EMTALA:

The Continued Evolution

Summary of CMS Interpretive Guidelines

4th Edition

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EMTALA
Emergency Medical Treatment and Active Labor Act

History and Overview

The Emergency Medical Treatment and Active Labor Act (EMTALA) is a Federal statute that was initially implemented to govern when and how a patient may be (1) refused treatment or (2) transferred from one hospital to another when an unstable medical condition exists.

The EMTALA statute was passed as part of the Consolidated Omnibus Budget Reconciliation Act of 1986, and is therefore sometimes referred to as "the COBRA law". EMTALA is also known as Section 1867(a) of the Social Security Act, and it is included as part of Section 42 Chapter IV §489.24 of the U.S. Code, which governs special responsibilities of Medicare hospitals in emergency cases.

EMTALA is primarily, but not exclusively, a non-discrimination statute. The purpose of the statute is to prevent hospitals from rejecting patients, refusing to treat them, or transferring them to "charity hospitals" or "county hospitals" because they are unable to pay for evaluation and/or treatment or are covered under the Medicare or Medicaid programs. The EMTALA statute was amended in 1988 and 1989 to add more stringent provisions regulating on-call physicians and the practice of obstetrics. In 1994 the statute continued to be expanded and the Health Care Financing Administration [HCFA, now the Centers for Medicare and Medicaid Services (CMS)] made additions to the statute that further defined the obligations of hospitals under the EMTALA statute, while imposing certain new requirements.

The following is a brief time line of some of the more significant changes and additions to the EMTALA statute over the years.

In 1998 the most significant change added language that prohibited hospitals from making any verification, courtesy, or pre-authorization calls to payers prior to completion of the medical screening examination and stabilization. Hospitals that made pre-authorization calls were considered to be in violation of the law. Under the EMTALA statute the issue of payment or authorization for payment must not be allowed to influence the physician's decision as to (1) whether an emergency medical condition exists or (2) the nature or timing of the treatment needed.

In 1999 new regulations addressing patient rights added language regarding restraint and seclusion of patients that placed significant restrictions on the use of physical and chemical restraint. These revisions placed heavy restrictions on use of these methods for control of patient behavior, required physician face-to-face evaluation, prohibited PRN orders for restraint (including drugs for management purposes), and set time limits on orders.

In 2000 CMS issued new regulations for the Outpatient Prospective Payment System (OPPS) that included significant expansion of EMTALA. Specifically, the OPPS requires the hospital to provide emergency response capabilities, beyond merely calling 911, for accidents, injuries, or patient presentations on the hospital campus, which was defined to include a zone of 250 yards surrounding the main hospital building.

In May of 2002 CMS proposed an extensive list of revisions and clarifications to the EMTALA statute which became effective November 10, 2003. The clarifications and revisions affect areas including: Pre-authorization language instituted in 1998: the definition of “dedicated emergency department”; definition of “comes to the emergency department”; on-campus and off-site responsibilities; in-patient applicability of EMTALA; on-call requirements; and clarification of conflicts regarding ambulance responsibility to community-wide EMS protocols versus the requirements of the EMTALA statutes.

In April 2008 CMS issued an updated State Operations Manual with updated language and clarifications regarding on-call requirements, special responsibilities of hospitals, “parking” Emergency Medical Service (EMS) patients, transport services for patient transfers, and waiver of EMTALA during public health emergencies.

In July 2010 CMS added new language to the State Operations Manual relating to EMTALA waivers. Under the updated guidelines, a hospital or critical access hospital (CAH) operating under an EMTALA waiver will not be sanctioned for:

- Redirecting an individual who “comes to the emergency department,” as defined in §489.24(b), to an alternate location for a MSE, according to a state emergency preparedness plan or state pandemic preparedness plan
- Inappropriately transferring an individual protected under EMTALA, when the transfer is necessitated by the circumstances of the declared emergency

Even when a waiver is in effect there is still the expectation that everyone who comes to the ED will receive an appropriate MSE. The guidelines define when a waiver can be issued, what criteria have to be met for the EMTALA waiver to apply, and how to apply for an EMTALA waiver.

