval of individuals with EMCs by insurer/payor-designated personnel as a condition for inpatient admission or transfer, including designation of transfer destination. 42 CFR 489.24(a)(1) requires that the MSE be performed by individuals determined qualified by hospital bylaws and regulations. If physician specialists are required to complete the MSE or provide stabilizing treatment for an EMC, 42 CFR 489.20(r) requires hospitals to maintain a list of on-call physicians who are on the hospital's medical staff or have privileges. If the hospital lacks the capability or capacity to stabilize an EMC, it must make an appropriate transfer in accordance with 42 CFR 489.24(e).

   Anecdotally we have become aware of some third-party payors with policies or proposed policies that seem to assume, incorrectly, that any individual for whom a transfer is being planned has been "stabilized," and thus is no longer protected under EMTALA. As indicated above, this is incorrect, and procedures for a third-party payor to intervene in the transfer decisions regarding an individual protected under EMTALA could, if adhered to by hospitals, place them at risk of violating EMTALA.

In addition to the above practices, there are other payor payment policies that have been under discussion in some States and which appear to have caused confusion among providers about their interaction with EMTALA requirements. Examples include the following:

Page 5 – State Survey Agency Directors

1. Payor refusal to pay for emergency department (ED) services because the payor views the diagnosis codes on the hospital's bill to the payor as representing conditions that are "non-emergent". In States where such payor practices have been under discussion, some hospitals and physicians have asked if a payor adopts such a policy, would the hospital's and physicians' EMTALA obligations also necessarily change. CMS has advised them that the EMTALA obligations would not change.

   In accordance with 42 CFR 489.24(a), the hospital must provide an appropriate MSE for any individual who "comes to the ED." If the individual is determined through the MSE to have an EMC, the hospital must provide stabilizing treatment or an appropriate transfer. The fact that the individual's third-party payor may subsequently deny payment to the hospital or to the physicians involved, does not change the hospital's or physicians' EMTALA obligations.

   Further, hospitals must assure that the EMTALA definition is used to determine whether the individual has an EMC. In accordance with the regulations at 42 CFR 489.24(a) (implementing Section 1867(e)(1) of the Act), an EMC is defined as:

   "(1) A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) 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

   (2) 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."

2. Payors restricting the number of consults that will be paid for during a hospital encounter/stay, including the use of consults for completing an MSE or providing stabilizing treatment of EMCs. Hospitals must not assume that such a coverage limitation by one or more payors would allow them to limit the services they are required to provide under EMTALA in accordance with 42 CFR 489.24(a).

3. Payors limiting the number of annual visits to the emergency department by a covered individual. Hospitals must not assume that such a coverage limitation means that they can limit the number of times they will provide an individual with an MSE and, if applicable, stabilizing treatment.

Page 6 – State Survey Agency Directors

Hospital Debt Collection Practices

CMS has learned of instances where hospitals request immediate payment, by cash, check, or credit card, from individuals who are in the ED. Payment demands have been made for the current emergency services being offered to the individual, even though their ED encounter is still in progress, as well as for past hospital services.

The EMTALA regulations at 42 CFR 489.24(a)(1) explicitly require a hospital to provide any individual who comes to the ED a medical screening examination and, if applicable, stabilizing treatment, regardless of the individual's ability to pay. Further, 42 CFR 489.24(d)(4)(i) explicitly prohibits a hospital from delaying examination or treatment in order to inquire about an individual's method of payment or insurance status. However, in the interest of allowing hospitals to continue to engage in reasonable administrative practices that support efficient operations without violating the spirit of EMTALA, the provisions at 42 CFR 489.24(d)(4)(ii) and (iv) also describe permitted exceptions to the general prohibition on inquiring about method of payment or insurance status.

A request to an individual to make immediate payment for services required under EMTALA while such required services are being provided does **not** fall under either of the permitted exceptions, since it is neither a request for insurer authorization of screening and stabilizing treatment that has already been initiated (42 CFR 489.24(d)(4)(ii)), nor is it a component of a reasonable patient registration practice (42 CFR 489.24(d)(4)(iv)).

- Generally, beyond furnishing an insurance card or other evidence of insurance, the individual is not involved in the processing of a request for insurance authorization, nor is the individual's stabilizing treatment disrupted when the hospital makes such a request to the insurer. Further, a request for insurer authorization is not a demand for immediate payment by the insurer. Accordingly, the regulation at 42 CFR 489.24(d)(4)(ii) permits such requests for insurer authorization to be made, but only after stabilizing treatment has been initiated, in order to assure that the request does not delay the screening examination and diagnosis of the individual's condition.

- Likewise, hospitals, in accordance with 42 CFR 489.24(d)(4)(iv), are permitted to employ reasonable registration practices that neither delay screening or treatment, nor unduly discourage individuals from remaining for further evaluation. Asking an individual for basic identifying information, emergency contact information, whether he or she is insured and if so by whom, are permitted practices, so long as there is no delay in screening or treatment.

- Under Section 1867(h) of the Act and the regulation at 42 CFR 489.24(d)(4), a hospital is prohibited from delaying appropriate screening or stabilizing treatment to inquire about an individual's method of payment. A request by the hospital for immediate payment by an individual who is protected under EMTALA goes well beyond a mere inquiry about payment method. Furthermore, a request for immediate payment risks creating the appearance that the

hospital is linking provision of services required under EMTALA to the individual's ability to pay, contrary to the requirement at 42 CFR 489.24(a)(1).

- The issue has been raised whether a request for the individual to make a payment is equivalent to a request for insurance authorization, making it therefore permissible under the regulation for a hospital to request payment, so long as the request is timed to occur after stabilizing treatment has been initiated. We see no basis for assuming these requests are equivalent, and thus a hospital's request to an individual for payment is not covered by the regulation governing insurance authorization requests. Moreover, a request for payment could readily be interpreted by an individual protected under EMTALA as conditioning provision of care, or linking the extent of care offered, upon ability to pay, contrary to the requirement at 42 CFR 489.24(a)(1), regardless of the manner in which such request is made and regardless of whether the request is made after stabilizing treatment has been initiated.

- A request for payment carries a very high risk of unduly discouraging individuals, particularly those who lack the ability to pay, from remaining for further evaluation, and thus does not satisfy the reasonable registration process requirements of 42 CFR 489.24(d)(4)(iv).

Once a hospital's EMTALA obligations to an individual have ended, i.e., the individual has been screened and determined not to have an EMC, or the individual's EMC has been stabilized, or the individual with an unstabilized EMC has been admitted in good faith as an inpatient for stabilizing treatment, hospitals may make payment requests. In the case of a hospital (but not a CAH), the manner of the payment request must be consistent with the patient's right under the hospital Conditions of Participation at42 CFR§482.13(c)(3) to be free from all forms of abuse or harassment.

Detailed guidance regarding EMTALA requirements can be found in Appendix V of the CMS State Operations Manual (SOM) at the following location: http://cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

Questions regarding this memo should be sent to: hospitalscg@cms.hhs.gov

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators within 30 days of this memorandum.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management

APPENDIX Y

Critical Access Hospital Emergency Services and Telemedicine

CMS Survey & Certification Memorandum 13-38 (June 7, 2013)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 13-38-CAH/EMTALA

DATE: **June 7, 2013**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Critical Access Hospital (CAH) Emergency Services and Telemedicine: Implications for Emergency Services Condition of Participation (CoPs) and Emergency Medical Treatment and Labor Act (EMTALA) On-Call Compliance

Memorandum Summary

- ***The Center for Medicare & Medicaid Services (CMS) Welcomes use of Telemedicine by CAHs:*** Telemedicine has great potential to expand availability of specialty care services, including emergency medicine services, to rural populations. However, misconceptions about CAH CoP and EMTALA requirements may cause unnecessary concerns about, or create barriers to, using telemedicine.

