

EMTALA: GUIDE FOR EXAMS, TREATMENT AND TRANSFERS

By [Kim C. Stanger](#)

The Emergency Medical Treatment and Active Labor Act (“EMTALA”) generally requires hospitals to provide emergency care to patients who come to the hospital regardless of their ability to pay.¹ Hospitals that violate EMTALA may be subject to civil penalties of approximately \$53,000 to \$105,000; private lawsuits by individuals or facilities injured by the violation; and/or termination of the hospital’s Medicare provider agreement.² This Guide summarizes EMTALA requirements for examining, treating, and transferring emergency patients and offers suggestions to help hospitals comply.³

1. Entities Covered by EMTALA. EMTALA applies to all hospitals that participate in Medicare, but the requirements differ depending on whether the hospital has an emergency department.

1.1 Hospitals with an Emergency Department. Hospitals with an emergency department must comply with all the EMTALA requirements, including the obligation to provide an emergency medical screening exam, stabilizing treatment and/or an appropriate transfer for patients who come to the hospital as described in section 3, below.⁴ For purposes of EMTALA, an “emergency department” is not only a licensed emergency department; it may also include provider-based departments or specialty hospitals where patients go to receive emergent care without an appointment, such as urgent care centers, psychiatric hospitals, or labor and delivery units.⁵

1.2 Hospitals without an Emergency Department. Hospitals without an emergency department are not required to provide emergency care to all patients who come to the facility; however, if the hospital has specialized capabilities, EMTALA requires that the hospital accept transfers and provide stabilizing treatment of patients from other hospitals if the patient needs the specialized capabilities as described in section 7, below.⁶

1.3 On-Call Physicians. EMTALA also applies to physicians providing care to emergency patients and physicians who are on-call to provide such care. Physicians who negligently violate EMTALA obligations, including those who fail to respond to call or improperly certify a transfer, may be subject to EMTALA fines of

¹ 42 USC 1395dd; 42 CFR 489.24. State laws may impose additional requirements. For example, Idaho Code 39-1391b also prohibits hospitals from refusing to provide “emergency or first aid services” to any person “by reason of race, creed, national origin or financial ability to pay therefor.” Hospitals should check their state laws and ensure compliance.

² For hospitals with fewer than 100 beds, the current penalty is \$52,414 per violation; for hospitals with 100 or more beds, the current penalty is \$104,826. 42 USC 1395dd(d); 42 CFR 1003.103(e) and 45 CFR 102.3. The penalty is subject to periodic adjustment for inflation. 45 CFR 102.3.

³ EMTALA contains additional requirements concerning required signage, on-call lists, community call plans, and disaster waivers. 42 CFR 489.20(m), (q), and (r), 489.24(a)(2), and 489.24(j). Those issues are outside the scope of this Guide.

⁴ 42 USC 1395dd(a)-(c); 42 CFR 489.24(a).

⁵ 42 CFR 489.24(b), definition of *Dedicated emergency department*; CMS State Operations Manual Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases (Rev. 7/16/10) (hereafter “Interpretive Guidelines”) at General Information.

⁶ 42 CFR 489.24(f).



up to \$105,000 per violation.⁷ The hospital may need to remind physicians of the penalties if they are failing to respond to call or live up to their EMTALA obligations.

1.4 Emergency Medical Services. EMTALA generally does not apply to independent emergency medical services (“EMS”) unless the service is owned and operated by a hospital. See discussion concerning ambulances at section 3.6, below.

2. Existing Patients. EMTALA does not apply to persons who are already patients of the hospital, including:

- (1) An individual who has begun to receive outpatient services ... other than an encounter that the hospital is obligated by [EMTALA] to provide;
- (2) An individual who has been admitted as an inpatient...⁸

Such patients are already protected by Medicare conditions of participation and common law malpractice claims; they do not need EMTALA protection.⁹ This rule applies even if an emergency condition arises during the course of their inpatient or outpatient care.¹⁰ Newborns are not considered to be existing patients; accordingly, when a newborn infant is born, they are deemed to have come to the hospital and are entitled to the EMTALA protections described below.¹¹

3. Persons Who Come to the Hospital for Emergency Care. For hospitals with an emergency department, EMTALA is triggered when a person who is not already a patient comes to the hospital seeking emergency care.¹² The rules differ slightly depending on where the person presents.

3.1 Dedicated Emergency Department. When the person presents at a hospital’s “dedicated emergency department”, EMTALA is triggered if “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.”¹³

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;

⁷ 42 USC 1395dd(d)(1)(B); 45 CFR 102.3.

⁸ 42 CFR 489.24(b), definitions of *Comes to the emergency department* and *Patient*.

⁹ 42 CFR 489.24(d)(2); Interpretive Guidelines for 489.24(a)(1)(ii).

¹⁰ Interpretive Guidelines for 489.24(a)(1)(i).

¹¹ *Id.*

¹² 42 USC 1395dd(a); 42 CFR 489.24(a)(1).

¹³ Interpretive Guidelines for 489.24(a)(1).