In May 2014 the Office of Inspector General (OIG) posted the following proposed changes in the Federal Register:

- Clarify on-call physicians at participating hospital (where the patient initially presents and the hospital with specialized capabilities), face potential CMP and exclusion liability under EMTALA
- Clarify aggravating circumstances include: request for proof of insurance or payment prior to screening or treatment, patient harm, unnecessary risk of patient harm, premature discharge, or a need for additional services or subsequent hospital admission that resulted or could have resulted from the incident, and whether the individual presented with a medical condition that was an EMC
- Put EMTALA authorities all in one section
- Remove outdated references to the pre-1991 knowing requirement
- Clarify that CMP may be assessed for each violation
- Clarify that all participating hospitals are subject to EMTALA (including those hospitals with specialized capabilities)
- Clarify that the on-call physician at any participating hospital is subject to EMTALA
    - This includes taking care of a patient when the hospital has receive an appropriate transfer request
- Clarify that any physician, including on-call physician, who fails to exam, treat, or transfer a patient appropriately can be penalized
- Clarify that an on-call physician who fails to appear within a reasonable amount of time or refuses to show up is subject to EMTALA liability

- This includes on-call physicians at the hospital where the patient appears and the other hospital that has specialized capabilities

To date, these proposed changes have not been finalized.

To Whom Does EMTALA Apply?

Participating Hospitals

EMTALA applies to "participating hospitals", i.e., to hospitals that have entered into "provider agreements" under which they will accept payment from the Department of Health and Human Services (DHHS) or CMS under the Medicare program for services provided to beneficiaries of that program. In practical terms, this means that it applies to virtually all hospitals, including Critical Access Hospitals (CAHs), in the United States. Its provisions apply to all patients insured or uninsured presenting to those hospitals, not just to Medicare patients.

Additional requirements are imposed upon a hospital that (1) has "specialized capabilities or facilities" such as burn, shock-trauma units, or neonatal intensive care units, or which (2) is a "regional referral center" in a rural area; which will be discussed further in another section of this document. However, CMS has clarified that specialized capabilities or facilities includes virtually any service that is available at the receiving hospital that is not available at the sending hospital. Therefore, having the availability of orthopedic, neurologic, pediatric, plastics providers, etc. also constitutes a “specialized” capability.

Dedicated Emergency Departments

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. A “dedicated emergency department” is defined as meeting one of the following criteria regardless of whether it is located on or off the main campus. The entity:

- Is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; or
- 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 (EMC) on an urgent basis without requiring a previously scheduled appointment; or
- During the preceding calendar year, (i.e., the year immediately preceding the calendar year in which a determination under §489.24 is being made), based on a representative sample of patient visits that occurred during the calendar year, it provided 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.

CMS emphasizes that the location of the department is not a determining factor. Under this definition other departments of the hospitals, such as labor and delivery and psychiatric units, that provide urgent or emergent evaluations without requiring a previously scheduled appointment, would be included. An Urgent Care Center, Acute Care Center, or Immediate Care Center, whether or not located on the main hospital campus, would also be included if it operates under the same license number as the hospital or advertises its services to the community using slogans such as *“For Life’s Little Emergencies”* as an example.

This language does not mean that a hospital must maintain emergency medical screening and/or treatment capabilities in each department or at each door of the hospital, nor anywhere else on hospital property other than the area that is commonly thought of as the Emergency Department. This would, however, require the hospital to have a policy and procedure that details where care of an individual that presents to an area outside of the emergency department should be provided, as well as how and with whom the patient will be transported to that area. Care should be provided in the most appropriate setting, as determined by the hospital.

In addition, **urgent care centers** are very specifically addressed and included in this definition. The comments by CMS state:

> "We believe 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. Indeed, to CMS, both terms seem to demonstrate a similar, if not exact functionality.

The statute clarifies for hospitals that they must provide at least a medical screening examination to all individuals who "come to the Emergency Room" (as defined by CMS) and request examination or treatment for a medical condition, or have such a request made on their behalf.

Applicability to Hospital Inpatients [§ 489.24(d)(2)]

The hospital's obligations under EMTALA end once an individual is admitted for inpatient care. An inpatient is further defined as "a person who has been admitted to a hospital for bed occupancy purposes of receiving inpatient hospital services. A person is considered an inpatient if "normally admitted as an inpatient with the expectation that he/she will remain at least overnight and occupy a bed even though it later develops that he/she can be discharged or transferred to another hospital and does not actually use a hospital bed overnight." Admitting an individual with no intention of treating the patient and then inappropriately transferring or discharging the patient without having met the stabilization requirement is absolutely not allowed and would be subject to harsh penalties.

