State Operations Manual

Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases

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(Rev. 60, 07-16-10)

Transmittals for Appendix V

Part I- Investigative Procedures

Part II - Interpretive Guidelines - Responsibilities of Medicare Participating Hospitals in Emergency Cases

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Part I- Investigative Procedures

I. General Information

Medicare participating hospitals must meet the Emergency Medical Treatment and Labor Act (EMTALA) statute codified at §1867 of the Social Security Act, (the Act) the accompanying regulations in 42 CFR §489.24 and the related requirements at 42 CFR 489.20(l), (m), (q), and (r). EMTALA requires hospitals with emergency departments to provide a medical screening examination to any individual who comes to the emergency department and requests such an examination, and prohibits hospitals with emergency departments from refusing to examine or treat individuals with an emergency medical condition (EMC). The term "hospital" includes critical access hospitals. The provisions of EMTALA apply to all individuals (not just Medicare beneficiaries) who attempt to gain access to a hospital for emergency care. The regulations define "hospital with an emergency department" to mean a hospital with a dedicated emergency department (ED). In turn, the regulation defines "dedicated emergency department" as any department or facility of the hospital that either (1) is licensed by the state as an emergency department; (2) held out to the public as providing treatment for emergency medical conditions; or (3) on one-third of the visits to the department in the preceding calendar year actually provided treatment for emergency medical conditions on an urgent basis. These three requirements are discussed in greater detail at Tag A406.

The enforcement of EMTALA is a complaint driven process. The investigation of a hospital's policies/procedures and processes and any subsequent sanctions are initiated by a complaint. If the results of a complaint investigation indicate that a hospital violated one or more of the anti-dumping provisions of §1866 or 1867 (EMTALA), a hospital may be subject to termination of its provider agreement and/or the imposition of civil monetary penalties (CMPs). CMPs may be imposed against hospitals or individual physicians for EMTALA violations.

The RO evaluates and authorizes all complaints and refers cases to the SA that warrant investigation. The first step in determining if the hospital has an EMTALA obligation is for the surveyor verify whether the hospital in fact has a dedicated emergency department (ED). To do so, the surveyor must check whether the hospital meets one of the criteria that define whether the hospital has a dedicated emergency department.

As discussed above, a dedicated emergency department is defined as meeting one of the following criteria regardless of whether it is located on or off the main hospital campus: The entity: (1) is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; or (2) is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions (EMC) on an urgent basis without requiring a previously scheduled appointment; or (3) during the preceding calendar year, (i.e., the year immediately preceding the calendar year in which a determination under this section is being made), based on a representative sample of patient visits that occurred during the calendar year, it provides at least one-third of all of its visits for the treatment of EMCs on an urgent

basis without requiring a previously scheduled appointment. This includes individuals who may present as unscheduled ambulatory patients to units (such as labor and delivery or psychiatric units of hospitals) where patients are routinely evaluated and treated for emergency medical conditions.

Hospitals with dedicated emergency departments are required to take the following measures:

- Adopt and enforce policies and procedures to comply with the requirements of 42 CFR §489.24;
- Post signs in the dedicated ED specifying the rights of individuals with emergency medical conditions and women in labor who come to the dedicated ED for health care services, and indicate on the signs whether the hospital participates in the Medicaid program;
- Maintain medical and other records related to individuals transferred to and from the hospital for a period of five years from the date of the transfer;
- Maintain a list of physicians who are on-call to provide further evaluation and or treatment necessary to stabilize an individual with an emergency medical condition;
- Maintain a central log of individual's who come to the dedicated ED seeking treatment and indicate whether these individuals:
    - Refused treatment,
    - Were denied treatment,
    - Were treated, admitted, stabilized, and/or transferred or were discharged;
- Provide for an appropriate medical screening examination;
- Provide necessary stabilizing treatment for emergency medical conditions and labor within the hospital's capability and capacity;
- Provide an appropriate transfer of an unstabilized individual to another medical facility if:
    - The individual (or person acting on his or her behalf) after being informed of the risks and the hospital's obligations requests a transfer,

- A physician has signed the certification that the benefits of the transfer of the patient to another facility outweigh the risks or

- A qualified medical person (as determined by the hospital in its by-laws or rules and regulations) has signed the certification after a physician, in consultation with that qualified medical person, has made the determination that the benefits of the transfer outweigh the risks and the physician countersigns in a timely manner the certification. (This last criterion applies if the responsible physician is not physically present in the emergency department at the time the individual is transferred.

- Provide treatment to minimize the risks of transfer;

- Send all pertinent records to the receiving hospital;

- Obtain the consent of the receiving hospital to accept the transfer,

- Ensure that the transfer of an unstabilized individual is effected through qualified personnel and transportation equipment, including the use of medically appropriate life support measures;

- Medical screening examination and/or stabilizing treatment is not to be delayed in order to inquire about payment status;

- Accept appropriate transfer of individuals with an emergency medical condition if the hospital has specialized capabilities or facilities and has the capacity to treat those individuals; and

- Not penalize or take adverse action against a physician or a qualified medical person because the physician or qualified medical person refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee who reports a violation of these requirements.

If the hospital does not have a dedicated emergency department as defined in 42 CFR §489.24(b), apply 42 CFR §482.12(f) which requires the hospital's governing body to assure that the medical staff has written policies and procedures for appraisal of emergencies and the provision of initial treatment and referral (Form CMS-1537, "Medicare/Medicaid Hospital Survey Report").

Hospitals that violate the provisions in 42 CFR §489.24 or the related requirements in 42 CFR §489.20(l), (m), (q), and (r) are subject to civil monetary penalties or termination.

A hospital is required to report to CMS or the State survey agency promptly when it suspects it may have received an improperly transferred individual. Notification should occur within 72 hours of the occurrence. Failure to report improper transfers may subject the receiving hospital to termination of its provider agreement.

To assure that CMS is aware of all instances of improper transfer or potential violations of the other anti-dumping requirements, the State survey agencies must promptly report to the RO all complaints related to violations of 42 CFR §489.24 and the related requirements at 42 CFR §489.20(l), (m), (q), and (r). The RO will decide whether a complaint alleges a violation of these requirements and warrants an investigation.

Quality of care review performed either by the SA or other physicians must not delay processing of a substantiated EMTALA violation. If during the course of the investigation, you identify possible quality of care issues other than those related to the provisions of this regulation, obtain a copy of the patient's medical record and send the case to the RO for referral to the appropriate Quality Improvement Organization (QIO). Contact the RO if the hospital refuses to provide a copy of the medical record.

If you suspect emergency services are being denied based on diagnosis (e.g., AIDS), financial status, race, color, national origin, or handicap, refer the cases to the RO. The RO will forward the cases to the Office of Civil Rights (OCR) for investigation of discrimination.

A hospital must formally determine who is qualified to perform the initial medical screening examinations, i.e., qualified medical person. While it is permissible for a hospital to designate a non-physician practitioner as the qualified medical person, the designated non-physician practitioners must be set forth in a document that is approved by the governing body of the hospital. Those health practitioners designated to perform medical screening examinations are to be identified in the hospital by-laws or in the rules and regulations governing the medical staff following governing body approval. It is not acceptable for the hospital to allow the medical director of the emergency department to make what may be informal personnel appointments that could frequently change.

If it appears that a hospital with an dedicated ED does not have adequate staff and equipment to meet the needs of patients, consult the RO to determine whether or not to expand the survey for compliance with the requirements of 42 CFR §482.55 ("Condition of Participation: Emergency Services").

Look for evidence that the procedures and policies for emergency medical services (including triage of patients) are established, evaluated, and updated on an ongoing basis.

The hospital should have procedures, which assure integration with other hospital services (e.g., including laboratory, radiology, ICU, and operating room services) to ensue continuity of care.

II. Principal Focus of Investigation

Investigate for compliance with the regulations in 42 CFR §489.24 and the related requirements in 42 CFR §489.20(l), (m), (q), and (r). All investigations are to be unannounced. The investigation is based on an allegation of noncompliance. The purpose of the investigation is to ascertain whether a violation took place, to determine whether the violation constitutes an immediate and serious threat to patient health and safety, to identify any patterns of violations at the facility, and to assess whether the facility has policies and procedures to address the provisions of the EMTALA law. The investigation must be completed within 5 working days of the RO authorization.