(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.¹⁴

The definition generally encompasses on- or off-campus hospital-based urgent care centers, labor and delivery departments, psychiatric units, and other provider-based facilities where persons go to receive emergent services without appointments.¹⁵

3.2 On Hospital Property. If the person presents on hospital property outside of a dedicated emergency department, EMTALA is 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.”¹⁶ “Hospital property” encompasses the hospital’s entire main campus, including “the physical area immediately adjacent to the [hospital’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 parking lots, sidewalks, and driveways.¹⁷

3.3 Non-Hospital Facilities. EMTALA only applies if the person is on property that is considered to be part of the hospital for Medicare purposes, *i.e.*, it is a provider-based department of the hospital.¹⁸ EMTALA does not apply to “[a]reas 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.”¹⁹ If a person presents at hospital facilities that are not provider-based or operated as part of the hospital, the hospital may have common law or other regulatory responsibilities, but EMTALA does not apply.

3.4 Off-Campus Departments. EMTALA applies to a hospital’s off-campus provider-based departments or facilities if they fit the definition of a dedicated emergency departments. EMTALA does not apply to such off-campus facilities if they do not have a dedicated emergency department.²⁰

3.5 Helipads. EMTALA generally applies to persons who are brought to the hospital’s on-campus helipad; however, EMTALA does not apply if a different hospital is simply using the helipad to transfer the patient elsewhere. For example, Hospital A’s use of a helipad on Hospital B’s property to transfer a patient

¹⁴ 42 CFR 489.24(b), definition of *Dedicated emergency department*.

¹⁵ 68 Fed. Reg. 53228-33 (9/9/03).

¹⁶ Interpretive Guidelines for 489.24(a)(1).

¹⁷ 42 CFR 413.65(b) and 489.24(b), definition of *Hospital property*.

¹⁸ Interpretive Guidelines at Tag A-2406; 68 Fed. Reg. 53249-50 (9/9/03).

¹⁹ 42 CFR 489.24(b), definition of *Hospital property*.

²⁰ Interpretive Guidelines for 489.24(a)(1).



does not trigger EMTALA for Hospital B so long as Hospital A conducted a medical screening exam prior to the transfer. If the patient's condition deteriorates while at the helipad and medical personnel accompanying the patient request assistance from Hospital B, Hospital B would be required to provide another medical screening exam and stabilizing treatment as required by EMTALA.²¹ Also, EMTALA does not apply if EMS is evacuating the patient as part of an EMS protocol unless EMS personnel, the patient, or the patient's personal representative requests that the hospital provide examination or treatment.²²

3.6 Ambulances. EMTALA rules for ambulances differ depending on who owns or controls the ambulance, and whether the ambulance is inbound or on hospital property.

3.6.1 Ambulance Owned and Operated by Hospital. EMTALA applies if the person 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."²³ In such cases, the hospital must perform a screening examination and stabilizing treatment, and may not transfer the patient to another facility without effecting an appropriate transfer as described in section 6, below. EMTALA does not apply if the ambulance is operated under a communitywide emergency medical service protocol that directs it to transport the patient elsewhere, or the ambulance is operated at the direction of a physician who is not employed by or affiliated with the hospital.²⁴

3.6.2 Ambulance Not Owned or Operated by Hospital. If the person is in an ambulance that is not owned by the hospital, EMTALA is not triggered unless and until the ambulance is inbound to the hospital or arrives on hospital property.²⁵ According to the Interpretive Guidelines, "[a]n 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 [the hospital] by telephone or telemetry communications" and, therefore, EMTALA does not apply; the hospital may direct the ambulance to another facility.²⁶ Once the ambulance is inbound to the hospital, however, the hospital may not divert the ambulance unless the hospital is on diversionary status.²⁷ Given the potential confusion over when and if an ambulance is inbound, hospitals generally should not refuse to accept a patient when contacted by the ambulance crew unless they are on diversionary status.

3.7 Diversion. At times, it may be necessary for a hospital to go on diversionary status because it does not have the staff or facilities to accept any additional emergency patients.²⁸ Hospitals should carefully document the time, need for, and notice of diversionary status to EMS personnel. If an inbound ambulance is not owned by the hospital, a hospital on diversionary status may divert the ambulance to another facility. "[I]f the ambulance is owned by the hospital, the diversion of the ambulance is only appropriate if the [ambulance]

²¹ *Id.*

²² *Id.*

²³ 42 CFR 489.24(b), definition of *Comes to the emergency department*.

²⁴ *Id.*; Interpretive Guidelines for 489.24(a)(1).

²⁵ 42 CFR 489.24(b), definition of *Comes to the emergency department*; Interpretive Guidelines for 489.24(a)(1).

²⁶ Interpretive Guidelines for 489.24(a)(1)(i). Although EMTALA may not apply, the refusal to accept a telephone or radio request for transfer or admission may violate Hill-Burton or other federal laws. *Id.* In addition, the failure to comply with a community-wide protocol or transfer agreement might also be argued as a basis for hospital liability.

²⁷ *Arrington v. Wong*, 237 F.3d 1066 (9th Cir. 2001).