The statute also addresses issues related to the "admitted" patient who is waiting in the emergency department for an inpatient bed in the following comments: "The hospital must provide stabilizing treatment, even if the individual is awaiting admission in the dedicated emergency department. **Once the individual has been stabilized, the EMTALA obligations end."**

Individuals who are "boarded" and admitted in the dedicated emergency department would be determined to be inpatients for the 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.

Individual Physicians

There are provisions that do, by their terms, apply to physicians. These provisions are unchanged, and include:

- Section 1395dd(d)(1)(C) imposes a penalty on a physician who fails to respond to an emergency situation when requested to do so, when he is assigned as the on-call physician.

- A physician who signs a certification in support of an appropriate transfer is liable if he knew or should have known that the certification was false.
- The Balanced Budget Act of 1997 amended section 1395dd(d)(1)(B) to provide directly for liability of physicians working at specialty hospitals (not just assigned on-call physicians) which violate the special obligations imposed on those hospitals.

The penalty imposed on physicians adds exclusion from the Medicare program in repeated cases or in a "gross and flagrant" violation.

Hospital Owned Ambulances

Ambulance services that are owned and operated by hospital systems, whether or not they are located on the main hospital campus have, to some extent, the same responsibilities as the hospital emergency department as defined in these statutes.

To avoid imposing requirements that are inconsistent with local EMS requirements, the 2003 language was revised to state that EMTALA would ***not*** be applicable if a hospital-owned ambulance is operating under community-wide EMS protocols that require it to transport an individual to a hospital other than the hospital that owns the ambulance (such as the geographically closest hospital). In addition, rather than being interpreted that an individual is considered to have "come to the emergency department" as soon as they enter a hospital-owned ambulance, the definition states that an individual would be considered to have "come to the emergency department" of the hospital to which the individual was transported at the time the individual is brought onto that hospital's property regardless of who owns the ambulance.

Additionally, there has long been controversy regarding the responsibilities of the emergency department when an ambulance delivers an individual through the dedicated emergency department as a direct admission to the hospital. As of 2003 CMS clarified that "**whenever there is a direct admission of a particular individual as an inpatient, EMTALA no longer applies**." This does not, however, mean that the emergency department can refuse to see the patient if the EMTs (regardless of their level of certification) have concerns regarding the appropriateness of the direct admission, or if they perceive a change in condition and request examination.

Who Investigates the Complaint?

The investigatory function is typically provided by the respective state department of health. At times, this may involve other parts of the public health continuum.

Who Enforces the Rules?

CMS is responsible for investigation and partially responsible for enforcement of this statute. The Office of Inspector General (OIG) under the aegis of DHHS is responsible for other enforcement aspects of the law. Violations of EMTALA are also reported to the Justice Department for evaluation for violations to the Hill-Burton Act, to the Office of Civil Rights for evaluation of discrimination implications, to the Internal Revenue Service for evaluation of implications for tax-exempt status, and to The Joint Commission for accreditation review. All of these agencies are potential enforcers of the law, but only CMS and the OIG are actively involved in most instances.

Definitions

Comes to the Emergency Department

The definition of “comes to the Emergency Department,” added in 2000, originally extended to include the entire main hospital campus, including the parking lot, sidewalk, and driveway, *and other property located within 250-yards*. This was added to the statute primarily in response to an incident that occurred in Chicago in 1998, in which hospital personnel would not leave the ED to assist a young man in the alley adjacent to the hospital who had suffered a gunshot wound. Hospital policy did not allow staff to leave the ED to assist someone ‘not on hospital property’. This policy was a common practice at the time, as leaving hospital property to assist someone outside was considered to be taking staff away from the patients in the ED for whom they were responsible. Although hospital personnel called 911 to assist the victim, he was brought into the facility by law enforcement and did not survive his injury due to the additional time elapsed prior to his care.

However, the 250-yard stipulation proved to be overly broad, as it could possibly include other privately owned properties, buildings, etc. This language had significant revisions in 2003 that clarified and limited the areas of responsibility. The revised definition is based, in part, on the definition of “hospital campus” as contained in §413.65(b), which reads: “*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.”

The 2003 revisions provide:

- A person who presents anywhere on the hospital campus and requests emergency services, or who would appear to a reasonably prudent person to be in need of medical attention, must be handled under EMTALA. Other presentations outside the emergency department do not invoke EMTALA.
- The 250-yard zone will continue to apply when defining the "hospital campus". The term ‘campus’ no longer includes non-medical businesses (shops and restaurants located close to the hospital), or physicians' offices or other medical entities that have a separate Medicare identity [§ 413.65(b)]. Nor does it include independent medical practices such as physician offices, Rehabilitation Centers, or Skilled Nursing Facilities.
- EMTALA does not apply to any off-campus facility, regardless of its provider-based status, unless it independently qualifies as a dedicated emergency department.