The focus of the investigation is on the initial allegation of violation and the discovery of additional violations. If the allegation is not confirmed, the surveyors must still be assured that the hospital's policies and procedures, physician certifications of transfers, etc., are in compliance with the requirements of 42 CFR §489.24 and the related requirements at 42 CFR §489.20(l), (m), (q), and (r). If the allegation(s) is confirmed, the investigation would continue, but with an emphasis on the hospital's compliance within the last 6 months.

Ensure that the case(s), if substantiated, is (are) fully documented on Form CMS-2567, Statement of Deficiencies and Plan of Correction. The investigation paperwork should be completed within ten working days following completion of the onsite survey if it appears there may be a violation of §§1866 and 1867 of the Act (**the paperwork is to be in the RO possession by the 20th working day or less following completion of the onsite survey. This includes the 5 days allowed to complete the onsite investigation**). If there appears not to be a violation, and the responsibilities of Medicare participating hospitals in emergency cases appear to be met, the time frame to complete the paperwork and return to the RO may be extended to 15 working days (**the paperwork is to be in the RO possession by the 25th working day or less following completion of the onsite survey. This includes the 5 days allowed to complete the onsite investigation**).

Once the investigation is complete the RO is strongly encouraged to share as much information with the hospital as possible in accordance with the Privacy Act and the Health Insurance Portability and Accountability Act (HIPAA) regarding the complaint and investigation. The RO may also include any facts about the violation, a copy of any medical reviews (the identity of the reviewer must be deleted), and the identity of the patient involved (not the identity of the complainant or source of the complaint). CMS will determine if the violation constitutes immediate jeopardy to patient health and safety.

The hospital has the opportunity to present evidence to CMS that it believes demonstrates its compliance and the opportunity to comment on evidence CMS believes demonstrates

the hospital's noncompliance. CMS' regional offices retain delegated enforcement authority and final enforcement decisions are made there**.**

III. Task 1 - Entrance Conference

A brief entrance conference must be held with the CEO/president of the hospital (or his or her designee) and any other staff the CEO considers appropriate to explain the nature of the allegation, the purpose of the investigation, and the requirements against which the complaint will be investigated. The identity of the complainant and patient must always be kept confidential unless written consent is obtained. Ask the CEO to have the staff provide you with the following information (as appropriate):

- Dedicated ED logs for the past 6-12 months;
- The dedicated ED policy/procedures manual (review triage and assessment of patients presenting to the ED with emergency medical conditions, assessment of labor, transfers of individuals with emergency medical conditions, etc.);
- Consent forms for transfers of unstable individuals;
- Dedicated ED committee meeting minutes for the past 12 months;
- Dedicated ED staffing schedule (physicians for the past 3 months and nurses for the last 4 weeks) or as appropriate;
- Bylaws/rules and regulations of the medical staff;
- Minutes from medical staff meetings for the past 6-12 months;
- Current medical staff roster;
- Physician on-call lists for the past 6 months;
- Credential files (to be selected by you) include the director of the emergency department and emergency department physicians. Review of credentials files is optional. However, if there has been a turnover in significant personnel (e.g., the ED director) or an unusual turnover of ED physicians, or a problem is identified during record review of a particular physician's screening or treatment in the ER, credentials files should be obtained and reviewed;
- Quality Assessment and Performance Improvement (QAPI) Plan (formally known as Quality Assurance);
- QAPI minutes (request the portion of the quality improvement minutes and plan, which specifically relates to EMTALA regulations. If a problem is identified that

would require a more thorough review, additional portions of the quality improvement plan and minutes may be requested for review);

- List of contracted services (request this list if a potential violation of §1866 and 1867 of the Act is noted during the investigation and the use of contracted services is questioned);

- Dedicated ED personnel records (optional);

- In-service training program records, schedules, reports, etc. (optional review if questions arise through interview and record review regarding the staff's knowledge of 42 CFR §489.24);

- Ambulance trip reports and memoranda of transfer, if available (to be selected by you if the cases you are reviewing concern transfers); and

- Ambulance ownership information and applicable State/regional/community EMS protocols.

In addition, if the case you are investigating occurred prior to the time frames mentioned, examine the above records for a three-month period surrounding the date of the alleged violation.

Inform the CEO that you will be selecting a sample of cases (medical records) for review from the ED log and that you will require those records in a timely fashion.

IV. Task 2 - Case Selection Methodology

Even though a single occurrence is considered a violation a sample is done to identify additional violations and/or patterns of violations.

A. **Sample Size**. Select 20-50 records to review in depth, using the selection criteria described below. The sample is not intended to be a statistically valid sample and the sample selection should be focused on potential problem areas. The sample size should be expanded as necessary in order to adequately investigate possible violations or patterns of violations.

B. **Sample Selection**. The type of records sampled will vary based on the nature of the complaint and the types of patients requesting emergency services. Do not allow the facility staff to select the sample. Use the emergency department log and other appropriate information, such as patient charts, to identify:

- Individuals transferred to other facilities;

- Gaps, return cases, or nonsequential entries in the log;

- Refusals of examination, treatment, or transfer;
- Patients leaving against medical advice or left without being seen (LWBS); and
- Patients returning to the emergency department within 48 hours.

Sample selection requires that:

1. You identify the number of emergency cases seen per month for each of the 6 months preceding the survey. Place this information on Form CMS-1541B, "Responsibilities of Medicare Participating Hospitals in Emergency Cases Investigation Report," (Exhibit 137).

2. You identify the number of transfers of emergency patients to other acute care hospitals per month for each of the preceding 6 months. Review in-depth, transfers of patients where it appears that the transferring hospital could have provided continuing medical care. Place this information on Form CMS-1541B.

3. You include the complaint case (s) in the sample, regardless of how long ago it occurred. Select other cases at the time of the complaint in order to identify patterns of hospital behavior and to help protect the identity of the patient.

4. If the complaint case did not involve an inappropriate transfer (e.g., the complaint was for failure to provide an adequate screening examination, or a hospital with specialized capabilities refused an appropriate transfer), identify similar cases and review them.

5. If you identify additional violations, determine, if possible, whether there is a pattern related to:

    - Diagnosis (e.g., labor, AIDS, psych);
    - Race;
    - Color;
    - Type of health insurance (Medicaid, uninsured, under-insured, or managed care);
    - Nationality; or
    - Disability.

Representative Sample Size for the dedicated emergency department if applicable:

The SA surveyor should consult with the RO prior to conducting the representative sample of patient visits for a hospital department to determine whether the department meets the criteria of being a dedicated emergency department.

To determine if a hospital department is a dedicated emergency department because it meets the "one-third requirement" described above (i.e., the hospital, in the preceding year, had at least one-third of all of its visits for the treatment of EMCs on an urgent basis without requiring a previously scheduled appointment) the surveyor is to select a representative sample of patient visits that occurred the previous calendar year in the area of the hospital to be evaluated for status as a dedicated emergency department. This includes individuals who may present as unscheduled ambulatory patients to units (such as labor and delivery or psychiatric units of hospitals) where patients are routinely admitted for evaluation and treatment. The surveyors will review the facility log, appointment roster and other appropriate information to identify patients seen in the area or facility in question. Surveyors are to review 20 - 50 records of patients with diagnoses or presenting complaints, which may be associated with an emergency medical condition (e.g., cardiac, respiratory, pediatric patients (high fever, lethargic), loss of consciousness, etc.). Surveyors have the discretion (in consultation with the regional office) to expand the sample size as necessary in order to adequately investigate possible violations or patterns of violations. Do not allow the facility staff to select the sample. Review the selected cases to determine if patients had an emergency medical condition and received stabilizing treatment. If at least one-third of the sample cases reviewed were for the treatment of EMCs on an urgent basis without requiring a previously scheduled appointment, the area being evaluated is a dedicated emergency department, and therefore, the hospital has an EMTALA obligation. Hospitals that may meet this one-third criterion may be specialty hospitals (such as psychiatric hospitals), hospitals without "traditional" emergency departments, and urgent care centers. In addition, it is not relevant if the entity that meets the definition of a dedicated ED is not located on the campus of the main hospital.