- ***The CAH Emergency Services CoP does not Require a Physician to Appear On-site Whenever an Individual Comes to the Emergency Department (ED):***
  - Under 42 CFR 485.618(d), a doctor of medicine (MD), a doctor of osteopathy (DO), a physician assistant (PA), a nurse practitioner (NP), or a clinical nurse specialist (CNS), with training or experience in emergency care, must be immediately available by telephone or radio, and available on-site within 30 minutes (60 minutes for CAHs in frontier areas that meet certain conditions). Under the CAH CoPs an MD or DO is *not* required to be available *in addition* to a non-physician practitioner.
  - Under the CoP at §485.618(e), an MD or DO must be immediately available by telephone or radio contact on a 24-hours a day basis to receive emergency calls, provide information on treatment of emergency patients, and refer patients. This requirement can be met by the use of a telemedicine MD/DO as well as by an MD/DO who practices on-site at the CAH.

- ***EMTALA is Not a Barrier to Using Telemedicine to Extend CAH Emergency Services:***
  - If using telemedicine for emergency and other services, a CAH is not required to include the telemedicine physicians on its physician on-call list mandated under the EMTALA regulations at 42 CFR 489.20(r)(2) and §489.24(j), nor would it be advisable for a CAH to do so.
  - The CAH is required under EMTALA to have an on-call list reasonably related to the services it offers, composed of physician(s) who practice on-site at the CAH. This does not mean that physicians who practice on site must be on-call and available to appear in person at all times. Nor does it mean that an on-call physician must be called to appear on-site in every case involving an emergency medical condition.

Page 2 – State Survey Agency Directors

Background

CMS welcomes use of telemedicine by CAHs to extend access to specialty care services, including emergency services, for the rural populations CAHs serve. However, we have learned that some CAHs have been under the impression that MDs/DOs who provide only telemedicine services to CAH patients and who participate in the screening and stabilizing of individuals in the emergency department (ED) must be on the CAH's EMTALA on-call list. This is incorrect, and it actually would not be prudent place an MD/DO who cannot make an in-person appearance at the CAH on the on-call list. Likewise, some CAHs have had the mistaken impression that even when there is involvement of a telemedicine MD/DO in the provision of care, an MD or DO who is on-call at the CAH must always be asked to come in to the CAH for emergency services.

Depending on the specific circumstances, there could be cases when it is sufficient for a telemedicine-only MD/DO to work with the qualified medical person (QMP) on site to screen and stabilize and/or appropriately transfer individuals who come to the CAH's ED. There could also be times when an on-call MD/DO would be requested to come to the CAH by the QMP, even though a telemedicine-only MD/DO is also providing services. We are taking this opportunity to clarify below the requirements under EMTALA and the CAH CoPs for MDs, DOs and other practitioners in CAHs that use telemedicine as a component of their ED services.

CAH CoP Emergency Services Requirements:

Section 1820(c)(2)(B)(ii) of the Social Security Act (the Act) requires a CAH to make 24-hour emergency care services available. Pertinent implementing regulations are:

- **§485.618(e), which requires an MD or DO to be immediately available by telephone or radio contact** on a 24-hours a day basis to receive emergency calls, provide information on treatment of emergency patients, and refer patients to the CAH or other appropriate locations for treatment. ***This requirement can be met in whole or in part through the use of an MD/DO via telemedicine.*** It is the CAH's decision whether to use a telemedicine MD/DO for this purpose, and to what extent in order to meet this requirement. For example, a CAH could use a telemedicine MD/DO 100 percent of the time, or could develop a schedule for the use of MDs/DOs who practice on-site for part of the time, with the telemedicine MDs/DOs providing these services for the rest of the time.

- **§485.618(d)(1), which requires an MD, DO, PA, NP, or CNS, with training or experience in emergency care, to be on-call and immediately available by telephone or radio contact, and be available on-site within 30 minutes on a 24-hours a day basis.** (The standard is 60 minutes for CAHs in frontier areas that meet the following conditions: the CAH is located in a frontier area or a remote location; the State has determined, that allowing an emergency response time longer than 30 minutes is the only feasible method of providing emergency care to residents of the area served by the CAH; and the State maintains documentation showing that the response time of up to 60 minutes is justified because other available alternatives would increase the time needed to stabilize a patient in an emergency).

Page 3 – State Survey Agency Directors

If the on-call practitioner is notified that he/she is needed at the CAH, that practitioner is required to physically appear at the CAH.

Note:

- In accordance with §485.618(d)(3), under specific conditions and only for a temporary period, instead of a practitioner a registered nurse (RN) may also satisfy this requirement, if the CAH has no more than 10 beds, is located in a frontier area or remote location, and the Governor has submitted a letter that meets specified requirements.

- ***Practitioner availability by telephone or radio (as required under §485.618(e)) may be satisfied by a telemedicine practitioner, but the requirement for on-site availability cannot be met via the use of telemedicine.***

- Any one of the listed types of practitioners satisfies the regulatory requirement. ***A CAH MD or DO is <u>not</u> required to be available <u>in addition to</u> a non-physician practitioner*** (or RN substituting for a practitioner).

EMTALA Requirements for CAHs

Section 1867 of the Act contains the EMTALA provisions, including a requirement for hospitals and CAHs to provide a medical screening examination to all individuals who come to the ED, and stabilizing treatment or an appropriate transfer for those who have been determined through the screening to have an emergency medical condition. Section 1866(a)(1)(I)(iii) of the Act contains an EMTALA-related requirement for hospitals and CAHs to maintain a list of physicians who are on-call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition.

- **§489.24(a)(i) requires that a medical screening examination be performed by a qualified medical person (QMP),** i.e., an individual determined to be qualified by the CAH by-laws or rules and regulations and who meet the requirements of §482.55 (the hospital CoP for emergency services), which requires the use of "…adequate medical and nursing personnel qualified in emergency care." ***The QMP on-site conducting the required screening examination may be assisted or directed by a qualified telemedicine practitioner.***

- **§489.20(r)(2) and §489.24(j) implement the on-call provisions related to EMTALA obligations.**

  - Unlike the CAH CoP requirements for practitioner availability in the ED, the EMTALA on-call requirement is specific to physicians. ***The EMTALA requirement <u>cannot</u> be satisfied by including non-physician practitioners*** on the on-call list.

  - ***A physician who is on-call and requested by the CAH's QMP to make an in-person appearance at the CAH*** after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition ***must come to the CAH within a reasonable amount of time.*** Failure by a physician to do so could subject both the CAH <u>*and*</u> the on-call physician to EMTALA enforcement action and penalties.

Page 4 – State Survey Agency Directors

Although CMS takes enforcement action only with respect to the CAH, the Office of Inspector General may levy penalties against either or both the CAH and the physician.

- There is no EMTALA requirement for all physicians holding CAH privileges to take call.

  - ***A CAH which has only a few MDs or DOs routinely practicing on-site is not expected to have one of them on-call at all times.*** In such a situation it would not be unreasonable for the CAH to have very limited on-call coverage.

  - ***There is no requirement under EMTALA for a CAH to include on its on-call list a physician who provides emergency or other services only via telemedicine*** to the CAH's patients. Since a physician providing services only by telemedicine may be located too far away to make an in-person appearance feasible, it might not be prudent for the CAH to include telemedicine-only practitioners on its on-call list.