Off-Campus responsibilities

Even though the “250-yard rule” has been revised, that does not absolve the facility of responsibility for off-campus departments. Off-campus departments that are held out to the public (by name, posted signs, advertising, or other means) as a place that:

1. Provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment, or
2. During the previous calendar year provided at least one-third of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment, or
3. Would be perceived by a prudent layperson as an appropriate place to go for emergency care, whether or not the words “Emergency Room” or “Emergency Department” were used by the hospital to identify the departments would be included.

Emergency Medical Condition

The term Emergency Medical Condition (EMC) is much broader under EMTALA than under typical medical usage. This is a primary cause for many EMTALA violations. The term EMC includes any condition that is a danger to the health and safety of the patient or unborn fetus; or may result in a risk of impairment or dysfunction to the smallest bodily organ or part if not treated in the foreseeable future; and includes a specific range of itemized conditions:

- Undiagnosed, acute pain sufficient to impair normal functioning—is considered an EMC
- Psychiatric disturbances e.g., severe depression, insomnia, suicide attempt or ideation, dissociative state, inability to comprehend danger or to care for one's self—is considered an EMC
- Symptoms of substance abuse e.g., alcohol ingestion—is considered an EMC
- A pregnant woman who is having contractions e.g., inadequate time to effect a safe transfer to another hospital before delivery, or transferring may pose a threat to the health or safety of the woman or her unborn child—is considered an EMC

Medical Screening Exam

The scope of the medical screening exam (MSE) under EMTALA is very comprehensive. The hospital must provide all necessary testing; including, history and physical, lab, x-ray, ECG, other diagnostic tests or procedures, as well as on-call services within the capability of the hospital to reach a diagnosis that excludes the presence of legally defined EMCs. 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.

In regard to a minor that presents unaccompanied to the ED, the 2008 revision states:

> "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 that no EMC is present, the staff can wait for parental consent before proceeding with further examination and treatment."

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 emergent 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." In other words, all EMTALA screenings do not need to be equally extensive. The medical screening exam may be tailored to the presenting complaint.

A qualified medical person (as defined in hospital policy/bylaws) may make the determination that an emergency medical condition does not exist, and may direct the patient to an outpatient clinic where non-emergency personnel will provide the services requested. Presentations that would fit this definition would be requests such as suture removal of a wound that is healing well, dressing change of a non-infected wound, request for pregnancy test, request for prescription refill, etc.

> " **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. A 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).*"

The nursing triage exam without a separate medical screening exam provided by qualified medical personnel, as defined in the hospital's bylaws, is not acceptable under EMTALA. However, if the MSE is appropriate and does not reveal an EMC, the hospital has no further obligation under the code of federal regulations (42 CFR 489.24).

Labor

According to the EMTALA statute, labor is defined as:

> "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."

Stabilization

As is the case with the term "emergency medical condition", the statute provides a definition, but this determination is ultimately a matter of clinical judgment on the part of the medical professional assessing the patient. Stability under EMTALA requires a much higher level of patient condition than that typically connoted by the word "stable" in usual medical usage.

The statute requires that, in non-maternity cases, the hospital must assure that the patient is **not reasonably at risk to deteriorate from, during, or following transfer or discharge**. If the patient is reasonably at risk to deteriorate from the natural process of their condition, they are legally unstable under this standard, just as if the transfer or discharge itself caused the deterioration. A pregnant woman experiencing contractions is not legally stable until the baby and placenta are delivered, as defined by the statute.

What Does EMTALA Require Hospitals to Do?