²⁸ *See* 42 CFR 489.24(b), definition of *Comes to the emergency department*.



is being diverted pursuant to community-wide EMS protocols.”²⁹ Even if diversion status is not appropriate, the hospital may still send the ambulance to another facility if it effects an appropriate transfer as discussed in section 6, below. To that end, it would be helpful if the hospital designated its EMS personnel as “qualified medical personnel” for certain emergency conditions as described in section 4.2, below. Also, even if a hospital is not in diversion status, the hospital may discuss the patient’s condition and hospital’s capability with the ambulance crew and, if appropriate, recommend that the patient be taken to another facility; in such situations, the hospital should ensure that the ambulance crew understands that the hospital is not diverting the ambulance and that the hospital will receive the patient if brought to the facility; instead, the hospital is merely discussing the best options for caring for the patient. The hospital should document the discussion to confirm it did not divert the ambulance. If the ambulance disregards the hospital’s direction or diversion and arrives on hospital property, the hospital’s EMTALA obligations are triggered and the hospital must provide the required screening examination, stabilizing treatment, and/or appropriate transfer.³⁰

4. Emergency Medical Screening Exam. If a person comes to a hospital for potential emergency care, the hospital must provide an appropriate medical screening examination (“MSE”) within its capability sufficient to determine whether the patient has an emergency medical condition (“EMC”).³¹ If the screening exam indicates that the person does not have an emergency medical condition, then the hospital’s EMTALA obligation ends: the hospital may discharge, transfer or take such other action without the need to comply with EMTALA.³² Of course, the hospital may still have other regulatory or common law duties to the patient, but EMTALA would no longer apply. On the other hand, if the medical screening exam reveals the existence of an emergency medical condition, the hospital must provide stabilizing treatment or an appropriate transfer as described in sections 5 and 6, below.³³

4.1 Emergency Medical Condition. “Emergency medical condition” means:

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 ... in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part...³⁴

A pregnant woman who is having contractions has an “emergency medical condition” if “(i) there is inadequate time to effect a safe transfer to another hospital before delivery; or (ii) transfer may pose a threat to the health or safety of the woman or the unborn child.”³⁵ “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

²⁹ Interpretive Guidelines for 489.24(a)(1).

³⁰ 42 CFR 489.24(b), definition of *Comes to the emergency department*; Interpretive Guidelines at Tag A-2406.

³¹ 42 USC 1395dd(a); 42 CFR 489.24(a)(1).

³² Interpretive Guidelines for 489.24(a)(1).

³³ 42 USC 1395dd(b)(1); 42 CFR 489.24(a)(1)(ii).

³⁴ 42 CFR 489.24(b), definition of *Emergency medical condition*; compare 42 USC 1395dd(e)(1)(A).

³⁵ 42 USC 1395dd(e)(1)(B); 42 CFR 489.24(b), definition of *Emergency medical condition*.



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.”³⁶

Persons experiencing “psychiatric disturbances” may have an emergency medical condition. For example, “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]”³⁷ requiring stabilizing treatment or an appropriate transfer.

4.2 Qualified Medical Personnel. The medical screening exam must be performed by qualified medical personnel (“QMP”) who have been approved by the hospital’s governing board in hospital bylaws, rules or regulations to provide such exams.³⁸ The designation need not be made by name; instead, the bylaws, rules or other policies approved by the governing body may designate the class or licensure of persons authorized to provide the medical screening exam. Ad hoc decisions or appointments are not sufficient: “[i]t 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.”³⁹ QMPs may include physicians, advanced practice professionals, or other appropriate persons. For example, it may be appropriate to designate and authorize nurses trained in obstetrics to conduct examinations to determine if a woman is in labor.⁴⁰ Similarly,

[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).⁴¹

The relevant bylaws or policies should specify the types of exams the designated person may perform within their scope of practice or privileges. “Hospital by-laws or rules or regulations must specify the criteria and process for granting medical staff privileges to QMP, and ... each individual QMP must be appropriately privileged.”⁴²

4.3 Sufficiency of Exam. The medical screening exam depends on the patient’s presenting signs and symptoms and capability of the hospital.⁴³ If a person requests examination or treatment 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 ... to determine that the individual does not have an emergency medical condition.”⁴⁴ As discussed above, a hospital may establish protocols that allow a nurse QMP to perform certain, limited exams relating to certain conditions, e.g., a blood pressure check for high blood pressure. “Once the individual is screened and it is determined the individual has only presented to the

³⁶ 42 CFR 489.24(b), definition of *labor*.

³⁷ Interpretive Guidelines for 489.24(d).

³⁸ 42 CFR 489.24(a)(i); Interpretive Guidelines for 489.24(a)(1).

³⁹ Interpretive Guidelines—General Information.

⁴⁰ *See, e.g.*, Interpretive Guidelines for 489.24(c).

⁴¹ Interpretive Guidelines for 489.24(c).

⁴² Interpretive Guidelines for 489.24(e).

⁴³ Interpretive Guidelines for 489.24(a)(i).

⁴⁴ 42 CFR 489.24(c).



ED for a nonemergency purpose, the hospital's EMTALA obligation ends...."⁴⁵ On the other hand, if the nature of the symptoms require further examination, the hospital must perform an exam sufficient to determine whether an emergency medical exam exists within the capabilities of the hospital.⁴⁶ If the hospital lacks capabilities needed to complete an appropriate exam, the hospital should effect an appropriate transfer to another hospital as described in section 6, below.

An appropriate medical screening exam is more than triage. Triage is "the clinical assessment of the individual's presenting signs and symptoms ... in order to prioritize when the individual will be seen by a physician or other qualified medical personnel (QMP)."⁴⁷ In contrast, the "[medical screening exam] is the process required to reach, with reasonable clinical confidence, the point at which it can be determined whether the individual has an [emergency medical condition]."⁴⁸ It would normally involve an appropriate history, vital signs, a documented exam of the involved area or system, and ancillary tests or specialty consults as appropriate.

[d]epending on the individual's presenting signs and symptoms, an appropriate [medical screening exam] 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.⁴⁹

The medical screening exam is not an isolated event. Instead,

[t]he medical record must reflect continued monitoring according to the individual's needs until it is determined whether or not the individual has an [emergency medical condition] 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.⁵⁰

The exam should be supported by appropriate documentation. According to CMS survey instructions:

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,

⁴⁵ Interpretive Guidelines for 489.24(c).