  - However, we also reiterate that ***CAHs have a responsibility under EMTALA to ensure that they are providing sufficient on-call services to meet the needs of their community in accordance with the resources the CAH has available.*** CMS expects a hospital or CAH to strive to provide adequate specialty on-call coverage consistent with the services routinely provided at the hospital or CAH. (73 FR 48662).

- ***When a telemedicine physician is providing/directing diagnosis or treatment of individuals in a CAH ED, there is no requirement or expectation under EMTALA that the CAH must always require one of the local on-call physicians to come to the ED as well.*** However, if the QMP on-site and/or the telemedicine physician determine that hands-on treatment that is beyond the capability of the on-site QMP is required to stabilize an individual's emergency medical condition, then ***a request for a local CAH physician to come to the ED could be required, depending on the circumstances:***

  - If one or more of the local physicians is on-call and able to provide the required hands-on stabilizing treatment, then the CAH is expected to request that an on-call physician come to the ED to stabilize the individual.

  - If the QMP and/or the telemedicine physician determine that the individual needs hands-on treatment that the CAH's on-call physician(s) cannot provide (e.g., the on-call physician is a family medicine practitioner and a surgical procedure is needed), then the CAH may transfer the individual to another hospital or CAH for stabilization, following the EMTALA rules for appropriate transfer. It is not necessary to have the local, on-call physician come to the ED just to certify the appropriateness of the transfer. Either the telemedicine physician or the on-site non-physician QMP, after consultation with the telemedicine physician, may sign the required certification that the anticipated benefits of the transfer outweigh its risks. If the on-site non-physician QMP signs it, the telemedicine physician must subsequently countersign. See §489.24(e)(1)(i)(B) and (C).

  - If no physician is on-call and the QMP and/or the telemedicine physician determine that hands-on treatment that is beyond the capability of the on-site QMP is required to stabilize an individual's emergency medical condition, the CAH may transfer the

individual to another hospital or CAH for stabilization, following the EMTALA rules for appropriate transfer. Either the telemedicine physician or the on-site non-physician QMP, after consultation with the telemedicine physician, may sign the required certification that the anticipated benefits of the transfer outweigh its risks. If the on-site non-physician QMP signs it, the telemedicine physician must subsequently countersign. See §489.24(e)(1)(i)(B) and (C).

Questions concerning this memorandum should be addressed to hospitalscg@cms.hhs.gov.

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators within 30 days of this memorandum.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management

APPENDIX Z

Detaining EMS Personnel and Equipment

CMS Survey & Certification Memoranda 06-21 and 07-20 (July 13, 2006 and April 27, 2007)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-06-21

DATE: **July 13, 2006**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: **EMTALA -** "Parking" of Emergency Medical Service Patients in Hospitals

Letter Summary

- The Centers for Medicare & Medicaid Services (CMS) has received reports from hospital emergency departments concerning patients being left on stretchers for extended periods of time with emergency medical service personnel in attendance, possibly in violation of the Emergency Medical Treatment and Labor Act.
- CMS recognizes the enormous strain and crowding many hospital emergency departments face every day; however, this practice is not a solution.
- "Parking" patients in hospitals impacts the ability of the emergency medical service personnel to provide emergency services to the rest of the community.

The Centers for Medicare & Medicaid Services (CMS) has learned that several hospitals routinely prevent Emergency Medical Service (EMS) staff from transferring patients from their ambulance stretchers to a hospital bed or gurney. Reports include patients being left on an EMS stretcher (with EMS staff in attendance) for extended periods of time. Many of the hospital staff engaged in such practice believe that unless the hospital "takes responsibility" for the patient, the hospital is not obligated to provide care or accommodate the patient. Therefore, they will refuse EMS requests to transfer the patient to hospital units.

This practice may result in a violation of the Emergency Medical Treatment and Labor Act (EMTALA) and raises serious concerns for patient care and the provision of emergency services in a community. Additionally, this practice may also result in a violation of 42 CFR 482.55, the Conditions of Participation for Hospitals for Emergency Services, which requires that a hospital meet the emergency needs of patients in accordance with acceptable standards of practice.

Page 2 – State Survey Agency Directors

A hospital has an EMTALA obligation as soon as a patient "presents" at a hospital's dedicated emergency department, or on hospital property (as defined at 42 CFR 489.24(b)) other than the dedicated emergency department, and a request is made on the individual's behalf for examination or treatment of an emergency medical condition. A patient who arrives via EMS meets this requirement when EMS personnel request treatment from hospital staff. Therefore, the hospital must provide a screening examination to determine if an emergency medical condition exists and, if so, provide stabilizing treatment to resolve the patient's emergency medical condition. Once a patient presents to the dedicated emergency department of the hospital, whether by EMS or otherwise, the hospital has an obligation to see the patient, as determined by the hospital under the circumstances and in accordance with acceptable standards of care.

EMTALA obligations would also apply to a hospital that has accepted transfer of a patient from another facility, as long as it is an "appropriate transfer" under EMTALA. An appropriate transfer is one in which the transferring hospital provides medical treatment that minimizes risks to an individual's health and the receiving hospital has the capability and capacity to provide appropriate medical treatment and has agreed to accept transfer (42 CFR 489.24(e)(2)). Therefore, the expectation is that the receiving facility has the capacity to accept the patient at the time the transfer is effectuated. A hospital that delays the medical screening examination or stabilizing treatment of a patient who arrives via transfer from another facility, by not allowing EMS to leave the patient, could also be in violation of EMTALA.

CMS recognizes the enormous strain and crowding many hospital emergency departments face every day. However, this practice is not a solution. "Parking" patients in hospitals and refusing to release EMS equipment or personnel jeopardizes patient health and impacts the ability of the EMS personnel to provide emergency services to the rest of the community.

For questions on this memo, please contact Donna Smith at (410) 786-3255 or by email at Donna.Smith@cms.hhs.gov.

Effective Date: Immediately. The State agencies should disseminate this information within 30 days of the date of this memorandum.

Training: The information contained in this announcement should be shared with all survey and certification staff, surveyors, their managers, and with managers who have responsibility for processing EMTALA complaints.

/s/

Thomas E. Hamilton

cc: Survey and Certification Regional Office Management (G-5)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-07-20

Date: **April 27, 2007**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: EMTALA Issues Related to Emergency Transport Services

Memorandum Summary

- Hospitals may not condition their acceptance of an Emergency Medical Treatment and Labor Act (EMTALA)-related transfer upon the sending hospital's agreement to use a specific transport service designated by the receiving hospital.
- S&C 06-21 should not be interpreted to mean that a hospital cannot ever ask Emergency Medical Services (EMS) staff to stay with an individual transported by EMS to the hospital when the hospital does not have the capacity or capability to immediately assume full responsibility for the individual.

The Emergency Medical Treatment and Labor Act Technical Advisory Group (EMTALA TAG) received testimony indicating that instances have occurred where a hospital has refused to accept an appropriate transfer of an individual with an emergency medical condition unless the sending hospital used an air medical service owned by the receiving hospital for the transfer. The EMTALA TAG recommended that the Centers for Medicare & Medicaid Services (CMS) issue guidance on this matter.

It is a violation of the EMTALA requirements for a receiving hospital to condition its acceptance of an appropriate transfer of an individual with an emergency medical condition upon the sending hospital's use of a particular transport service to accomplish the transfer. Specifically, 42 CFR 489.24 (f) reads in pertinent part as follows:

> *Recipient hospital responsibilities. A participating hospital that has specialized capabilities…may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual.*

Page 2 - State Survey Agency Directors

If in the course of an EMTALA investigation there is evidence that a hospital with specialized capabilities or facilities and the necessary capacity to treat an individual with an emergency medical condition conditioned, or attempted to condition, its acceptance of an appropriate transfer of the individual on the use by the sending hospital of a particular transport service instead of the transport arrangements made by the attending physician at the sending hospital, then the receiving hospital is to be cited for violation of EMTALA Tag A411.