1. Adopt and enforce policies and procedures to comply with the requirements of 42 CFR§489.24.
2. Conspicuously post signage which must be visible from a distance of 20 feet, and located in places likely to be noticed by all individuals entering the emergency department, as well as those waiting for an exam and treatment. Signage posted must specify rights of individuals under United States Code (USC) 1395(dd) with respect to examination and treatment for emergency medical conditions and women in labor. Signage must also include information indicating whether or not the hospital participates in the Medicaid program under a state plan approved under subchapter XIX of this chapter.
3. Any individual who comes to the hospital seeking emergency service must receive an appropriate medical screening examination (within the capabilities of the facility) to determine whether he/she has an EMC. This examination must be in compliance with a

facility's written policy and protocol and must be conducted by a "qualified medical provider" (QMP)—as defined by the hospital bylaws. Triage and medical screening exam should be recognized as separate functions. The medical screening exam must be:

a. Performed in the hospital rather than by referral to a physician office, HMO or other provider.
b. Performed by a QMP.
c. Defined by facility policies and procedures and is designed to support or rule out an EMC.
d. Performed consistently to ensure that all patients seeking emergency care receive the same screening exam as appropriate to their condition and complaint. Therefore, as discussed previously, a patient presenting with a complaint of a minor problem such as a paronychia would not require the same degree of assessment as someone presenting with chest pain.
e. Clearly documented in the medical record.

4. Discussion or verification of insurance coverage or ability to pay cannot delay the medical screening exam (MSE). The September 2003 clarifications clearly state that:
   a. "It is acceptable for hospitals to follow reasonable registration processes for individuals for whom examination or treatment is required under EMTALA, 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."
   Additionally, the clarifications allow hospitals to seek authorization for all service concurrently with providing any stabilizing treatment as long as obtaining this information does not result in a delay in treatment.
5. If a patient is found to have an emergency medical condition, his condition must be stabilized before transfer or discharge. There are two exceptions to this requirement:
   a. The patient cannot be stabilized because the facility lacks the needed equipment or necessary personnel and a physician certifies that the benefits of the transfer outweigh the risks of the transfer, or
   b. The patient insists on being transferred. This assumes that the patient has had the risks and benefits of such a transfer explained to him/her and he/she is competent to make such a decision. The medical record must clearly reflect this *informed* decision.
6. Provide medically appropriate transfers in which the patient is transferred for medical necessity. The term "transfer" does not apply to the individual who has been declared dead or the patient that leaves the hospital without the permission and/or the knowledge of the hospital's staff. The transfer process requires:
   a. Physician certification that at the time of transfer, the risks of transfer are outweighed by the reasonably anticipated benefits. Specific individual risks and benefits must be listed and the record must support them, or
   b. Written request for transfer by the patient, without suggestion or pressure of the hospital or physician to induce the request. The request should be documented using a form which is signed by the patient (or legally designated responsible party), contains a brief statement of the hospital's EMTALA obligations, indicates the reason for the transfer (patient request) and describes the benefits and risks of the transfer which were outlined to the patient.

c. Transfer by the appropriate medical transfer vehicle—private passenger vehicles are not permitted unless ambulance transport has been refused in writing.
d. Medical orders for appropriate attendant personnel—must have the licensure and skill level to maintain and/or initiate/re-initiate ordered treatment or drugs and deal with the known potential adverse effects of the procedures or drugs.
e. Medical orders for appropriate life support equipment—field ambulance equipment may not be sufficient for a specific transfer. Equipment such as an IV pump, balloon pump, etc. should be specified.
f. The transferring hospital must obtain permission from the receiving (recipient) hospital to transfer the individual. The transferring hospital should document its communication with the receiving hospital, including the date and time of the transfer request and the name and title of the person accepting the transfer.
g. Copies of medical records, tests, and x-rays must be sent with the patient, unless delay for records might jeopardize the patient, in which case records must be transported to the receiving hospital as soon as completed and on a STAT basis.

7. If the patient refuses to accept further examination, stabilizing treatment or transfer, the hospital should take all reasonable steps to obtain the patient's informed written refusal (aka Against Medical Advice [AMA] form). There should be documentation in the patient record describing the refused examination, treatment, or transfer, and the reasons for the patient's refusal. Hospitals must use their best efforts to obtain a signature from an individual refusing further care; however, if the patient refuses to sign the AMA form, this too should be documented.
8. If a pregnant woman is having contractions, she should not be sent home unless a physician, certified nurse-midwife, or other QMP acting within his or her scope of practice as defined in hospital medical staff bylaws and state law, after a reasonable period of observation, certifies that the woman is not in active labor. It is no longer a requirement that the QMP consult a physician prior to discharging the patient.
9. Maintain an on-call system to provide coverage and be available to assist with the stabilization of patients. Hospitals are allowed flexibility to comply with EMTALA obligations by maintaining a level of on-call coverage that is within their capability, and each hospital has the discretion to maintain the on-call list in a manner to best meet the needs of its patients. However, the following are requirements:
    a. The list of on-call physicians must be physicians who are current members of the medical staff or those who have hospital privileges. If the hospital participates in a community call plan then the list must 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 current privileges of the physician on-call. Physician group names are not acceptable for identifying an on-call physician. A named individual must be designated as responsible for call at a given time in a given specialty and should be listed as such on a call list. That call list must be conspicuously posted in the ED at all times. An accurate record of each on-call list must be maintained for five years.
    b. The 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. The policies and procedures must also address the steps to be followed if a

particular specialty is not available or the on-call physician cannot respond because of situations *beyond his or her control*.