Guidelines to determine if a department of a hospital meets the one-third criteria of being a dedicated emergency department:

For each case, the surveyors should answer three questions.

1. Was the individual an outpatient?

   Y N If not, what was his or her status (e.g., inpatient, visitor or other)?

2. Was the individual a walk-in (unscheduled appointment)?

   Y N

3. Did the individual have an EMC, and received stabilizing treatment?

   Y N

   (**NOTE**- an affirmative yes must be present for both parts of this question for the case to be counted toward the one-third criterion to be met. If **no** is answered for any part of this question, the criterion was **not met**, and select no for the overall answer).

All questions must have an answer of yes to confirm that the case is included as part of the percentage (one-third) to determine if the hospital has a dedicated emergency department. If one-third of the total cases being reviewed receive answers of "yes" to the three questions above, then the hospital has an EMTALA obligation.

Document information concerning your sample selection on a blank sheet of paper or SA worksheet and label it "Summary Listing of Sampled Cases." Include the dates the individuals requested services, any identifier codes used to protect the individual's confidentiality, and the reasons for your decision to include these individuals in your sample.

V. Task 3- Record Review

While surveyors may make preliminary findings during the course of the investigation, a physician must usually determine the appropriateness of the MSE, stabilizing treatment, and transfer. Because expert medical review is usually necessary, obtain copies of the medical and other record(s) of the alleged violation case (both hospitals if an individual sought care at two hospitals or were transferred) and any other violation cases identified in the course of the investigation.

Also, review documents pertaining to QAPI activities in the emergency department and remedial actions taken in response to a violation of these regulations. Document hospital corrective actions taken prior to the survey and take such corrective action into account when developing your recommendation to the RO.

In an accredited hospital, if it appears that CoPs are not met, contact the RO for authorization to extend the investigation. If you are conducting the investigation in a non-accredited hospital, you may expand the investigation to include other conditions without contacting the RO first. When there is insufficient information documented on the emergency record regarding a request for emergency care, it may be helpful to interview hospital staff, physicians, witnesses, ambulance personnel, the individual, or the individual's family. Ask for RO guidance if you are still unable to obtain a consistent and reliable account of what happened.

Any time delivery of a baby occurs during transfer, obtain a copy of all available records and refer the case for review to the QIO physician reviewer.

If you are unsure whether qualified personnel and or transportation equipment were used to effectuate a transfer, review the hospital's transfer policies, and obtain a copy of the medical record and transfer records.

In cases where treatment is rendered to stabilize an EMC, the medical records should reflect the medically indicated treatment necessary to stabilize it, the medications, treatments, surgeries and services rendered, and the effect of treatment on the individual's emergency condition or on the woman's labor and the unborn child.

The medical records should contain documentation such as: medically indicated screenings, tests, mental status evaluation, impressions, and diagnoses (supported by a history and physical examination, laboratory, and other test results) as appropriate.

For pregnant women, the medical records should show evidence that the screening examination included ongoing evaluation of fetal heart tones, regularity and duration of uterine contractions, fetal position and station, cervical dilation, and status of the membranes, i.e., ruptured, leaking, intact.

For individuals with psychiatric symptoms, the medical records should indicate an assessment of suicide or homicide attempt or risk, orientation, or assaultive behavior that indicates danger to self or others.

In cases where an individual (or person acting in the individual's behalf) withdrew the initial request for a medical screening examination (MSE) and/or treatment for an EMC and demanded his or her transfer, or demanded to leave the hospital, look for a signed informed refusal of examination and treatment form by either the individual or a person acting on the individual's behalf. Hospital personnel must inform the individual (or person acting on his or her behalf) of the risks and benefits associated with the transfer or the patient's refusal to seek further care. If the individual (or person acting in the individual's behalf) refused to sign the consent form, look for documentation by the hospital personnel that states that the individual refused to sign the form. The fact that an individual has not signed the form is not, however, automatically a violation of the

screening requirement. Hospitals must, under the regulations, use their best efforts to obtain a signature from an individual refusing further care.

Examine the ambulance trip reports in questionable transfer cases (if available). These records can answer questions concerning the appropriateness of a transfer and the stability of the individual during the transfer.

Appropriate record review should also be conducted at the receiving (or recipient) hospital if the alleged case and any other suspicious transfer cases involve the transfer or movement of the individual to another hospital.

Document all significant record review findings in the complaint investigation narrative.

VI. Task 4- Interviews

To obtain a clear picture of the circumstances surrounding a suspected violation of the special responsibilities of Medicare hospitals in emergency cases, it is necessary to interview facility staff. For example, you may be able to gather a great deal of information from the admitting clerk in the emergency department, the nurses on shift at the time the individual sought treatment, and the Director of Quality Improvement in the hospital to name a few. You may also need to interview witnesses, the patient, and/or the patient's family. The physician(s) involved in the incident should be interviewed. Document each interview you conduct on a blank sheet of paper or SA worksheet and label it "Summary of Interviews." Include the following information, as appropriate, in your notes for each interview:

- The individual's job title and assignment at the time of the incident;
- Relationship to the patient and/or reason for the interview; and
- Summary of the information obtained.

Appropriate interviews should also be conducted at the receiving hospital in cases of transfer or movement of the individual to another hospital.

VII. Task 5-Exit Conference

The purpose of the exit conference is to inform the hospital of the scope of the investigation, including the nature of the complaint, investigation tasks, and requirements investigated, and any hospital CoPs surveyed. Explain to the hospital staff the consequences of a violation of the requirements in 42 CFR §489.24 or the related requirements in 42 CFR §489.20(l), (m), (q), and (r) and the time frames that will be followed if a violation is found. Do not tell the hospital whether or not a violation was identified since it is the responsibility of the RO to make that determination. Inform the CEO (or his or her designee) that the RO will make the determination of compliance

based on the information collected during this investigation and any additional information acquired from physician review of the case. Do not leave a draft of the deficiencies of Form CMS-2567 with the hospital. Inform the hospital that the RO will send that information to the hospital once it is complete.

VIII. Task 6- Professional Medical Review

The purpose of a professional medical review (physician review) is to provide peer review using information available to the hospital at the time the alleged violation took place. Physician review is required prior to the imposition of CMPs or the termination of a hospital's provider agreement to determine if:

- The screening examination was appropriate. Under EMTALA, the term "appropriate" does not mean "correct", in the sense that the treating emergency physician is not required to correctly diagnose the individual's medical condition. The fact that a physician may have been negligent in his screening of an individual is not necessarily an EMTALA violation. When used in the context of EMTALA, "appropriate" means that the screening examination was suitable for the symptoms presented and conducted in a non-disparate fashion. Physician review is not necessary when the hospital did not screen the individual;

- The individual had an emergency medical condition. The physician should identify what the condition was and why it was an emergency (e.g., what could have happened to the patient if the treatment was delayed);

- In the case of a pregnant woman, there was inadequate time to affect a safe transfer to another hospital before delivery, or the transfer posed a threat to the health and safety of the woman or the unborn child;

- The stabilizing treatment was appropriate within a hospital's capability (**NOTE** that the clinical outcome of an individual's medical condition is not the basis for determining whether an appropriate screening was provided or whether the person transferred was stabilized);

- The transfer was effected through qualified personnel and transportation equipment, including the use of medically appropriate life support measures;

- If applicable, the on-call physician's response time was reasonable; and

- The transfer was appropriate for the individual because the individual; requested the transfer or because the medical benefits of the transfer outweighed the risk.

If you recommend a medical review of the case, indicate on Form CMS-1541B that you recommend such a review.