The EMTALA TAG also requested that CMS issue a clarification of the guidance provided in S&C-06-21, issued on July 13, 2006, concerning "parking" of individuals transported by emergency medical services (EMS) to hospitals. The memorandum was intended to address the specific concern that some hospital Emergency Department (ED) staff may deliberately delay the transfer of individuals from the EMS provider's stretcher to an ED bed under the mistaken impression that the ED staff is thereby relieved of their EMTALA obligation. However, it was reported to the TAG by hospital representatives that some EMS organizations have cited this memorandum as requiring hospitals to take instant custody of all individuals presenting via EMS transport at the hospital's dedicated emergency department.

The memorandum was intended to reinforce that the EMTALA responsibility of a hospital with a dedicated ED begins when an individual arrives on hospital property (ambulance arrival) and not when the hospital "accepts" the individual from the gurney. An individual is considered to have "presented" to a hospital when he/she arrives at the hospital's dedicated ED or on hospital property and a request is made by the individual or on his/her behalf for examination or treatment of an emergency medical condition. (42 CFR 489.24(b)). Once an individual comes to the emergency department of the hospital, whether by EMS or otherwise, the hospital has an obligation to provide an appropriate medical screening examination and, if an emergency medical condition is determined to exist, provide any necessary stabilizing treatment or an appropriate transfer. (42 CFR 489.24(a) and (b)). Failure to meet these requirements constitutes a potential violation of EMTALA.

On the other hand, this does not mean that a hospital will necessarily have violated EMTALA if it does not, in every instance, immediately assume from the EMS provider all responsibility for the individual, regardless of any other circumstances in the ED. For example, there may be situations when a hospital does not have the capacity or capability at the time of the individual's presentation to provide an immediate medical screening examination (MSE) and, if needed, stabilizing treatment or an appropriate transfer. So, if the EMS provider brought an individual to the dedicated ED at a time when ED staff was occupied dealing with multiple major trauma cases, it could under those circumstances be reasonable for the hospital to ask the EMS provider to stay with the individual until such time as there were ED staff available to provide care to that individual. However, even if a hospital cannot immediately provide an MSE, it must still triage the individual's condition immediately upon arrival to ensure that an emergent intervention is not required and that the EMS provider staff can appropriately monitor the individual's condition. All cases of this kind will be reviewed on a case-by-case basis and any decision regarding EMTALA compliance will be made by the CMS Regional Office only after a full review of all relevant facts and circumstances.

Page 3 - State Survey Agency Directors

For questions on this memo, please contact Donna Smith at (410) 786-3255 or by email at Donna.Smith@cms.hhs.gov.

Effective Date: Immediately. The State agencies should disseminate this information within 30 days of the date this memorandum.

Training: The information contained in this announcement should be shared with all survey and certification staff, surveyors, their managers, and with managers who have responsibility for processing EMTALA complaints.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management

APPENDIX AA

EMTALA and Ebola

CMS Survey & Certification Memoranda 15-10 and 15-24 (Nov. 21, 2014 and Feb. 13, 2015)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Survey and Certification Group

Ref: S&C: 15-10-Hospitals

DATE: **November 21, 2014**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Emergency Medical Treatment and Labor Act (EMTALA) Requirements and Implications Related to Ebola Virus Disease (Ebola)

Memorandum Summary

- ***Ebola and EMTALA requirements:*** This Memorandum conveys information useful in responding to inquiries from hospitals concerning implications of Ebola for their compliance with EMTALA.
- ***EMTALA Screening Obligation:*** Every hospital or critical access hospital (CAH) with a dedicated emergency department (ED) is required to conduct an appropriate medical screening examination (MSE) of all individuals who come to the ED, including individuals who are suspected of having been exposed to Ebola, and regardless of whether they arrive by ambulance or are walk-ins. Every ED is expected to have the capability to apply appropriate Ebola screening criteria when applicable, to immediately isolate individuals who meet the screening criteria to be a potential Ebola case, to contact their state or local public health officials to determine if Ebola testing is needed, and, when a decision to test is made, to provide treatment to the individual, using appropriate isolation precautions, until a determination is made whether the individual has Ebola.
- ***EMTALA Stabilization, Transfer & Recipient Hospital Obligations:*** In the case of individuals who have Ebola, hospitals and CAHs are expected to consider current guidance of public health officials in determining whether they have the capability to provide appropriate isolation required for stabilizing treatment and/or to accept appropriate transfers. In the event of any EMTALA complaints alleging inappropriate transfers or refusal to accept appropriate transfers, CMS will take into consideration the public health guidance in effect at the time.
- ***Centers for Disease Control and Prevention (CDC) Website*:** CMS strongly urges State Survey Agencies (SAs), hospitals and CAHs to monitor the CDC website at http://www.cdc.gov/vhf/ebola/ for the most current guidance and information concerning Ebola identification, treatment, and precautions to prevent the spread of the disease, as well as their State public health website.

Background

Due to increasing public concerns with Ebola, CMS is receiving inquiries from the hospital industry concerning implications for their compliance with EMTALA. Concerns center around

the ability of hospitals and CAHs to fulfill their EMTALA screening obligations while minimizing the risk of exposure from Ebola infected individuals to others in the ED, including healthcare workers, and the isolation requirements for Ebola. In addition, we have also received questions about the applicability of EMTALA stabilization, transfer and recipient hospital obligations in the case of individuals who are found to have met the screening criteria for possible Ebola disease or who have been determined to have Ebola.

EMTALA requires Medicare-participating hospitals and CAHs that have a dedicated emergency department to, at a minimum:

- Provide an MSE to every individual who comes to the ED, for examination or treatment for a medical condition, to determine if they have an emergency medical condition (EMC); and

- Provide necessary stabilizing treatment for individuals with an EMC within the hospital's capability and capacity; and

- Provide for transfers of individuals with EMCs, when appropriate.

In addition, all Medicare-participating hospitals with specialized capabilities are required to accept appropriate transfers of individuals with EMCs if the hospital has the specialized capabilities an individual requires for stabilization as well as the capacity to treat these individuals. This recipient hospital obligation applies regardless of whether the hospital has a dedicated emergency department.

EMTALA Obligations when Screening Suggests Possible Ebola

It may be the case that hospitals, emergency medical services (EMS), and their State or local public health officials develop protocols for bringing individuals who meet criteria for a suspected case of Ebola only to hospitals that have been designated to handle potential or confirmed cases of Ebola. These pre-hospital arrangements do not present any conflict with EMTALA. This is the case even if the ambulance carrying the individual is owned and operated by a hospital other than the designated hospital, so long as the ambulance is operating in accordance with a community wide EMS protocol.

On the other hand, if an individual comes to an ED of a hospital or CAH, as the term "comes to the emergency department" is defined in the regulation at §489.24(b), either by ambulance or as a walk-in, the hospital must provide the individual with an appropriate MSE. We emphasize that it is a violation of EMTALA for hospitals and CAHs with EDs to use signage that presents barriers to individuals who may have been exposed to Ebola from coming to the ED, or to otherwise refuse to provide an appropriate MSE to anyone who has come to the ED for examination or treatment of a medical condition. However, use of signage designed to help direct individuals to various locations on the hospital property, as that term is defined in the regulation at §489.24(b), for their MSE would be acceptable.