c. On-call physicians must respond to the hospital in-person within a reasonable amount of time and render evaluation and care to a patient if requested to do so by the treating ED physician or advanced practice provider. The on-call physician may send a representative, licensed non-physician practitioner, on his behalf unless the ED physician or advanced practice provider caring for the patient objects. It is not permissible to send a patient experiencing an EMC to a specialist's office for definitive care.
d. It is permissible to utilize modern telecommunications (i.e. telephone, video conferencing, transmission of test results, or any other means of communication) to facilitate consultation with specialists who are not present in the hospital/CAH. There is also 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.

10. The statute and the regulations provide that any participating hospital that (1) has "specialized capabilities or facilities" such as burn units, shock-trauma units, or neonatal intensive care units, or which (2) is a "regional referral center" that serves a rural area, 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 [42 USC 1395dd(g); CFR 489.24(e)]. This requirement applies to any participating hospital with specialized capabilities, regardless of whether the hospital has a dedicated emergency department. The hospital may decline a patient who does not need the services of the facility, who can be adequately and completely cared for at the originating facility, or when the hospital lacks the physical capacity to handle the patient. However, CMS has clarified that specialized capabilities or facilities includes virtually any service that is available at the receiving hospital that is not available at the sending hospital. Therefore, having orthopedic, neurologic, pediatrics, plastics, etc., also constitutes a specialized capability. These hospitals are at great risk if they decline a transfer. Further expectations of the receiving hospital include the following:
    a. If the receiving hospital has the ability to utilize on-call personnel—it must do so to accommodate the patient.
    b. If the receiving hospital has handled patients in excess of its stated capacity on prior occasions—it is required to accept the patient.
    c. If the receiving hospital could use step-down beds or early discharge to accommodate a patient—it must do so and accept the patient.
    d. The receiving hospital must accept the patient regardless of means or ability to pay, or third-party payer involvement.
11. Hospitals that routinely prevent Emergency Medical Service (EMS) staff from transferring patients from ambulance stretchers to a hospital bed/gurney, including patients kept on EMS stretchers (with EMS staff in attendance) for extended periods of time, is referred to as "parking EMS patients". This issue was addressed by CMS and should be avoided at all costs.

a. CMS has stated that the agency “recognizes the enormous strain and crowding many hospital emergency departments face every day; however, this practice is not a solution.” They clarify that a hospital has an EMTALA obligation as soon as a patient "presents" and a request is made on the individual’s behalf for examination or treatment of an emergency medical condition.
b. However, CMS further clarified that 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 instance, if the EMS provider brought an individual to the dedicated ED at a time when ED staff was occupied dealing with an issue such as multiple major trauma cases, it could, under those circumstances, be reasonable for the hospital to ask the EMS provider to stay with the individual for a short period of time until ED staff becomes available to provide care to that individual. However, even if a hospital cannot immediately provide a medical screening exam (MSE), ***it must still triage the individual’s condition immediately upon arrival*** to ensure that an emergent intervention is not required.

12. Allow free choice of transport services. If you are transferring a patient to a hospital with specialized capabilities (neonatal ICU, interventional cardiology, etc.) the receiving hospital may not dictate use of an air medical or other transportation service owned by the receiving hospital for the transfer. In other words, ***the acceptance of the patient may not be predicated upon any specific qualifications outside those defining an appropriate transfer in the EMTALA statute*.**
13. Mandatory reporting. If it is necessary to transfer a patient because an on-call physician failed or refused to come to the emergency department, the emergency physician must list the name and address of the on-call physician in the transfer documentation. This results in the receiving hospital reporting the incident for EMTALA investigation, with the resulting likelihood that the transferring hospital and on-call physician will be cited for an EMTALA violation. Failure to list the name is a specific violation that may result in the hospital, ED physician, and on-call physician being cited.