⁴⁶ 42 CFR 489.24(a)(1).

⁴⁷ Interpretive Guidelines for 489.24(a)(1)(i).

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ *Id.*

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.⁵¹

4.4 Request for Non-Medical Care. EMTALA only applies to requests for medical care for a current medical condition, not purely evidentiary or preventive services.

[I]f 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 [medical screening exam] under EMTALA⁵²

If while providing the test or service it becomes apparent that the patient may have an emergency medical condition, EMTALA may be triggered.⁵³ For example, if the police bring a person for a blood alcohol test or sexual assault evaluation and a request is made for medical treatment or a prudent layperson would believe that the person needs examination or treatment for a potential emergency condition, then EMTALA would apply.⁵⁴ Similarly, “[w]hen law enforcement officials request hospital emergency personnel to provide clearance for incarceration, the hospital has an EMTALA obligation to provide a [medical screening exam] to determine if an [emergency medical condition] exists.”⁵⁵

4.5 Request for Medication. If an individual presents to the hospital to obtain medication, the hospital must generally provide an appropriate medical screening examination to determine if the patient has an emergency medical condition and, if so, provide stabilizing treatment, which may or may not include medication. However, “[h]ospitals are not required by EMTALA to provide medication to individuals who do not have an [emergency medical condition] 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.”⁵⁶ In such cases, the hospital should carefully document its decisions and confirm that the patient either did not have an emergency condition, the patient was stabilized, or the medication was not necessary or otherwise inappropriate for the patient’s condition.

4.6 Prescheduled Tests or Services. EMTALA generally does not apply if a patient presents at the emergency department for prescheduled appointments or prescheduled tests ordered by their physician.⁵⁷ In

⁵¹ Interpretive Guidelines--Survey Instructions.

⁵² Interpretive Guidelines for 489.24(c).

⁵³ *See id.*

⁵⁴ *Id.*

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ *Id.*



such cases, “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.”⁵⁸

5. Stabilizing Treatment. If the medical screening examination reveals an emergency medical condition, the hospital must provide either (i) stabilizing treatment within its capacity and its capability or (ii) an appropriate transfer before discharging the patient home or sending the patient outside the hospital.⁵⁹ The hospital’s EMTALA obligations end once the patient is either (i) admitted as an inpatient or (ii) stabilized. Of course, the hospital may still have non-EMTALA duties or obligations to the patient.

5.1 Admitted as Inpatient. “If a hospital ... admits [an] individual as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its [EMTALA] responsibilities...”⁶⁰ Per the Interpretive Guidelines,

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.⁶¹

“Individuals who are placed in observation status are not inpatients, even if they occupy a bed overnight”; therefore, placement of a person in observation status does not end the hospital’s EMTALA obligations.⁶² A hospital may not avoid EMTALA liability by admitting the patient without an intent to provide treatment.⁶³ Upon admission, the hospital would still need to comply with applicable conditions of participation relating to the patient, including those governing emergency services, quality assurance, discharge planning, *etc.*⁶⁴

Admission of the patient not only ends the admitting hospital’s obligations; it also ends the obligation of any hospital with specialized capabilities to receive a patient transfer.⁶⁵ Accordingly, a hospital that intends to transfer the patient to another hospital with specialized capabilities should carefully consider whether it should admit the patient before effecting the transfer; otherwise, the receiving hospital may refuse the transfer.

5.2 Stabilized. As a general matter, a patient is “stabilized” when the underlying emergency medical condition is resolved:

⁵⁸ *Id.*

⁵⁹ 42 USC 1395dd(b); 42 CFR 489.24(a)(1)(ii) and (d).

⁶⁰ 42 CFR 489.24(d)(2).

⁶¹ Interpretive Guidelines for 489.24(d)(2)(i); *see also* 42 CFR 489.24(b), definition of *Inpatient*.

⁶² Interpretive Guidelines for 489.24(f).

⁶³ Interpretive Guidelines for 489.24(a)(1)(ii).

⁶⁴ Interpretive Guidelines for 489.24(d).

⁶⁵ 42 CFR 489.24(f)(2).

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.⁶⁶

As a practical matter, the standard for determining whether the patient is "stable" depends on the context.

5.2.1 Stable for Transfer. Under the EMTALA regulations, a patient is considered stable for purpose of transfer if "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 [a pregnant woman in labor], that the woman has delivered the child and the placenta." Theoretically, a patient meeting this test may be transferred without effecting an appropriate transfer under EMTALA. As a practical matter, however, the hospital should effect an appropriate transfer under EMTALA unless the hospital can document that the emergency medical condition has resolved.

5.2.2 Stable for Discharge Home. EMTALA treats a discharge from the facility as a transfer.⁶⁷ EMTALA prohibits discharging a patient home unless the patient is stable or an appropriate transfer is effected.

[a]n individual is considered stable and ready for discharge when, within reasonable clinical confidence, ... 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.⁶⁸

Hospitals are expected to assist and/or provide discharged individuals with information they may need to obtain any appropriate follow-up care to prevent a relapse or worsening of the medical condition.⁶⁹ Medicare conditions of participation or the relevant standard of care may impose additional obligations beyond EMTALA.

5.2.3 Pregnant Women. Although the regulations are a bit complicated, it appears that a woman who is in labor is presumed to have an unstabilized emergency condition.