If during the MSE the hospital or CAH concludes, consistent with accepted standards of practice for Ebola screening, that an individual who has come to its ED may be a possible Ebola case, the hospital or CAH is expected to isolate the patient immediately. Although levels of services

provided by EDs vary greatly across the country, it is CMS' expectation that all hospitals and CAHs are able to, within their capability, provide MSEs and initiate stabilizing treatment, while maintaining the isolation requirements for Ebola and coordinating with their State or local public health officials, who will in turn arrange coordination, as necessary, with the CDC.

At the time of the drafting of this memo, CDC's screening guidance called for hospitals and CAHs to contact their State or local public health officials when they have a case of suspected Ebola. According to that guidance, the State or local public health officials, together with the hospital, will make a determination as to whether Ebola testing of the individual is required.

- If it is determined that Ebola testing is not required, the hospital or CAH is expected to complete its MSE in accordance with accepted standards of practice and to take appropriate actions, depending on whether or not the individual has an EMC.

- If it is determined that Ebola testing is required, the hospital or CAH is expected to maintain the individual in isolation, providing treatment within its capability for the individual's symptoms as needed, until it has the test results or if, prior to test results, there is a determination by the responsible public health authorities that the case presents a strong probability of Ebola.

- If the individual tests negative for Ebola, the hospital or CAH is expected to complete its MSE in accordance with accepted standards of practice and to take appropriate actions, depending on whether or not the individual has an EMC.

- If the individual tests positive for Ebola, or the hospital together with state or local public health officials otherwise conclude that the individual likely has Ebola, even prior to obtaining test results, the hospital or CAH is expected to comply with the most recent State or local public health guidance in determining whether it has the capability to provide stabilizing treatment on site, or whether to initiate an appropriate transfer, in accordance with §489.24(e), to a hospital which has the capability to provide the required stabilizing treatment.

We appreciate the work of public health authorities, the Centers for Disease Control and Prevention (CDC) and hospitals to develop specialized capabilities to treat patients with Ebola. However, the existence of hospitals with specialized capabilities does not relieve any other hospital or CAH of its obligation to provide an appropriate medical screening examination, or fulfill any other EMTALA requirement relevant to the situation.

Other Enforcement Considerations

Should CMS receive complaints alleging either inappropriate transfers by a sending hospital or refusal of a recipient hospital to accept an appropriate transfer, it will take into consideration the State or local public health direction and designations of hospitals as Ebola treatment centers at the time of the alleged noncompliance concerning where Ebola treatment should be provided. It will also take into consideration any clinical considerations specific to the individual case(s).

Page 4 State Survey Agency Directors

Surveyors and managers responsible for EMTALA enforcement are expected to be aware of the flexibilities hospitals are afforded under EMTALA and to assess incoming EMTALA complaints accordingly in determining whether an on-site investigation is required. They are also expected to keep these flexibilities in mind when assessing hospital compliance with EMTALA during a survey.

Consistent with their obligations under the hospital and CAH Conditions of Participation (CoPs) §482.42 and §485.635(a)(3)(vi), hospitals and CAHs are expected to adhere to accepted standards of infection control practice to prevent the spread of Ebola. Since the Ebola virus is transmitted via droplets, strict adherence to droplet and contact isolation precautions must be followed. The CDC has issued extensive guidance on applicable isolation precautions and CMS strongly urges hospitals to follow this guidance. CMS recognizes the difficulties securing the recommended personal protective equipment (PPE) required for training and patient care that may be present in some circumstances at the time of this Memorandum.

The U.S. Department of Labor Occupational Health and Safety Administration (OSHA) has also provided guidance on worker protection related to Ebola at https://www.osha.gov/SLTC/ebola/ . Hospitals and CAHs are expected under their respective CoPs at §482.11(a) and §485.608(a) to comply with OSHA requirements, but CMS and state surveyors acting on its behalf do not assess compliance with requirements of other Federal agencies.

Latest CDC Guidance

The most up-to-date guidance regarding screening, testing, treatment, isolation, and other Ebola-related topics can be found on the CDC website at http://www.cdc.gov/vhf/ebola/index.html . Hospitals and CAHs are strongly urged to monitor this site as well as their State public health website and follow recommended guidelines and acceptable standards of practice. (See also S&C 15-02: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-15-02.pdf) SAs are also encouraged to monitor the CDC and their state public health websites for up-to-date information.

Questions about this document should be addressed to hospitalSCG@cms.hhs.gov.

Effective Date: The information contained in this letter should be shared with all survey and certification staff, their managers, and the state/Regional Office training coordinators immediately.

/s/

Thomas E. Hamilton

cc: Survey and Certification Regional Office Management

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 15-24-Hospitals

DATE: **February 13, 2015**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Emergency Medical Treatment and Labor Act (EMTALA) and Ebola Virus Disease (EVD) – Questions and Answers (Q+A)

Memorandum Summary

***EMTALA & Ebola Requirements*:**

- On November 21, 2014 the Centers for Medicare & Medicaid Services (CMS) Survey & Certification Group released SC 15-10-Hospitals concerning EMTALA Requirements and Implications Related to the EVD.
- The CMS has received follow-up questions regarding EMTALA and Ebola and has produced a Q+A document in response.

The CMS released S&C 15-10 on November 21, 2014 to provide guidance to hospitals and critical access hospitals (CAHs) regarding meeting EMTALA requirements in the case of individuals potentially exposed to Ebola. The memo is available via the following link:

http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-15-10.pdf

Subsequently CMS has received questions seeking additional clarification or details. In response, we have developed the attached Q+A document.

Questions related to this memo and the attached Q+A document should be addressed to hospitalscg@cms.hhs.gov

Effective Date: Immediately. This document should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators within 30 days of this memorandum.

Page 2 – State Survey Agency Directors

/s/
Thomas E. Hamilton

Attachment- EMTALA Obligations & Ebola Virus Disease (EVD) Question and Answer Document

cc: Survey and Certification Regional Office Management

EMTALA Obligations & Ebola Virus Disease (EVD)
Question and Answer Document

Note: *For the purpose of this document, the term "hospital" includes all types of Medicare-participating hospitals and critical access hospitals (CAHs)*

A. Patient Insurance/Payor Status:

A.1. Is a Medicare-participating hospital required to provide EMTALA-mandated screening and stabilizing treatment for non-Medicare beneficiaries with likely or confirmed EVD?

EMTALA applies to all individuals who come to the dedicated emergency department (ED) of a Medicare-participating hospital, regardless of type or presence of insurance coverage or ability to pay. Further, Medicare-participating hospitals with specialized capabilities are required within the limits of their capability and capacity to accept appropriate transfers of individuals protected under EMTALA from other hospitals, without regard to insurance or ability to pay.

B. Specialized Capabilities

B.1. EMTALA requires that hospitals with specialized capabilities to treat EVD accept appropriate transfers of individuals who require those services, if they have capacity to provide them. In the event of an EMTALA complaint related to an inappropriate transfer and/or a refusal of a recipient hospital to accept an appropriate transfer, how will CMS determine whether a hospital had the "specialized capabilities" with respect to EVD required by the individual?

If the responsible State or local public health officials have designated or otherwise formally identified the hospital as an EVD treatment facility, or if the hospital has held itself out to the public as qualified to treat EVD patients, then the hospital might be considered to have specialized capabilities to treat EVD. In an area where no hospitals have been designated or self-identified as EVD treatment centers, in the event of an EMTALA complaint alleging either an inappropriate transfer by a hospital that could have stabilized an individual with EVD, or refusal by a recipient hospital to accept an appropriate transfer, CMS would conduct a case-specific review to determine whether the hospitals in question had the capability and capacity to provide the treatment necessary to stabilize an individual with EVD.