IX. Task 7- Assessment of Compliance and Completion of the Deficiency Report

A. **Analysis**. Analyze your findings relative to each provision of the regulations for the frequency of occurrence, dates of occurrence, and patterns in terms of race, color, diagnosis, nationality, handicap, and financial status. A single occurrence constitutes a violation and is sufficient for an adverse recommendation. Older cases where the hospital implemented corrective actions with no repeat violations may require consultation with the RO concerning appropriate recommendations.

If a team conducted the investigation, the team should meet to discuss the findings. Consider information provided by the hospital. Ask the hospital for additional information or clarification about particular findings, if necessary.

Review each regulation tag number sequentially in this Appendix, and come to a consensus as to whether or not the hospital complies with each stated requirement. The following outline may be helpful in this review. For each requirement recommended as not met, record all salient findings on the Form CMS-2567.

Outline of Data Tags Used for Citing Violations of Responsibilities of Medicare Participating Hospitals in Emergency Cases

Deficiency Tags	Requirements
A400	(§489.20) Policies and Procedures Which Address Anti-Dumping Provisions
A401	(§489.20(m)) Receiving Hospitals Must Report Suspected Incidences of IndividualsWith An Emergency Medical Condition Transferred in Violation of §489.24(e)
A402	(§489.20(q)) Sign Posting
A403	(§489.24(r)) Maintain Transfer Records for Five Years
A404	(§489.20(r)(2); §489.24(j)) On-Call Physicians
A405	(§489.20(r)(3)) Logs

Deficiency Tags	Requirements
A406	(§489.24(a); §489.24(c)) Appropriate Medical Screening Examination
A407	(§489.24(d)(3)) Stabilizing Treatment (§489.24(d)(4))
A408	(§489.24(d)(4) and (5)) No Delay in Examination or Treatment in Order to Inquire About Payment Status
A409	(§489.24 (e)(1) and (2)) Appropriate Transfer
A410	(§489.24(e)(3)) Whistleblower Protections
A411	(§489.24(f)) Recipient Hospital Responsibilities (Nondiscrimination)

B. **Composing the Statement of Deficiencies (Form CMS-2567)**. Support all deficiency citations by documenting evidence obtained from your interviews and record reviews on Form CMS-2567, "Statement of Deficiencies and Plan of Correction." Deficiencies related to the Conditions of Participation should also be documented on Form CMS-2567. Indicate whether your findings show that the deficiency constitutes an immediate jeopardy to patient health and safety (e.g., a situation that prevents individuals from getting medical screening examinations and/or a lack of treatment reflecting both the capacity and capability of the hospital's full resources, as guaranteed under §1867 of the Act). Some examples include stabilizing treatment not provided when required; failure of an on-call physician to respond appropriately, improper transfer; or evidence that there was a denial of medical screening examinations and/or treatment to persons with emergency medical conditions as a direct result of requesting payment information before assessment of the individual's medical condition. Examples of noncompliance, which usually does not pose an immediate jeopardy, include the following scenarios:

1. A transfer which was appropriate, but the physician certification was not signed or dated by the physician;

2. An appropriate, functioning central log that on one particular day in not fully completed; and

3. A written hospital policy that is missing, but nonetheless being implemented.

Do not make a medical judgment, but focus on the processes of the facility "beyond the paper." Identify whether single incidents of patient dumping, which do not represent a hospital's customary practice, are nonetheless serious and capable of being repeated.

Immediate jeopardy violations require a 23-day termination track. Non-immediate jeopardy violations require a 90-day termination track.

Write the deficiency statement in terms specific enough to allow a reasonably knowledgeable person to understand the aspect(s) of the requirement(s) that is (are) not met. **Do not prescribe an acceptable remedy**. Indicate the data prefix tag and regulatory citation, followed by a summary of the deficiency and supporting findings. When it is necessary to use specific examples, use individual identifier codes, not individual names.

The emergency services condition, or any other condition, is not automatically found out of compliance based on a violation of 42 CFR §489.20 and/or 42 CFR §489.24. A determination of noncompliance must be based on the regulatory requirements for the individual condition.

X. Additional Survey Report Documentation

Upon completion of each investigation, the team leader assures that the following additional documentation has been prepared for submission, along with Forms CMS-1541B, CMS-562, CMS-2567, and a copy of the medical record(s) to the RO:

A. **Summary Listing of Sample Cases and Description of Sample Selection (See Task 2).** At a minimum, identify:

- The name of each individual chosen to be a part of the sample and the date of their request for emergency services;
- Any individual identifier codes used as a reference to protect the individual's confidentiality;
- The reason for including the individual in the sample (e.g., unstabilized transfer, lack of screening, lack of treatment, failure to stabilize, diagnosis, race, color, financial status, handicap, nationality); and
- Include a copy of the medical record(s) for all individuals where the hospital violated the provisions in 42 CFR §489.24.

Also identify:

- How the sample was selected;
- The number of individuals in the sample; and
- Any overall characteristics of the individuals in the sample, such as race, color, nationality, handicap, financial status, and diagnosis.

B. **Summary of Interviews (See Task 4)**. Document interviews conducted with patients, families, staff, physicians, administrators, managers, and others. At a minimum, include the individual's job title and/or assignment at the time of the incident, the relationship to the patient and/or reason for the interview, and a summary of the information obtained in each interview.

C. **Complaint Investigation Narrative (See Task 3)**. Summarize significant findings in the medical records, meeting minutes, hospital policies and procedures, staffing schedules, quality assurance plans, hospital by-laws, rules and regulations, training programs, credential files, personnel files, and contracted services reviewed in the course of the investigation. Briefly summarize your findings in the investigation and the rationale used for the course of action recommended to the RO.

Part II - Interpretive Guidelines - Responsibilities of Medicare Participating Hospitals in Emergency Cases

The Interpretive Guidelines is a tool for surveyors where the regulation is broken into regulatory citations (tag numbers), followed by the regulation language and provides detailed interpretation of the regulation(s) to surveyors.

Basic Section 1866 Commitments Relevant to Section 1867 Responsibilities – Tags A-2400/C2400 – A2405/C2405

(Rev. 46, Issued: 05-29-09, Effective/Implementation: 05-29-09)

Tag A-2400/C-2400

(Rev. 46, Issued: 05-29-09, Effective/Implementation: 05-29-09)

§489.20(l)

[The provider agrees to the following:]

(l) In the case of a hospital as defined in §489.24 (b) to comply with §489.24 .

Interpretive Guidelines: §489.20(l)

The term "hospital" is defined in §489.24(b) as including critical access hospitals as defined in §1861(mm)(1) of the Act. Therefore, a critical access hospital that operates a dedicated emergency department (as that term is defined below) is subject to the requirements of EMTALA.

Section 42 CFR 489.20(l) of the provider's agreement requires that hospitals comply with 42 CFR 489.24, special responsibilities of Medicare hospitals in emergency cases. Under the provisions of §489.24, hospitals with an emergency department that participate in Medicare are required under EMTALA to do the following:

- Provide an appropriate MSE to any individual who comes to the emergency department;
- Provide necessary stabilizing treatment to an individual with an EMC or an individual in labor;
- Provide for an appropriate transfer of the individual if either the individual requests the transfer or the hospital does not have the capability or capacity to

provide the treatment necessary to stabilize the EMC (or the capability or capacity to admit the individual);

- Not delay examination and/or treatment in order to inquire about the individual's insurance or payment status;

- Obtain or attempt to obtain written and informed refusal of examination, treatment or an appropriate transfer in the case of an individual who refuses examination, treatment or transfer; and

- Not take adverse action against a physician or qualified medical personnel who refuses to transfer an individual with an emergency medical condition, or against an employee who reports a violation of these requirements.

Further, any participating Medicare hospital is required to accept appropriate transfers of individuals with emergency medical conditions if the hospital has the specialized capabilities not available at the transferring hospital, and has the capacity to treat those individuals.

Hospitals are required to adopt and enforce a policy to ensure compliance with the requirements of §489.24. Noncompliance with EMTALA requirements will lead CMS to initiate procedures for termination from the Medicare program. Noncompliance may also trigger the imposition of civil monetary penalties by the Office of the Inspector General.