Transfer of Unstable Patients

If the hospital determines that an EMC exists, the hospital must provide for further medical examination and treatment as required to stabilize the individual. If the hospital does not have the capabilities to stabilize the individual, an appropriate transfer to another facility is permitted. Transfer of an unstable patient must include the following:

1. A Physician’s Certification for Transfer which includes:
    a. The medical reason for transfer
    b. The medical benefits for the transfer outweigh the increased risks for the transfer to the patient (or unborn child)
    c. Physician signature
2. The certification provides a complete picture of the benefits to be expected from the transfer and the risks associated with the transfer—including requests made for transfer by an unstable individual (or person acting on his or her behalf). The summary should reflect informed consent and the thought processes of the physician—what was considered, what

care and testing was provided to evaluate and stabilize the patient, the working diagnosis, and a clear statement of why the patient is being transferred.

3. Consent from the receiving hospital to accept the transfer must be obtained. Additionally, all pertinent records regarding the patient or care given should be sent to the receiving hospital.
4. The physician's transfer order defines:
    a. The appropriate mode of transfer. If a patient is being transferred because of lack of capability, he or she is being transferred to a higher level of care, and requires medical oversight. A patient being transferred for a higher level of care should never be transferred via a private vehicle. If the patient insists, document discussion of the risks very completely, and obtain a written, signed refusal of the recommended mode of transportation.
    b. The level of medical professional (MD, RN, level of EMT) needed to accompany the patient.
    c. The equipment needed to manage the known and possible needs of the patient. The hospital must supplement the transport vehicle's equipment if necessary.
    d. Who will maintain continuous medical management via radio control.
    e. Contingency plans regarding what to do if the patient worsens during the transfer.
    f. Orders for medication that may be continued or administered during transport.

Hospital Diversion

Hospitals should have written policy/procedure to address what to do when staff and/or resources are overwhelmed or unavailable and the facility is no longer able to accept emergency patients, and is being placed on "diversionary status". This policy should complement and conform to the community EMS diversion policy. When a hospital goes on temporary ambulance diversion status the following steps should be taken:

- Document the time the hospital is placed on temporary ambulance diversion status
- Document resources not available, such as:
    - No beds available
    - Saturation of hospital resources
    - No monitors available
    - No CT scanner available
- Divert status should be reviewed and updated at regularly defined intervals.
- Notification of appropriate agencies should take place in a timely manner.
- Ensure continued provision of safe, appropriate, and timely care of patients who continue to enter the EMS system during periods of diversion.

If 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. The hospital is obligated to conduct a medical screening exam for the individual.

Public Health Emergencies

Hospitals with dedicated emergency departments in a localized or nationwide "emergency area" (as defined below) will not, for a 72-hour period (starting with the activation of the hospital's disaster protocol) be subject to EMTALA sanction for:

- "Redirecting individuals seeking an MSE when a state emergency preparedness plan or a pandemic preparedness plan has been activated in the emergency area; or

- Inappropriate transfers arising out of the circumstances of the emergency."

An emergency area is defined as one in which:

- "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 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 Social Security Act ("the Act") and notified Congress at least 48 hours in advance of exercising his/her waiver authority."

Areas of Concern

Careful adherence to the regulations outlined here will help to ensure compliance at the facility level. Transfer of any patient presents a risk. It is essential to make sure all steps have been addressed:

- Documented physician to physician contact.
- Document verification of acceptance by receiving hospital.
- DO NOT transfer potentially unstable patients unless they require a higher level of care, or specialized serivce that your hospital is not able to provide.
- Transfer form is filled out completely – do not assume that the nurse has taken care of it; many sections are solely the responsibility of the physician.
- Complete and sign the certification for transfer attesting to the fact that the transfer was either medically necessary, or was requested by the patient/family.
- Make sure that all appropriate medical records are sent with the patient.
- Transfer of any pregnant patient is fraught with risk. Unless the transferring physician can guarantee that the patient will not begin to have active labor while in transit (which is virtually impossible) the pregnant woman in labor should not be transferred. All emergency departments should be equipped to deliver a baby.
- Transfer at the request of the patient or family does not absolve the ED physician of responsibility.
- The transferring physician, usually an ED physician, is 100% responsible for the patient until they have arrived at their destination.
- A patient should never be transferred to another facility via private vehicle, even if requested by the patient or family. If their condition is serious enough to require transfer, they require medical observation en-route.

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