B.2: Do the CDC's recommendations for State and local public health officials and hospitals to employ a tiered framework for designation of hospitals in relation to EVD conflict with hospital obligations under EMTALA?

No. The CDC's interim guidance recommending that State and local public health officials and hospitals employ a tiered framework for designating hospitals for the screening, assessment and treatment of potential EVD-infected patients does not conflict with EMTALA. The CDC released interim guidance recommendations on December 2, 2014 suggesting three categories of designation of hospitals with respect to EVD:

1. Frontline Healthcare Facilities
2. Ebola Assessment Hospitals
3. Ebola Treatment Hospitals

Specific details regarding this framework and the expectations for EBV assessment and treatment for hospitals in each category are available at the following link: http://www.cdc.gov/vhf/ebola/hcp/us-hospital-preparedness.html

This guidance presumes that hospitals at any of these levels would be expected to screen, isolate and begin stabilizing treatment, as necessary, of any individual who presents to the ED with possible EVD symptoms. The guidance also calls for hospitals to immediately contact their State and local health departments to coordinate ongoing care of individuals suspected to have EVD, including when transfers to higher levels of care are appropriate. This guidance is consistent with the EMTALA requirements for screening, stabilization and appropriate transfers.

See also the related CDC guidance recommendations for preparing hospitals in each tier:

http://www.cdc.gov/vhf/ebola/hcp/preparing-frontline-healthcare-facilities.html

http://www.cdc.gov/vhf/ebola/hcp/preparing-ebola-assessment-hospitals.html

http://www.cdc.gov/vhf/ebola/hcp/preparing-ebola-treatment-centers.html

B.3: If a hospital that does not have the specialized capabilities associated with a designated Ebola Assessment or Treatment Center has provided an appropriate medical screening examination to an individual who has come to its ED and concluded the individual meets the criteria to be considered a suspected case of EVD, how does it know where to make a transfer that would be appropriate under EMTALA?

A list of current designated Ebola Treatment Centers is updated weekly by the CDC and may be found at http://www.cdc.gov/vhf/ebola/hcp/current-treatment-centers.html. However, first and foremost, hospitals should be working with their State and local public health officials and be aware of the Ebola response plan within their region. They should work with these public health officials to assure the implementation of the regional plan, including facilitating appropriate transfers. The CDC is working with States and hospitals to assure that every "Frontline Healthcare Facility" would be able to make appropriate transfers of individuals with suspected or confirmed EBV in a timely fashion to a hospital with the requisite specialized capabilities for further assessment or treatment.

However, it is a State public health agency decision whether or not to adopt the CDC's recommended tiered hospital EVD response framework, and to make designations of specific hospitals accordingly. Further, if a State has not made any designations of Ebola Assessment or Treatment Centers within the State, this does not mean that every hospital in that State would automatically be considered a "Frontline Healthcare Facility" for EMTALA purposes. In the event of a complaint that a transfer of an individual suspected of having EVD was inappropriate, CMS would follow its standard EMTALA investigation procedures and consider the specific

facts of the case, informed by the available guidance from the CDC as well as any regional Ebola response plans and/or State designations of hospitals, when determining whether a violation of EMTALA had occurred.

B.4: Are hospitals required to accept transfers of patients with suspected or confirmed EVD from small or rural hospitals that don't have negative pressure rooms or other capabilities to care for patients with EVD?

Hospitals with capacity and the specialized capabilities needed for stabilizing treatment are required to accept appropriate transfers from hospitals without the necessary capabilities. Hospitals should coordinate with their State/local public health officials regarding appropriate placement of individuals who meet specified EVD assessment criteria, and the most current standards of practice for treating individuals with confirmed EVD infection status.

As in any case concerning a hospital's EMTALA obligations with respect to transfers of individuals, CMS would evaluate the capabilities and capacity of both the referring and recipient hospitals in order to determine whether a violation has occurred. Among other things, we would take into account the CDC's recommendations at the time of the event in question in assessing whether a hospital had the requisite capabilities and capacity. We note that the CDC's recommendations focus on factors such as the individual's recent travel history and presenting signs and symptoms in differentiating the types of capabilities hospitals should have to screen and treat that individual. The presence or absence of negative pressure rooms would not be the sole determining factor, and in some cases all that would be required would be a private room. See the CDC website for the most current infection prevention and control recommendations for hospital patients with suspected or known EVD: http://www.cdc.gov/vhf//hcp/infection-prevention-and-control-recommendations.html

B.5: If a State has, consistent with the CDC recommendations, designated hospitals according to their capabilities to handle differing levels of suspected or confirmed cases of EVD, does this affect a hospital's EMTALA obligations with respect to transfers from out of the State?

No. Hospitals with specialized capabilities and the capacity to provide the necessary stabilizing treatment required by an individual protected under EMTALA may not refuse an appropriate transfer from a referring hospital within the boundaries of the United States.

C. Screening Examinations and Stabilizing Treatment Requirements

C.1: What are the EMTALA requirements for hospitals in regard to screening and treating individuals with possible EVD?

The EMTALA requirements for hospitals are the same for individuals with possible EVD symptoms as all other possible emergency medical conditions (EMCs):

- Provide an appropriate Medical Screening Exam (MSE) to every individual who comes to the Emergency Department (ED) for examination or treatment of a medical condition, to determine if they have an emergency medical condition (EMC); and

- Provide necessary stabilizing treatment for individuals with an EMC within the hospital's capability and capacity; and
- Provide for appropriate transfers of individuals with EMCs if the hospital lacks the capability to stabilize them.

Specific to EVD, hospitals are encouraged to follow the CDC guidance for appropriate isolation procedures to minimize the risk of cross-contamination to other patients, visitors, and healthcare workers. For example, the CDC publishes and updates accepted national standards of infection control practice for EVD. Hospitals should consult the latest CDC guidance and coordinate with State/local public health authorities for guidance related to ongoing care and treatment of patients with EVD.

C.2: Are all hospitals expected to screen and treat individuals with possible EVD symptoms?

Yes, all hospitals are expected, at a minimum to screen, isolate, and begin stabilizing treatment, as appropriate, for any individual with possible EVD symptoms. Hospitals should coordinate with their State/local public health authorities regarding ongoing care and treatment, including when it is appropriate to transfer individuals to hospitals with specialized capabilities and capacity to provide further assessment and/or stabilizing treatment for suspected or confirmed EVD.

C.3: If a hospital does not have Intensive Care Unit (ICU) capabilities is it required to screen and, when appropriate, initiate stabilizing treatment for individuals with suspected or confirmed EVD?

Yes. The lack of ICU capabilities does not exempt a hospital from performing an MSE and initiating stabilizing treatment for individuals with known or suspected EVD who come to the hospital's ED seeking examination or treatment. Qualified medical personnel in hospitals that conduct the screening examination should be aware of the criteria for initial EVD screening and should apply such screening when appropriate. Note that the CDC guidance for preparing "frontline" hospitals, i.e., those hospitals in the lowest tier of the EVD framework, indicates that they should be able to do the following:

- "Rapidly identify and triage patients with relevant exposure history AND signs or symptoms (http://www.cdc.gov/vhf/ebola/hcp/case-definition.html) compatible with EVD as outlined in CDC's guidance for Emergency Department Evaluation and Management for Patients Who Present with Possible Ebola Virus Disease(http://www.cdc.gov/vhf/ebola/hcp/ed-management-patients-possible-ebola.html).
- Immediately isolate any patient with relevant exposure history and signs or symptoms compatible with EVD and take appropriate steps to adequately protect staff caring for the patient, including appropriate use of personal protective equipment (PPE) as outlined in CDC's guidance for Emergency Department Evaluation and Management of Patients with Possible Ebola Virus Disease(http://www.cdc.gov/vhf/ebola/hcp/ed-management-patients-possible-ebola.html) .