Surveyors review the following documents to help determine if the hospital is in compliance with the requirement(s):

- Review the bylaws, rules, and regulations of the medical staff to determine if they reflect the requirements of §489.24 and the related requirements at §489.20.

- Review the emergency department policies and procedure manuals for procedures related to the requirements of §489.24 and the related requirements at §489.20.

If a hospital violates §489.24, surveyors are to cite a corresponding violation of §489.20(l), Tag A-2400/C-2400.

Tag A-2401/C-2401

(Rev. 46, Issued: 05-29-09, Effective/Implementation: 05-29-09)
§489.20(m)

[The provider agrees to the following:]

In the case of a hospital as defined in §489.24(b), to report to CMS or the State survey agency any time it has reason to believe it may have received an individual who has been transferred in an unstable emergency medical condition from another hospital in violation of the requirements of §489.24(e).

Interpretive Guidelines: §489.20 (m)

A hospital (recipient) that suspects it may have received an improperly transferred (transfer of an unstable individual with an emergency medical condition who was not provided an appropriate transfer according to §489.24(e)(2)), individual is required to promptly report the incident to CMS or the State Agency (SA) within 72 hours of the occurrence. If a recipient hospital fails to report an improper transfer, the hospital may be subject to termination of it's provider agreement according to 42 CFR489.53(a).

Surveyors are to look for evidence that the recipient hospital knew, or suspected the individual had been to a hospital prior to the recipient hospital, and had not been transferred in accordance with §489.24(e). Evidence may be obtained in the medical record or through interviews with the individual, family members or staff.

Review the emergency department log and medical records of patients received as transfers. Look for evidence that:

- The hospital had agreed in advance to accept the transfers;
- The hospital had received appropriate medical records;
- All transfers had been effected through qualified personnel, transportation equipment and medically appropriate life support measures; and
- The hospital had available space and qualified personnel to treat the patients.

Tag A-2402/C-2402

(Rev. 46, Issued: 05-29-09, Effective/Implementation: 05-29-09)

§489.20(q)

[The provider agrees to the following:]

In the case of a hospital as defined in §489.24 (b)—

(1) To post conspicuously in any emergency department or in a place or places likely to be noticed by all individuals entering the emergency department, as well as those individuals waiting for examination and treatment in areas other than traditional emergency department (that is, entrance, admitting area, waiting room, treatment area) a sign (in a form specified by the Secretary) specifying the rights of individuals under section 1867 of the Act with respect to examination and treatment of emergency medical conditions and women in labor; and

(2) To post conspicuously (in a form specified by the Secretary) information indicating whether or not the hospital or rural primary care hospital (e.g., critical access hospital) participates in the Medicaid program under a State plan approved under Title XIX;

Interpretive Guidelines: §489.20(q)(1) and (2)

Section 1866(a)(1)(N)(iii) of the Act requires the posting of signs which specify the rights of individuals with EMCs and women in labor.

To comply with the requirements hospital signage must at a minimum:

- Specify the rights of individuals with EMCs and women in labor who come to the emergency department for health care services;
- Indicate whether the facility participates in the Medicaid program;
- The wording of the sign(s) must be clear and in simple terms and language(s) that are understandable by the population served by the hospital; and
- The sign(s) must be posted in a place or places likely to be noticed by all individuals entering the emergency department, as well as those individuals waiting for examination and treatment (e.g., entrance, admitting area, waiting room, treatment area).

Tag A-2403/C-2403

(Rev. 46, Issued: 05-29-09, Effective/Implementation: 05-29-09)

§489.20(r)

[The provider agrees to the following:]

In the case of a hospital as defined in §489.24(b) (including both the transferring and receiving hospitals), to maintain—

(1) Medical and other records related to individuals transferred to or from the hospital for a period of 5 years from the date of transfer;

Interpretive Guidelines: §489.20(r)(1)

The medical records of individuals transferred to or from the hospital must be retained in their original or legally reproduced form in hard copy, microfilm, microfiche, optical disks, computer disks, or computer memory for a period of 5 years from the date of transfer.

Tag A-2404/C-2404

(Rev. 46, Issued: 05-29-09, Effective/Implementation: 05-29-09)

§489.20(r)(2)

[The provider agrees to the following:

In the case of a hospital as defined in §489.24(b) (including both the transferring and receiving hospitals), to maintain--]

(2) An on-call list of physicians who are on the hospital's medical staff or who have privileges at the hospital, or who are on staff or have privileges at another hospital participating in a formal community call plan, in accordance with §489.24(j)(2)(iii), available to provide treatment necessary after the initial examination to stabilize individuals with emergency medical conditions who are receiving services under §489.24 in accordance with the resources available to the hospital;

§489.24(j) - Availability of On-call Physicians

In accordance with the on-call requirements specified in §489.20(r)(2), a hospital must have written policies and procedures in place--

(1) To respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control;

(2) To provide that emergency services are available to meet the needs of individuals with emergency medical conditions if a hospital elects to—

(i) Permit on-call physicians to schedule elective surgery during the time they are on call

(ii) Permit on-call physicians to have simultaneous on-call duties;

(iii) Participate in a formal community call plan. Notwithstanding participation in a community call plan, hospitals are still required to perform medical screening examinations on individuals who present seeking treatment and to conduct appropriate transfers. The formal community call plan must include the following elements:

(A) A clear delineation of on-call coverage responsibilities; that is, when each hospital participating in the plan is responsible for on-call coverage.

(B) A description of the specific geographic area to which the plan applies.

(C) A signature by an appropriate representative of each hospital participating in the plan.

(D) Assurances that any local and regional EMS system protocol formally includes information on community-call arrangements.

(E) A statement specifying that even if an individual arrives at a hospital that is not designated as the on-call hospital, that hospital still has an obligation under §489.24 to provide a medical screening examination and stabilizing treatment within its capability, and that hospitals participating in the community call plan must abide by the regulations under §489.24 governing appropriate transfers.

(F) An annual assessment of the community call plan by the participating hospitals.

Interpretive Guidelines §489.20(r)(2) and §489.24(j)

On-Call List Requirements and Options

Section 1866(a)(1)(I)(iii)of the Act states, as a requirement for participation in the Medicare program, that hospitals must maintain a list of physicians who are on-call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition. This on-call list requirement is a general provider agreement requirement for all hospitals and is thus technically an "EMTALA-related" requirement rather than a specific requirement of the EMTALA portion of the Act. When determining compliance with the on-call list requirement as part of an EMTALA survey it must be remembered that the on-call list requirement applies not only to hospitals with dedicated emergency departments, but also to hospitals subject to EMTALA requirements to accept appropriate transfers. (See discussion of §489.24(f).) The on-call list clearly identifies and ensures that the hospital's personnel is prospectively aware of which physicians, including specialists and sub-specialists, are available to provide stabilizing treatment for individuals with emergency medical conditions.

The list of on-call physicians must be composed of physicians who are current members of the medical staff or who have hospital privileges. If the hospital participates in a community call plan then the list must also include the names of physicians at other hospitals who are on-call pursuant to the plan. The list must be up-to-date, and accurately reflect the current privileges of the physicians on-call. Physician group names are not acceptable for identifying the on-call physician. Individual physician names are to be identified on the list with their accurate contact information.

Hospital administrators and the physicians who provide the on-call services have flexibility regarding how to configure an on-call coverage system. Several options to enhance this flexibility are permitted under the regulations. It is crucial, however, that hospitals are aware of their responsibility to ensure that they are providing sufficient on-call services to the meet the needs of their community in accordance with the resources they have available. CMS expects a hospital to strive to provide adequate specialty on-call coverage consistent with the services provided at the hospital and the resources the hospital has available. (73 FR 48662).