⁶⁶ Interpretive Guidelines for 489.24(b).

⁶⁷ 42 CFR 489.24(b), definition of *Transfer*.

⁶⁸ Interpretive Guidelines for 489.24(d)(1).

⁶⁹ *Id.*

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 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.⁷⁰

By definition, the only way to stabilize a woman in labor is to deliver the child and placenta.⁷¹ Accordingly,

If a woman is in labor, the hospital must deliver the baby and the placenta or transfer appropriately. She may not be transferred [or discharged home] 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.⁷²

Thus, a hospital should not discharge or send home a woman who is having contractions unless a qualified medical person has certified false labor or the hospital effects an appropriate transfer as discussed in section 6, below.

5.2.4 Psychiatric Patients. “Psychiatric patients are considered stable when they are protected and prevented from injuring or harming him/herself or others.”⁷³ CMS has cautioned that simply administering chemical or physical restraints does not necessarily mean that a psychiatric patient is stabilized:

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 [emergency medical condition] but the underlying medical condition may persist and if not treated for longevity the patient may experience exacerbation of the [emergency medical condition]. Therefore, practitioners should use great care when determining if the medical condition is in fact stable after administering chemical or physical restraints.⁷⁴

Providers should carefully evaluate the circumstances before concluding that a psychiatric patient is stable for purposes of EMTALA. To discharge the patient home, the emergent nature of the psychiatric condition likely must be resolved. When sending a psychiatric patient to another facility, the hospital should assume that it must effect an appropriate transfer rather than characterizing the patient as “stable” for purposes of the transfer.

⁷⁰ 42 CFR 489.24(b), definition of *Labor*.

⁷¹ 42 CFR 489.24(b), definition of *Stabilized*.

⁷² Interpretive Guidelines for 489.24(d)(1)(ii).

⁷³ Interpretive Guidelines for 489.24(d)(1)(i).

⁷⁴ *Id.*



6. Appropriate Transfers. For purposes of EMTALA,

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.⁷⁵

A hospital may not discharge or transfer an unstabilized patient outside the hospital unless either (i) the hospital complies with the EMTALA transfer requirements described in this section, or (ii) a competent patient or their personal representative insists on leaving without permitting the hospital to effect an appropriate transfer as otherwise required by EMTALA.⁷⁶ If a patient requires services that are not available at the hospital to either complete the medical screening examination or stabilize the patient, or the hospital has exhausted its capabilities in trying to resolve the emergency medical condition, the hospital must generally effectuate an appropriate transfer.⁷⁷ To be appropriate, the hospital must have either (i) the patient's request for the transfer, or (ii) physician certification that the benefits of transfer outweigh the risks.⁷⁸ In addition, the hospital must take certain steps to ensure the transfer is appropriate as described below.

6.1 Patient Request for Transfer. A competent patient or their legally authorized representative may request a transfer to another facility.⁷⁹ The hospital should inform the person of the hospital's EMTALA obligations and the risks associated with the transfer.⁸⁰ The patient's 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."⁸¹ If the patient refuses to provide a written request, the hospital should document the foregoing information. If an unstabilized patient requests the transfer, the hospital should try to effect an appropriate transfer consistent with the requirements in sections 6.3 to 6.6, below, including contacting the receiving facility to arrange for the transfer. It may be that the receiving facility refuses to accept the transfer because, *e.g.*, the receiving hospital does not have specialized capabilities or is not able or obligated to accept the transfer. In such situations, the patient or their authorized surrogate may decide to leave the hospital, anyway. If so, the hospital should document that it discussed its EMTALA obligations and the relevant risks and benefits with the patient or personal representative, and that the patient or personal representative insisted on leaving against medical advice. The hospital should take appropriate steps to facilitate care, including providing instructions or information to the patient and alerting the receiving facility that the patient is planning to leave or has left the hospital against medical advice and is heading to the receiving facility.

6.2 Physician Certification. In the absence of—or, better yet, in addition to—the patient's or personal representative's request, the hospital may transfer a patient if a physician certifies in writing that,

⁷⁵ 42 CFR 489.24(b), definition of *Transfer*.

⁷⁶ 42 USC 1395dd(c); 42 CFR 489.24(e).

⁷⁷ Interpretive Guidelines for 489.24(d)(1)(ii).

⁷⁸ 42 USC 1395dd(c)(1); 42 CFR 489.24(e).

⁷⁹ 42 USC 1395dd(c)(1)(i); 42 CFR 489.24(e)(1)(ii)(A).

⁸⁰ 42 CFR 489.24(e)(1)(ii)(A).

⁸¹ *Id.*

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.⁸²

Only physicians may provide the required certification, *i.e.*, “[a] doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action.”⁸³ If the physician is not physically present, a qualified medical person (as described in section 4.2, above) may consult with the physician and, if the physician agrees that transfer is appropriate, the qualified medical person may sign the certification, but the physician must subsequently countersign the certification within the timeframe established by hospital policies and procedures.⁸⁴

The required certification may appear in the medical record or a separate physician certification form; however, simply checking a box likely does not satisfy the certification requirement. “[T]he certification must contain a summary of the risks and benefits supporting the transfer.”⁸⁵ According to the Interpretive Guidelines,

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.... This rationale may be included on the certification form or in the medical record.⁸⁶

“The date and time of the physician (or the QMP) certification should closely match the date and time of the transfer.”⁸⁷ “Certifications may not be backdated.”⁸⁸ Regardless of whether the transfer is initiated by patient request or physician certifications, all transfers must satisfy the requirements in sections 6.3 to 6.6, below, to be considered “appropriate” under EMTALA.