- Immediately notify the hospital/facility infection control program, other appropriate facility staff, and the state and local public health agencies that a patient has been identified who has relevant exposure AND signs or symptoms compatible with EVD; discuss level of risk, clinical and epidemiologic factors, alternative diagnoses, plan for EVD testing, plan for possible patient transfer to another facility, and further care.

- Ensure there is no delay in the care for these patients by being prepared to test, manage, and treat alternative etiologies of febrile illness (e.g., malaria in travelers) as clinically indicated."

C.4: May hospitals refuse to allow individuals with suspected cases of EVD into their ED if other nearby hospitals have been designated as Ebola Assessment Hospitals or Ebola Treatment Centers?

No. For every individual who "comes to the emergency department," as that term is defined in §489.24(b) of the EMTALA regulations, for evaluation or treatment of a medical condition, whether by ambulance or by walking-in, hospitals are required to provide an appropriate medical screening examination. Qualified medical personnel in hospitals that conduct the screening examination should be aware of the criteria for initial EVD screening and should apply such screening when appropriate. Hospitals that refuse to screen an individual who comes to their emergency department would likely be found to have violated EMTALA, regardless of presenting signs, symptoms, and possible diagnoses.

C.5: Are all hospitals expected to have Personal Protective Equipment (PPE) and other equipment/facilities to screen and take care of suspected or confirmed EVD patients, even on a temporary basis until transferred?

There are no requirements established under EMTALA for hospitals to have specific PPE or equipment/facilities. Consistent with their obligations under the hospital and CAH Conditions of Participation (CoPs) at §482.42 and §485.635(a)(3)(vi), hospitals and CAHs are expected to adhere to accepted standards of infection control practice to prevent the spread of EVD. Ebola is transmitted through direct contact with blood or body fluids of a person who is sick with Ebola; the virus is not transmitted through the air (like measles virus). However, large droplets (splashes or sprays) of respiratory or other secretions from a person who is sick with Ebola could be infectious, and therefore specific precautions are recommended for use in healthcare settings to prevent the transmission of Ebola from patients to healthcare personnel and other patients or family members. The CDC has issued extensive guidance on applicable isolation precautions and CMS strongly urges hospitals to follow this guidance.

CMS anticipates that many State and local public health authorities will employ the tiered hospital approach recommended by the CDC in their planning for potential EVD cases. That framework envisions that hospitals would have differing needs for PPE and specialized equipment or facilities, based on their designated status under the tiered hospital approach.

C.6: May hospitals decline to perform an MSE on an individual who comes to their ED with potential or suspected EVD due to a lack of PPE or specialized equipment/facilities?

No. For every individual who "comes to the emergency department," as that term is defined in §489.24(b) of the EMTALA regulations, for evaluation or treatment of a medical condition, whether by ambulance or by walking-in, hospitals are required to provide an appropriate medical screening examination. Qualified medical personnel in hospitals that conduct the screening examination must be aware of the criteria for initial EVD screening and apply such screening when appropriate. Hospitals that refuse to screen an individual who comes to their emergency department would likely be found to have violated EMTALA, regardless of presenting signs, symptoms, and possible diagnoses.

C.7: May a physician who is present in the hospital conduct the MSE through the use of telemedicine equipment in lieu of physically being in the same exam room as the patient?

The use of audio, video and other telehealth equipment by an on-site physician to perform medical screening examinations is not specifically prohibited under EMTALA. However, the hospital is still obligated to perform an appropriate medical screening examination to determine the presence or absence of an emergency medical condition. In investigating any complaints related to this, the appropriateness of an examination using this type of equipment would be determined based on the specific facts of each individual case, including the clinical signs and symptoms of the individual at the time of presentation. If an in-person or hands-on examination is necessary, use of equipment alone would not meet the EMTALA requirements for an appropriate screening examination.

Further, when the screening examination indicates an individual has an emergency medical condition, hospitals are required to provide stabilizing treatment within their capability/capacity prior to making an appropriate transfer. We recognize that not every hospital will have the same capabilities with regard to EVD, and that transfers of individuals who meet the criteria for suspected EVD to other hospitals, based on current State public health guidance, may be appropriate. But prior to the transfer, it is difficult to envision that the individual's care needs could be met via remote technology alone. Again, the individual facts of any case would be reviewed to determine what the individual's care needs were prior to transfer and what the hospital was capable of providing.

C.8: Will CMS issue EMTALA waivers for hospitals related to EVD?

The statute governing EMTALA waivers sets a high threshold for issuing such waivers and also limits the nature and duration of an EMTALA waiver. At this time the requirements for CMS to issue EMTALA waivers have not been met (i.e., issuance of a Presidential disaster declaration and a Secretary's declaration of a public health emergency). See Survey and Certification policy memorandum SC-10-05, issued November 6, 2009, for more information on EMTALA waivers: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SCLetter10_05.pdf

C.9: What about ambulances operating under emergency medical services (EMS) systems – are they subject to EMTALA?

Only ambulances that are owned and operated by a hospital are subject to EMTALA. Otherwise EMS services are considered pre-hospital care that is outside the scope of EMTALA. Public health officials, EMS systems and hospitals are free to develop protocols governing where EMS should transport individuals for emergency care. This includes developing protocols specific to individuals who meet criteria to be considered suspected cases of EVD.

Even in the case of ambulances that are owned and operated by a hospital, it is permissible to transport an individual to a different hospital for screening and treatment, so long as they are operating in accordance with a communitywide EMS protocol, or they are operating under the direction of a physician who is not employed or otherwise affiliated with the hospital that owns the ambulance.

C.10: May hospitals turn away an EMS ambulance that comes to the "wrong" hospital ED and send it to another hospital that has been designated to assess or treat suspected or confirmed cases of EVD?

No. For every individual who "comes to the emergency department," as that term is defined in §489.24(b) of the EMTALA regulations, for evaluation or treatment of a medical conditions, whether by ambulance or by walking-in, hospitals are required to provide an appropriate medical screening examination for every individual who comes to the hospital's emergency department. Qualified medical personnel in hospitals that conduct the screening examination must be aware of the criteria for initial EVD screening and apply such screening when appropriate. Further, if an individual meets the initial screening criteria for possible EVD, hospitals are expected to isolate them and begin stabilizing treatment of symptoms.

C.11: May hospitals set up alternative screening sites within the hospital to screen possible EVD patients, even if they don't have an EMTALA waiver?

Yes, hospitals have flexibilities to set up alternative screening sites at other parts of the hospital, both on- and off-campus. See, for example, Survey and Certification policy memorandum SC-09-52, issued August 14, 2009, for guidance related to influenza that may also be informative for other types of situations: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SCLetter09_52.pdf

However, absent an EMTALA waiver issued by CMS pursuant to a declaration of a public health emergency, hospitals may not direct an individual who has already come to their on-site emergency department to any off-campus location for screening.

C 11(a): What constitutes an alternative hospital location? For instance, can this include a tarped-off area of another room, a room constructed in the ambulance bay, or the room previously used as the decontamination room?