<u>Permitted On-Call Options</u>

Community Call Plan

CMS permits hospitals to satisfy their on-call obligations through participation in a community call plan (CCP). It is strictly voluntary. Under such a community on-call plan, a hospital may augment its on-call list by adding to it physicians at another hospital. There are different ways a CCP could be organized. For example, if there are two hospitals that choose to participate in community call, Hospital A could be designated as the on-call facility for the first 15 days of the month and Hospital B could be designated as the on-call facility for the remaining days of the month. Alternatively, Hospital A

could be designated as on-call for cases requiring specialized interventional cardiac care, while Hospital B could be designated as on-call for neurosurgical cases.
Ideally, a CCP could allow various physicians in a certain specialty in the aggregate to be on continuous call (24 hours a day, 7 days a week) without putting a continuous call obligation at the participating hospitals on any one physician. Even if this ideal cannot be achieved, given the resources of the participating hospitals, at a minimum, hospitals choosing to participate in a CCP should to be able to provide more on-call specialty coverage than they would on their own.

The plan must clearly articulate which on-call services will be provided on which dates/times by each hospital participating in the plan. Furthermore, the DED in each hospital must have specific information based on the allocation of on-call responsibilities in the plan readily available as part of the on-call list, so that personnel who are providing required services to individuals protected under EMTALA know which specialists based in which hospital(s) are available on-call to provide the necessary specialist services.

Participation in a community call plan does not mean that on-call physicians must travel from the hospital where they practice to the hospital needing their on-call services. Instead, this arrangement facilitates appropriate transfers to the hospital providing the specialty on-call services pursuant to the plan. The hospital where the individual initially presents still has an EMTALA obligation to conduct a medical screening examination, and, for individuals found to have an emergency medical condition, to provide stabilizing treatment within its capability and capacity. However, when the individual is appropriately transferred pursuant to a CCP for further stabilizing treatment, it can generally be assumed that the transferring hospital has provided treatment within its capability and capacity and that its on-call list is adequate for that specialty. For example, if an individual requires the services of a neurologist on a date when the neurologist on-call pursuant to the CCP is based at hospital B, and that neurologist is part of hospital A's on-call list, then a transfer to hospital B to obtain the services of the neurologist on-call would be in order, assuming all other transfer requirements have been met.

In those cases where, for example, hospitals A and B participate in a CCP and a physician who is a member of the medical staff or has privileges at both hospitals is on-call directly at hospital B, but only indirectly through the CCP to hospital A, there is no regulatory prohibition against the on-call physician going to hospital A to provide the stabilizing treatment, rather than transferring the individual to hospital B. The treating and on-call physician might consider which approach is in the best interests of the patient and also maintains the availability of the on-call specialist pursuant to the CCP.

The regulations establish a number of specific requirements for community call plans:

- The plan must include the geographic parameters of the on-call coverage, indicating what patient origin areas the plan expects to service (e.g., certain communities, counties, regions, municipalities). CMS does not stipulate geographic criteria that a community call plan must meet, since the intent of the plan is to promote flexibility amongst the participating hospitals in

developing a call plan that best meets the needs of their communities and utilizes the resources within the region. Similarly, there is no requirement that all hospitals within a defined geographic area must participate in the community call plan.

Regardless of the geographic specifications of the community call plan, the existence of a CCP in a specific area does not eliminate the EMTALA obligations of hospitals with respect to making appropriate transfers. Among other things this means that:

- hospitals participating in the community call plan are not relieved of their recipient hospital obligations to accept appropriate transfers from hospitals not participating in the plan.

- non-participating hospitals must accept appropriate transfers, regardless of whether the transferring hospital participates in a CCP with the recipient hospital or any other hospital.

- non-participating hospitals must provide stabilizing treatment within their capability and capacity before seeking to transfer an individual to another hospital, regardless of whether the recipient hospital is providing on-call services to other hospitals pursuant to a CCP.

In other words, all Medicare-participating hospitals must fulfill their transfer responsibilities under EMTALA, notwithstanding the presence or absence of a transfer agreement and regardless of whether the transferring or recipient hospital is participating in a formal community call plan (73 FR 48667).

- The community call plan for each participating hospital must show evidence that the duly authorized representative of each hospital has officially signed the plan. The regulations do not require that the plan be signed by an appropriate representative as part of the annual assessment but it is expected that updated signatures would be included in any subsequent revision of the CCP.

- The delivery of pre-hospital medical services is quite varied throughout the country and there are no specific EMTALA requirements that pertain to the development of EMS protocols. However, if there are EMS protocols in effect in part or all of the areas served by the CCP, then there must be an attestation by the CCP-participating hospitals that the CCP arrangement information has been communicated to the EMS providers and will be updated as needed so that EMS providers have the opportunity to consider this information when developing protocols. In addition, hospitals which are in the process of developing and refining their own CCPs may want to consider including input from the EMS providers that serve their DEDs so

as to facilitate the efficient implementation of the CCP. For communities that do not have formalized EMS protocols, hospitals participating in a CCP would still be well-advised to inform individual EMS providers of the CCP arrangements amongst the hospitals in the geographic area specified in the plan.

- The formal language of the CCP must contain a statement that each hospital participating in the CCP will continue to follow the regulations requiring the provision of MSEs, and stabilizing treatment for individuals determined to have EMCs.

- Hospitals must conduct an annual reassessment of their CCP, including an analysis of the specialty on-call needs of the communities for which the CCP is effective (73 FR 48665). It is expected that the CCP would expand specialty coverage to the communities served by the plan and improve, within the hospitals' capabilities and capacities, the adequacy of the on-call list for the hospitals participating in the plan. CMS expects the annual assessment to support a Quality Assurance/Performance Improvement approach to the functioning of the CCP, and that hospitals would, as necessary and feasible, adjust the CCP based on the annual reassessment. Hospitals participating in the CCP have flexibility to determine how to design and implement the assessment.

Simultaneous Call

Hospitals are permitted to allow physicians to be on-call simultaneously at two or more facilities. Hospitals are also permitted to adopt a policy that does not allow physicians to take simultaneous call at more than one hospital. If a hospital permits simultaneous call, then it must have written policies and procedures to follow when the on-call physician is not available to respond because he/she has been called to another hospital. All hospitals where the physician is on-call need to be aware of the details of the simultaneous call arrangements for the physician and have back-up plans established.

Scheduled Elective Surgery

Hospitals are permitted to allow physicians to perform elective surgery or other procedures while they are on-call. Hospitals are also permitted to adopt a policy that does not allow physicians to perform elective surgery or other procedures while they are on-call. (Critical Access Hospitals (CAHs) should be aware that if they reimburse physicians for being on-call, there are Medicare payment policy regulations, outside the scope of EMTALA requirements, that the CAH might want to consider before making a decision to permit on-call physicians to schedule elective procedures.)

When a physician has agreed to be on-call at a particular hospital during a particular period of time, but also has scheduled elective surgery or an elective diagnostic or therapeutic procedure during that time as permitted by hospital policy, that physician and

the hospital must have planned back-up in the event the physician is called while performing elective surgery and is unable to respond to an on-call request in a reasonable time.

Medical Staff Exemptions

There is no EMTALA or Medicare provider agreement requirement for all physicians on the medical staff and/or having hospital privileges to take call. A hospital policy allowing exemptions to medical staff members (e.g., senior physicians) would not in of itself violate EMTALA-related Medicare provider agreement requirements. However, if a hospital permits physicians to selectively take call only for their own established patients who present to the ED for evaluation, then the hospital must be careful to assure that it maintains adequate on-call services, and that the selective call policy is not a substitute for the on-call services required by the Medicare provider agreement.

Other On-call List Regulatory Requirements

A hospital must have written on-call policies and procedures and must clearly define the responsibilities of the on-call physician to respond, examine and treat patients with an EMC. Among other things, the policies and procedures must address the steps to be taken if a particular specialty is not available or the on-call physician cannot respond due to circumstances beyond his/her control (e.g., transportation failures, personal illness, etc.). The policies and procedures must also ensure that the hospital provides emergency services that meet the needs of an individual with an EMC if the hospital chooses to employ any of the on-call options permitted under the regulations, i.e., community call, simultaneous call, or elective procedures while on-call. In other words, there must be a back-up plan to these optional arrangements. For instance, some hospitals may employ the use of "jeopardy" or back-up call schedules to be used only under extreme circumstances. The hospital must be able to demonstrate that hospital staff is aware of and able to execute the back-up procedures.