6.3 Stabilizing Treatment. The transferring hospital must provide medical treatment within its capacity that minimizes the risks to the patient’s health and, in the case of a woman in labor, the health of the unborn child during the transfer.⁸⁹

⁸² 42 CFR 489.24(e)(1)(ii)(B).

⁸³ 42 USC 1395dd(c)(1)(a)(ii) and 1395x(r)(1); 42 CFR 489.24(e)(1)(ii)(B).

⁸⁴ 42 CFR 489.24(e)(1)(ii)(C); Interpretive Guidelines for 489.24(e).

⁸⁵ 42 CFR 489.24(e)(1)(ii)(B) and (C).

⁸⁶ Interpretive Guidelines for 489.24(e).

⁸⁷ *Id.*

⁸⁸ *Id.*

⁸⁹ 42 USC 1395dd(c)(2)(A); 42 CFR 489.24(e)(2)(i).



6.4 Receiving Facility’s Agreement. The transferring hospital must contact the receiving facility to confirm that the receiving facility “[h]as available space and qualified personnel for the treatment of the individual; and has agreed to accept transfer of the individual and to provide appropriate medical treatment.”⁹⁰ While “[t]he transferring hospital must obtain permission from the receiving (recipient) hospital to transfer an individual,”⁹¹ the regulations do not mandate any specific process for obtaining the agreement. For example, the regulations do not require doctor-to-doctor communications. As a practical matter, the transferring facility should ensure that the person contacted has authority to accept the transfer on behalf of the receiving facility. On the other hand, the receiving facility may want to put policies or protocols in place so that all such requests are routed to appropriate persons to act on behalf of the receiving hospital. For example, a transferring hospital may call a specialist at the receiving facility to request a transfer, but the specialist may lack knowledge concerning the current capacity of the receiving facility, or may fail to alert the relevant specialty services of the transfer. It may be more appropriate to route such calls to the emergency department director or other appropriate persons. Regardless, “[t]he 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.”⁹²

As described in section 7, below, hospitals with specialized capabilities are required to accept transfers of patients needing the specialized services unless the patient was admitted as an inpatient at the transferring facility.⁹³ It may be necessary for the transferring facility to remind hospitals with specialized capabilities of their obligations to receive the patient.

6.5 Records. The transferring hospital must send to the receiving facility all medical records (or copies thereof) related to the patient’s emergency condition 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 [physician] certification ... required [by EMTALA].⁹⁴

Available records should be sent with the patient at the time of transfer.⁹⁵ “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.”⁹⁶ “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.”⁹⁷

⁹⁰ 42 USC 1395dd(c)(2)(B); 42 CFR 489.24(e)(2)(ii).

⁹¹ Interpretive Guidelines for 489.24(e)(2)(ii).

⁹² *Id.*

⁹³ 42 CFR 489.24(f).

⁹⁴ 42 CFR 489.24(e)(2)(iii).

⁹⁵ Interpretive Guidelines for 489.24(e)(2)(iii).

⁹⁶ 42 CFR 489.24(e)(2)(iii).

⁹⁷ Interpretive Guidelines for 489.24(e)(2)(iii).



In addition to treatment records, the transferring hospital must send “the name and address of any on-call physician [at the transferring facility] who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment.”⁹⁸ Advising physicians of this requirement may help encourage them to faithfully fulfill their call obligations.

6.6 Appropriate Means of Transfer. The transferring hospital must effect the transfer “through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.”⁹⁹ The regulations and Interpretive Guidelines appear to recognize that the resources of transferring hospitals and circumstances surrounding each transfer vary greatly; accordingly, they do not prescribe specific requirements for transfers. Instead, the Interpretive Guidelines simply state:

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.¹⁰⁰

Hospitals should address potential transportation issues in advance by confirming available transportation resources and, where appropriate, entering transfer agreements. Among other things, hospitals should work with local EMS providers to confirm their qualifications and capabilities, including regulatory limits applicable to the services they may offer. As appropriate, hospitals may want to develop protocols or orders applicable to EMS transfers, or enter medical supervision agreements necessary to facilitate the transfer. Hospitals should develop policies or protocols for handling transfers that may exceed EMS capabilities, *e.g.*, identifying and/or training nurses, advanced practice professionals, physicians or others who may accompany or assist in transfers as appropriate to the patient’s condition; providing additional needed equipment for ambulance crews; maintaining adequate supervision and direction during the transport; *etc.* Beware: surveyors may review transfer policies in reviewing the appropriateness of transfers,¹⁰¹ so ensure the policies are appropriate and that you are willing to comply with the policies.

When considering the means of transport, the hospital should consider the patient’s condition and reasonably foreseeable needs; the length and risks associated with the transfer; the training, capabilities, and scope of practice of medical personnel assigned to the transfer; the availability and adequacy of supervision or direction during transfer; needed and available equipment along with the ability of staff to use the equipment; and

⁹⁸ *Id.*

⁹⁹ 42 USC 1395dd(c)(2)(D); 42 CFR 489.24(e)(2)(iv).

¹⁰⁰ Interpretive Guidelines for 489.24(e)(2)(iv); *see also* 59 Fed. Reg. 32103-04 (6/22/94).