Hospitals have flexibilities under EMTALA to determine alternative locations outside the ED but within the hospital for screening examinations of individuals potentially exposed to or infected

with EVD. Survey and Certification policy memorandum SC 09-52, issued August 14, 2009, provided guidance for handling a surge in demand for ED services related to the H1N1 influenza virus, and may be helpful in other situations: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SCLetter09_52.pdf

C11(b): Do the Life Safety Code (LSC) requirements under the hospital or critical access hospital Conditions of Participation apply to alternative care sites?

Since alternative care sites are expected to be within the hospital, they would be expected to meet LSC requirements.

However, there may be situations where temporary examination areas are set up. The following information on alternative care sites from the CMS emergency preparedness website may be helpful:

> If compliance issues come up in such localized situations where no applicable section 1135 waiver [for declared public health emergencies] is available, CMS focuses on fundamentals, such as assuring medical and nursing staff have proper credentials and, in the case of medical staff, have privileges; assuring that care is safe, that patients' rights are protected and that medical records with sufficient information to promote safe care are maintained. Additionally, for facilities subject to the Life Safety Code (LSC), past experience has demonstrated that many facilities, even when functioning in a degraded status, or in the case of the establishment of alternative care sites, may continue to meet the LSC by implementing reasonable and prudent measures. For example, there were several hospitals that were damaged by Hurricane Katrina which continued to comply with the LSC by implementing reasonable and prudent measures, and therefore were able to continue operations in a degraded but safe environment for weeks or months until repairs could be completed.

The fact sheet on alternative care sites is available at this link: https://www.cms.gov/About-CMS/Agency-Information/H1N1/downloads/AlternativeCareSiteFactSheet.pdf

C.11(c): Can alternative sites include outbuildings on the campus or use of tents in the parking lot?

Alternative screening sites may be located in other buildings on the campus of a hospital or in tents in the parking lot, as long as they are determined to be an appropriate setting for medical screening activities and meet the clinical requirements of the individuals referred to that setting.

However, we note the following from the CDC's guidance for frontline healthcare facilities: "State and local public health departments are actively monitoring persons with a recognized EVD exposure risk within the last 21 days (CDC's Interim U.S. Guidance for Monitoring and Movement of Persons with Potential Ebola Virus Exposure (http://www.cdc.gov/vhf/ebola/exposure/monitoring-and-movement-of-persons-with-exposure.html)). Therefore, these persons will be directed to designated facilities for evaluation if they become ill, making it unlikely that patients with unrecognized EVD disease will present

to a frontline healthcare facility without warning. However, it is also possible that patients with unrecognized EVD will present to a frontline healthcare facility unannounced, or rarely, patients may be temporarily referred to frontline healthcare facilities when it is not feasible to refer to an Ebola assessment hospital or treatment center (e.g. based on distance, bed availability, or other considerations)."

Given the unlikelihood that persons with a recognized EVD exposure will present to a hospital that has not been designated for EVD assessment or treatment, it may be misguided for hospitals to be contemplating measures more suitable to handling a surge in the volume of ED patients, such as setting up tents in the parking lot. This is particularly the case when such arrangements may expose individuals to inclement weather conditions.

C.11(d): What would be an acceptable alternative location <u>on campus</u>? Must the location currently exist as a part of the certified facility?

The location must be part of the certified hospital. If it is not currently part of the certified hospital, then the hospital must take steps to add the location as a new practice location of the hospital.

C.11(e): What type of approval process needs to be in place for a hospital to use an alternative location?

CMS does not require any approval process to use an alternative screening location that is already part of the certified hospital. If the hospital is adding a practice location, it must file a Form 855A with its Medicare Administrative Contractor to advise it of this action. The hospital is not required to obtain prior approval from CMS in order to bill Medicare for services at the added location. There is also no requirement for all added locations to be surveyed for compliance with the Medicare Hospital Conditions of Participation, but CMS retains the discretion to require a survey in individual cases.

States may have licensure requirements for prior approval of any additional practice locations, so hospitals are encouraged to consult with their State licensure authority on any applicable State requirements.

C.11(f): In the past when there have been disasters that resulted in ED surges alternative locations needed to be submitted and approved by State licensure authorities and also by CMS. Does this hold true for alternative locations for screening of potential EVD patients?

See answer to the prior question. As stated, CMS does not require prior approval for hospitals that are adding a practice location. Hospitals should consult with their State licensure authority on any applicable State requirements.

D. Patient Rights

D.1: What action should the hospital take if an individual who meets the screening criteria for suspected EVD wants to leave the hospital against medical advice?

Hospitals do not have authority to prevent the individual from leaving against medical advice. However, State or local public health authorities may have such authority under State or local law, and hospitals should coordinate with their local authorities on the appropriate way to handle an individual suspected of having EVD who wants to leave the hospital environment.

Note that there is an EMTALA requirement at §489.24(d)(3) for a hospital to take all reasonable steps to secure the individual's written informed refusal (or that of the individual's representative) of further medical examination or treatment that the hospital has offered.

D.2: What should the hospital do if a patient who has been deemed likely to have Ebola refuses to be transferred to a designated EVD treatment facility or other facility with the capabilities to treat this condition?

Hospitals do not have authority to compel the patient to accept a transfer. However, State or local public health authorities may have authority under State or local law to address such situations, and hospitals should coordinate with their local authorities on the appropriate way to handle an individual deemed likely to have EVD who refuses to be transferred to another hospital that has the specialized EVD capabilities the individual needs and which the referring hospital lacks.

Note that there is an EMTALA requirement at §489.24(d)(5) for a hospital to take all reasonable steps to secure the individual's written informed refusal (or that of the individual's representative) of an appropriate transfer. The written document must indicate that the individual has been informed of the risks and benefits of the transfer and state the reasons for the individual's refusal.

E. Enforcement

E.1: What will CMS do when a survey reveals that a hospital is not following nationally recognized guidelines regarding EVD infection control processes?

EMTALA does not establish requirements for infection control practices. However, consistent with their obligations under the hospital and CAH Medicare CoPs at §482.42 and §485.635(a)(3)(vi), hospitals and CAHs are expected to adhere to accepted standards of infection control practice to prevent the spread of EVD. Ebola is transmitted through direct contact with blood or body fluids of a person who is sick with Ebola; the virus is not transmitted through the air (like measles virus). However, large droplets (splashes or sprays) of respiratory or other secretions from a person who is sick with Ebola could be infectious, and therefore specific precautions are recommended for use in healthcare settings to prevent the transmission of Ebola from patients to healthcare personnel and other patients or family members. The CDC has issued extensive guidance on applicable isolation precautions and CMS strongly urges hospitals to

follow this guidance. Hospitals may be cited for deficiencies under the CoPs related to failure to follow accepted infection prevention and control standards of practice.

E.2: How will CMS handle complaints about violations of EMTALA related to transfers/attempts to transfer individuals suspected or confirmed as having EVD?

If CMS receives complaints alleging either inappropriate transfers by a referring hospital or refusal of a recipient hospital to accept an appropriate transfer, the agency will consider the following (along with other factors) when making a determination of whether violations of EMTALA have occurred:

- The individual's clinical condition at the time of presentation to the referring hospital and at the time of the transfer request;
- The capabilities of the referring hospital, including whether State or local public health authorities have designated it as having specialized capabilities related to EVD, and the hospital's capacity at the time of the transfer request;
- The screening and treatment activities performed by the referring hospital for the individual;
- Whether the request for transfer was consistent with any nationally recognized guidelines in effect at the time of the transfer request for EVD screening, assessment, or treatment, including guidance about transfer for further assessment or treatment of suspected or confirmed EVD; and
- The capabilities of the recipient hospital, including whether State or local public health authorities have designated it as having specialized capabilities related to EVD and the recipient hospital's capacity at the time of the transfer request.