Assessment of On-call List Adequacy by Surveyors

CMS expects that a hospital should strive to provide adequate on-call coverage consistent with the services provided at the hospital and the resources the hospital has available, including the availability of specialists. (42 FR 48662). CMS does not have specified requirements regarding how frequently on-call physicians are expected to be available to provide on-call coverage. However, CMS recognizes that in order to supply safe and effective care it would not be prudent for a hospital to expect one physician to be on-call every day of the week, every week of the year. There is also no pre-determined ratio CMS uses to identify how many days a hospital must provide medical staff on-call coverage for a particular specialty based on the number of physicians on staff for that particular specialty. In particular, CMS has no rule stating that whenever there are at least three physicians in a specialty, the hospital must provide 24-hour/7-day coverage in that specialty.

If a hospital participates in a community call plan, its on-call list must reflect this. The plan does not have to be pre-approved or require formal authorization by CMS or any local, State or Federal agency, in order to be instituted. However, during a complaint investigation, the design and implementation of the CCP will come under review.

Generally, in determining a hospital's on-call list compliance, CMS will consider all relevant factors in a case-specific manner, including the number of physicians on the medical staff/holding hospital privileges, other demands on these physicians, the frequency with which individuals with EMCs typically require the stabilizing services of the hospital's on-call physicians, and the provisions the hospital has made for situations in which a physician on-call is not available or is unable to respond due to circumstances beyond his/her control.

For instance, if the hospital under investigation performs a significant amount of interventional cardiac catheterizations and holds itself out to the public through various advertising methods as a center of excellence in providing this specialized procedure to the community, it would be reasonable to expect that there would be adequate on-call coverage by a physician who is able to perform an emergent interventional cardiac procedure on individuals who present to that hospital's DED in need of such an intervention or who are appropriately transferred to that hospital for such an intervention. On the other hand, it may not be reasonable to expect a CAH to have an interventional radiologist on call if that service is not routinely provided at the CAH or in the local vicinity of the CAH, unless the CAH participates in a community call plan that provides for this service.

On-call Physician Appearance Requirements

Although the on-call list requirement is found in Section 1866, which is the provider agreement section of the Act, Section 1867, the EMTALA section of the Act, provides for enforcement actions against both a physician and a hospital when a physician who is on the hospital's on-call list fails or refuses to appear within a reasonable period of time after being notified to appear. Hospitals would be well-advised to make physicians who are on-call aware of the hospital's on-call policies and the physician's EMTALA obligations when on call.

If a physician is listed as on-call and requested to make an in-person appearance to evaluate and treat an individual, that physician must respond in person in a reasonable amount of time. If an individual presents to Hospital A with an EMC that requires the specialty services provided by Hospital B pursuant to the CCP, then the physician who is based at Hospital B is required to report to Hospital B to provide the stabilizing treatment for the individual who presented to Hospital A and was subsequently transferred to Hospital B.

When a physician is on-call for the hospital and seeing patients with scheduled appointments in his/her private office, it is generally not acceptable to refer emergency cases to his or her office for examination and treatment of an EMC. The physician must

come to the hospital to examine the individual if requested to do so by the treating physician. If, however, it is medically indicated, the treating physician may send an individual needing the specialized services of the on-call physician to the physician's office if it is a provider-based part of the hospital (i.e., department of the hospital sharing the same CMS certification number as the hospital) It must be clear that this transport is not done for the convenience of the specialist but that there is a genuine medical reason to move the individual, that all individuals with the same medical condition, regardless of their ability to pay, are similarly moved to the specialist's office, and that the appropriate medical personnel accompany the individual to the office.

If it is permitted under the hospital's policies, an on-call physician has the option of sending a representative, i.e., directing a licensed non-physician practitioner as his or her representative to appear at the hospital and provide further assessment or stabilizing treatment to an individual. This determination should be based on the individual's medical need and the capabilities of the hospital and the applicable State scope of practice laws, hospital by-laws and rules and regulations. There are some circumstances in which the non-physician practitioner can provide the specialty treatment more expeditiously than the physician on-call. It is important to note, however, that the designated on-call physician is ultimately responsible for providing the necessary services to the individual in the DED, regardless of who makes the in-person appearance. Furthermore, in the event that the treating physician disagrees with the on-call physician's decision to send a representative and requests the actual appearance of the on-call physician, then the on-call physician is required under EMTALA to appear in person. Both the hospital and the on-call physician who fails or refuses to appear in a reasonable period of time may be subject to sanctions for violation of the EMTALA statutory requirements.

There is no EMTALA prohibition against the treating physician consulting on a case with another physician, who may or may not be on the hospital's on-call list, by telephone, video conferencing, transmission of test results, or any other means of communication. CMS is aware that it is increasingly common for hospitals to use telecommunications to exchange imaging studies, laboratory results, EKGs, real-time audio and video images of patients and/or other clinical information with a consulting physician not on the hospital's premises. Such practices may contribute to improved patient safety and efficiency of care. In some cases it may be understood by the hospitals and physicians who establish such remote consulting arrangements that the physician consultant is not available for an in-person assessment of the individual at the treating physician's hospital. However, if a physician:

- is on a hospital's on-call list;
- has been requested by the treating physician to appear at the hospital; and
- fails or refuses to appear within a reasonable period of time;

then the hospital and the on-call physician may be subject to sanctions for violation of the EMTALA statutory requirements.

It is an entirely separate issue, outside the scope of EMTALA enforcement, whether or not insurers or other third party payers, including Medicare, will provide reimbursement to physicians who provide remote consultation services. Hospitals and/or physicians interested in Medicare reimbursement policy for telemedicine or telehealth services should consult Medicare Benefit Policy Manual, Pub. 100-02, Chapter 18, §270.

If a physician who is on-call, either directly, or indirectly pursuant to a CCP, refuses or fails to appear at the hospital where he/she is directly on call in a reasonable period of time, then that physician as well as the hospital may be found to be in violation of EMTALA. Likewise, if a physician who is on-call typically directs the individual to be transferred to another hospital instead of making an appearance as requested, then that physician as well as the hospital may be found to be in violation of EMTALA. While CMS' enforcement of the EMTALA section of the Act and regulations and the EMTALA-related provisions of the provider agreement section of the Act and regulations are directed solely against hospitals, it is important to note that Section 1867 of the Act also provides for the Office of the Inspector General (OIG) to levy civil monetary penalties or take other actions against hospitals or physicians for EMTALA violations. CMS refers cases it has investigated to the OIG when CMS finds violations that appear to fall within the OIG's EMTALA jurisdiction. Section 1867(d)(1)(C) of the Act specifically provides for penalties against both a hospital and the physician when a physician who is on-call either fails to appear or refuses to appear within a reasonable period of time. Thus, a hospital would be well-advised to establish in its on-call policies and procedures specific guidelines-- e.g., the maximum number of minutes that may elapse between receipt of a request and the physician's appearance for what constitutes a reasonable response time, and to make sure that its on-call physicians and other staff are aware of these time-sensitive requirements.

If a physician on-call does not fulfill his/her on-call obligation, but the hospital arranges in a timely manner for another of its physicians in that specialty to assess/stabilize an individual as requested by the treating physician in the DED, then the hospital would not be in violation of CMS' on-call requirements. However, if a physician on-call does not fulfill his/her on-call obligation and the individual is, as a result, transferred to another hospital, then the hospital may be in violation of CMS's requirements and both the hospital and the on-call physician may be subject to enforcement action by the OIG under the Act.

Tag A-2405/C-2405

(Rev. 46, Issued: 05-29-09, Effective/Implementation: 05-29-09)

Section 489.20(r)(3) - A central log on each individual who "comes to the emergency department," as defined in §489.24(b), seeking assistance and whether he or she refused treatment, was refused treatment, or whether he or she was transferred, admitted and treated, stabilized and transferred, or discharged.

Interpretive Guidelines: §489.20(r)(3)

The purpose of the central log is to track the care provided to each individual who comes to the hospital seeking care for an emergency medical condition.