¹⁰¹ *See, e.g.*, Interpretive Guidelines--Survey Instructions.



other available transportation options. Rural facilities must also consider the risk to other hospital patients if key providers are assigned to the transport—will there be adequate coverage at the hospital to address other existing or relatively imminent risks? In some situations, the method of transportation may not be ideal, but it may present the best (or only) option for the patient. In such cases, the hospital should carefully document the risks, benefits, and bases for the transportation decision. In most cases, EMTALA does not pose a significant risk so long as the hospital does what is best for the patient and documents the reasons for its actions. The hospital should ensure that it discusses the risks and benefits with the patient or personal representative so that it obtains and documents informed consent for the transfer, and that the hospital otherwise satisfies the applicable standard of care.

Hospitals should take steps to minimize its risks if and to the extent it uses its employees or agents to effect appropriate transfers, including but not limited to ensuring that it has adequate professional liability, vehicle, workers compensation and other insurance coverage for services rendered during the transport.

6.6.1 Transfer by Private Vehicle. EMTALA does not expressly prohibit transfer by private care, but CMS may look closely at the circumstances if there is a complaint or adverse outcome. In *Wey v. Evangelical Comm. Hosp.*, 833 F. Supp. 453 (M.D. Pa. 1993), the court held that transfer by private care did not violate EMTALA where an expert opined that transfer by private vehicle was medically appropriate under the circumstances of that case. To be safe, hospitals should do the following before transferring a patient by private vehicle: (i) offer an ambulance or other alternative form of transport; (ii) explain the hospital's EMTALA obligations to effect an appropriate transfer; (iii) explain the risks and benefits of transfer by private vehicle and any offered alternative transportation; (iv) confirm that, despite the foregoing, the patient or their legal representative declines the offered transportation and opts instead for transfer by private vehicle; (v) ensure that appropriate measures are taken to protect the patient and minimize risk during the transport, *e.g.*, ensure that other appropriate person(s) accompany the patient, give appropriate instructions, and provide a telephone number that the person(s) may call if problems or questions arise during the transport; and (vi) document the foregoing, including obtaining the patient's or personal representative's signature on an appropriate AMA or similar form.

6.6.2 Transferring Psychiatric Patients. When transferring a psychiatric patient, the hospital must ensure that adequate protections are put in place to protect the patient from harming himself, herself, or others. Rural hospitals often use police to transfer psychiatric patients. That may be appropriate in some if not most cases; however, the hospital must still evaluate the situation to ensure that such a transfer is medically appropriate and provides the protections required by EMTALA. Among other things, the hospital should confirm that the police (or other person assisting in the transfer) is properly trained to protect the patient or others, and that the vehicle used is appropriate and safe under the circumstances. Hospitals should document their analysis and decisions in case they need to justify their conclusions.

6.7 Community Transfer Protocols. EMTALA preempts community EMS transfer protocols to the extent they contradict EMTALA. If a patient is brought to the hospital, the hospital must provide the screening examination, stabilizing treatment, and/or an appropriate transfer as required by EMTALA even if a community transfer protocol mandates otherwise. However, the existence of a community transfer plan may indicate that the benefits of transfers outweigh the risks. Hospitals which receive a patient may transfer the patient per the



community plan so long as the hospital satisfies its EMTALA obligations before doing, including arranging for an appropriate transfer as required by EMTALA.¹⁰²

6.8 Transfer Distances. EMTALA does not expressly require that hospitals transfer patients to the nearest facility; however, CMS has stated that hospital transfers of patients with unstabilized emergency medical conditions “should not routinely be made over great distances, bypassing closer hospitals with the needed capability and capacity.”¹⁰³

6.9 Liability for Transportation. As a general matter, “the sending hospital is ultimately responsible [under EMTALA] for ensuring that the transfer is effected appropriately”¹⁰⁴; however, the hospital likely fulfills its EMTALA obligations if it uses qualified personnel and equipment to effect the transfer. It is not the guarantor of a safe transfer. The hospital may be liable for its own negligence and vicariously liable for the negligent acts of its employees or agents who, while acting within the course of their employment, assist in the transport. The hospital should not be liable for the negligent acts or omissions of independent entities, *e.g.*, independent EMS personnel, independent providers participating in the transport, or others unless such persons were performing services under the direction of or as the agents of the hospital. Ultimately, liability depends on the particular circumstances of each case, the relationships of the parties, and the applicable standard of care. EMTALA does not impose different standards or impose vicarious liability on transferring hospitals.

7. Receiving 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 ... 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.¹⁰⁵

The obligation to receive such transfers applies if the hospital participates in Medicare even if the hospital does not have an emergency department.¹⁰⁶

7.1 No Inpatients. The obligation to accept transfers does not apply if the person to be transferred has been admitted as an inpatient at another hospital.¹⁰⁷ The admission of a person as an inpatient terminates EMTALA obligations for both the admitting hospital and any other hospital to which the patient may have been transferred.

¹⁰² Interpretive Guidelines for 489.24(d)(1)(i).

¹⁰³ Interpretive Guidelines for 489.24(f); *see also* 73 Fed. Reg. 48666 (8/19/08) (hospitals “should attempt to avoid transporting individuals long distances when a shorter transport to a hospital with specialized capabilities and capacity is possible.”).

¹⁰⁴ Interpretive Guidelines for 489.24(e)(2)(iv).

¹⁰⁵ 42 CFR 489.24(f).

¹⁰⁶ Interpretive Guidelines for 489.24(f).

¹⁰⁷ 42 CFR 489.24(f)(2).



7.2 Specialized Capabilities. The obligation to accept transfers only applies if the receiving hospital has specialized capabilities that the transferring hospital does not have, and the capacity to treat persons in need of such capabilities.¹⁰⁸

Lateral transfers, that is, transfers between facilities of comparable resources and capabilities, are not required by [EMTALA], 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.¹⁰⁹

Whether a hospital has specialized capabilities and capacity depends on the circumstances at both the transferring and receiving facility.

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.... If a hospital has customarily accommodated patients in excess of its occupancy limits by whatever means (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.¹¹⁰

If the receiving facility believes that it lacks capacity or that the transferring facility has the same capabilities, it should discuss the situation with the transferring hospital instead of rejecting the transfer outright; otherwise, it may expose itself to EMTALA liability for improperly refusing a transfer.

7.3 Conditioning Acceptance of Transfer. The transferring hospital has the responsibility to determine and arrange for the appropriate transfer of the individual, not the receiving hospital.¹¹¹ Accordingly, the receiving hospital "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

¹⁰⁸ 42 CFR 489.24(f); Interpretive Guidelines for 489.24(f).

¹⁰⁹ Interpretive Guidelines for 489.24(f).

¹¹⁰ Interpretive Guidelines for 489.24(f).

¹¹¹ 42 CFR 489.24(e)(2)(iv); Interpretive Guidelines for 489.24(f).



service.”¹¹² Similarly, and assuming that the receiving facility has needed specialized capabilities, there is nothing in the EMTALA regulations that permits the receiving facility to condition acceptance of the patient on the performance of pre-transfer tests or services. Receiving facilities that impose such pre-conditions may be exposing themselves to EMTALA liability.

8. Patient Consent to and Refusal of Care. EMTALA does not change principles of informed consent. A competent patient or their legally authorized personal representative still has the right to consent to or refuse the screening examination, stabilizing treatment, and/or transfer otherwise required by EMTALA.¹¹³ In the case of minors, the EMTALA Interpretive Guidelines state:

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.¹¹⁴

Competent patients or their legal representatives may refuse care otherwise required by EMTALA, but EMTALA requires that the hospital “offer[] the individual the ... medical examination and treatment [required by EMTALA] and inform[] the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of the examination and treatment.”¹¹⁵ Furthermore,

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.¹¹⁶

Similarly, a patient or their representative may refuse a transfer that would otherwise be required by EMTALA. When the patient refuses an appropriate transfer, the EMTALA regulations state that the hospital must offer the transfer and “inform[] the individual (or a person acting on his or her behalf) of the risks and benefits to the individual of the transfer.”¹¹⁷ Furthermore,

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

¹¹² Interpretive Guidelines for 489.24(f).

¹¹³ See, e.g., 42 CFR 489.24(d)(3) and (d)(5).

¹¹⁴ Interpretive Guidelines for 489.24(a)(1).

¹¹⁵ 42 CFR 489.24(d)(3).

¹¹⁶ *Id.*

¹¹⁷ 42 CFR 489.24(d)(5).

medical record must contain a description of the proposed transfer that was refused by or on behalf of the individual.¹¹⁸

“If an individual leaves a hospital Against Medical Advice (AMA) ..., on his or her own free will (no coercion or suggestion) the hospital is not in violation of EMTALA.”¹¹⁹ In such cases, the hospital should document the circumstances and its efforts to comply with EMTALA requirements. EMTALA requires hospitals to maintain “[a] central log on each individual who comes to the emergency department ... 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.”¹²⁰

9. Reporting EMTALA Violations. There is generally no obligation to self-report EMTALA violations to CMS or the Office for Civil Rights, although a hospital may choose to do so if it believes that a third party is likely to report the violation. As discussed above, if an on-call physician “has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment,” the transferring hospital must send the physician’s name and address to the receiving facility.¹²¹ Also, if a hospital “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 [EMTALA],” the hospital must report the event to CMS or the relevant state contractor “within 72 hours of the occurrence.”¹²² “If a recipient hospital fails to report an improper transfer, the hospital may be subject to termination of its provider agreement ...”¹²³ Hopefully, the receiving hospital will contact the transferring hospital to confirm the facts before reporting. Hospitals often conclude there was no EMTALA violation after obtaining all the facts, thereby avoiding the need for a report to CMS or BFS.

10. Conclusion. Given the significant EMTALA penalties, hospitals and hospital-based providers need to understand and comply with EMTALA requirements. If you are dazed and confused by the rules, regulations, and Interpretive Guidelines, just remember this: in the end, EMTALA is all about ensuring persons receive necessary emergency medical care. So long as providers exercise common sense, do what is best for the patient, and document their actions and the reason for their actions, chances are they will never face significant EMTALA penalties. Even if CMS does investigate, they may usually resolve the concerns through an appropriate plan of correction.

For questions regarding this update, please contact: Kim C. Stanger at kcstanger@hollandhart.com or at 208-383-3913. For more information, please visit www.hollandhart.com or www.hhhealthlawblog.com.

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¹¹⁸ 42 CFR 489.24(d)(3).

¹¹⁹ Interpretive Guidelines for 489.24(a)(1).

¹²⁰ 42 CFR 489.20(r)(3).

¹²¹ 42 CFR 489.24(e)(2)(iii).

¹²² 42 CFR 489.20(l) and Interpretive Guidelines for 489.20(m).

¹²³ Interpretive Guidelines—Investigative Procedures.