Each hospital has the discretion to maintain the log in a form that best meets the needs of the hospital. The central log includes, directly or by reference, patient logs from other areas of the hospital that may be considered dedicated emergency departments, such as pediatrics and labor and delivery where a patient might present for emergency services or receive a medical screening examination instead of in the "traditional" emergency department. These additional logs must be available in a timely manner for surveyor review. The hospital may also keep its central log in an electronic format.

Review the emergency department log covering at least a 6-month period that contains information on all individuals coming to the emergency department and check for completeness, gaps in entries or missing information.

Section 489.24 - Special Responsibilities of Medicare Hospitals in Emergency Cases (Section 1867 EMTALA Requirements – Tags A2406/C2406 – A2411/C2411)

Tag A-2406/C-2406

(Rev. 60, Issued: 07-16-10, Effective: 07-16-10, Implementation: 07-16-10)

§489.24(a) - Applicability of Provisions of this Section

(1) In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) "comes to the emergency department", as defined in paragraph (b) of this section, the hospital must—

(i) Provide an appropriate medical screening examination within the

capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations and who meets the requirements of §482.55 of this chapter concerning emergency services personnel and direction; and

Interpretive Guidelines §489.24(a)(1)(i)

A "hospital with an emergency department" is defined in §489.24(b) as a hospital with a dedicated emergency department. An EMTALA obligation is triggered for such a hospital when an individual comes by him or herself, with another person, to a hospital's **dedicated emergency department** (as that term is defined above) and a request is made by the individual or on the individual's behalf, or a prudent layperson observer would conclude from the individual's appearance or behavior a need, for examination or treatment of a **medical condition.** In such a case, the hospital has incurred an obligation to provide an appropriate medical screening examination (MSE) for the individual and stabilizing treatment or an appropriate transfer. The purpose of the MSE is to determine whether or not an emergency medical condition exits.

If an individual who is not a hospital patient comes elsewhere on **hospital property** (that is, the individual comes to the hospital but not to the dedicated emergency department), an EMTALA obligation on the part of the hospital may be triggered if either the individual requests examination or treatment for an **emergency** medical condition or if a prudent layperson observer would believe that the individual is suffering from an **emergency** medical condition. The term "hospital property" means the entire main hospital campus as defined in §413.65(a), including the parking lot, sidewalk and driveway or hospital departments, including any building owned by the hospital that are within 250 yards of the hospital).

If an individual is registered as an outpatient of the hospital and they present on hospital property but not to a dedicated emergency department, the hospital does not incur an obligation to provide a medical screening examination for that individual if they have begun to receive a scheduled course of outpatient care. Such an individual is protected by the hospital Conditions of Participation (CoPs) that protect patient's health and safety and to ensure that quality care is furnished to all patients in Medicare-participating hospital. If such an individual experiences an EMC while receiving outpatient care, the hospital does not have an obligation to conduct an MSE for that patient. As discussed in greater detail below, such a patient has adequate protections under the Medicare CoPs and state law.

If an individual is initially screened in a department or facility on-campus outside of the ED, the individual could be moved to another hospital department or facility on-campus to receive further screening or stabilizing treatment without such movement being regarded as a transfer, as long as: (1) all persons with the same medical condition are

moved in such circumstances, regardless of their ability to pay for treatment; (2) there is bona fide medical reason to move the individual; and (3) appropriate medical personnel accompany the individual. The same is also true for an individual who presents to the dedicated emergency department (e.g., patient with an eye injury in need of stationary ophthalmology equipment located in the eye clinic) and must be moved to another hospital-owned facility or department on-campus for further screening or stabilizing treatment. The movement of the individual between hospital departments is not considered an EMTALA transfer under this section, since the individual is simply being moved from one department of a hospital to another department or facility of the same hospital.

Hospitals should not move individuals to off-campus facilities or departments (such as an urgent care center or satellite clinic) for a MSE. If an individual comes to a hospital-owned facility or department, which is off-campus and operates under the hospital's Medicare provider number, §1867 (42 CFR 489.24) will not apply to that facility and/or department unless it meets the definition of a dedicated emergency department.

If, however, such a facility does not meet the definition of a dedicated ED, it must screen and stabilize the patient to the best of its ability or execute an appropriate transfer if necessary to another hospital or to the hospital on whose Medicare provider number it is operated. Hospital resources and staff available at the main campus are likewise available to individuals seeking care at the off campus facilities or departments within the capability of the hospital. Movement of the individual to the main campus of the hospital is not considered a transfer since the individual is simply being moved from one department of a hospital to another department or facility of the same hospital. In addition, a transfer from such an entity (i.e., an off-campus facility that meets the definition of a dedicated ED) to a nonaffiliated hospital (i.e., a hospital that does not own the off-campus facility) is allowed where the facility at which the individual presented cannot stabilize the individual and the benefits of transfer exceed the risks of transfer. In other words, there is no requirement under EMTALA that the individual be always transferred back to the hospital that owns and operates the off-campus dedicated ED. Rather, the requirement of EMTALA is that the individual be transferred to an appropriate facility for treatment.

If a request were made for emergency care in a hospital department **off** the hospital's main campus that does not meet the definition of a dedicated emergency department, EMTALA would not apply. However, such an off-campus facility must have policies and procedures in place as how to handle patients in need of immediate care. For example, the off-campus facility policy may direct the staff to contact the emergency medical services/911 (EMS) to take the patient to an emergency department (not necessarily the emergency department of the hospital that operates the off-campus department, but rather the closest emergency department) or provide the necessary care if it is within the hospital's capability. Therefore, a hospital off-campus facility that does not meet the definition of a dedicated emergency department does not have an EMTALA obligation and not required to be staffed to handle potential EMC.

Medicare **hospitals** that do not provide emergency services must meet the standard of §482.12 (f) , which requires hospitals to have written policies and procedures for the appraisal of emergencies, initial treatment within its capability and capacity, and makes an appropriate referral to a hospital that is capable of providing the necessary emergency services.

If a hospital has an EMTALA obligation, it must screen individuals to determine if an EMC exists. It is not appropriate to merely "log in" an individual and not provide a MSE. An MSE is the process required to reach, with reasonable clinical confidence, the point at which it can be determined whether the individual has an EMC or not. An MSE is not an isolated event. It is an ongoing process that begins, but typically does not end, with triage.

Triage entails the clinical assessment of the individual's presenting signs and symptoms at the time of arrival at the hospital, in order to prioritize when the individual will be seen by a physician or other qualified medical personnel (QMP).

Individuals coming to the emergency department must be provided an MSE appropriate to the individuals' presenting signs and symptoms, as well as the capability and capacity of the hospital. Depending on the individual's presenting signs and symptoms, an appropriate MSE can involve a wide spectrum of actions, ranging from a simple process involving only a brief history and physical examination to a complex process that also involves performing ancillary studies and procedures, such as (but not limited to) lumbar punctures, clinical laboratory tests, CT scans, and/or other diagnostic tests and procedures. The medical record must reflect continued monitoring according to the individual's needs until it is determined whether or not the individual has an EMC and, if he/she does, until he/she is stabilized or appropriately transferred. There should be evidence of this ongoing monitoring prior to discharge or transfer.

The MSE must be the same MSE that the hospital would perform on any individual coming to the hospital's dedicated emergency department with those signs and symptoms, regardless of the individual's ability to pay for medical care. If a hospital applies in a nondiscriminatory manner (i.e., a different level of care must not exist based on payment status, race, national origin, etc.) a screening process that is reasonably calculated to determine whether an EMC exists, it has met its obligations under EMTALA. If the MSE is appropriate and does not reveal an EMC, the hospital has no further obligation under 42 CFR 489.24.

Regardless of a positive or negative individual outcome, a hospital would be in violation of the anti-dumping statute if it fails to meet any of the medical screening requirements under 42 CFR 489.24. The clinical outcome of an individual's condition is not a proper basis for determining whether an appropriate screening was provided or whether a person transferred was stable. However, the outcome may be a "red flag" indicating that a more thorough investigation is needed. Do not make decisions base on clinical information that was not available at the time of stabilizing or transfer. If an individual was

misdiagnosed, but the hospital utilized all of its resources, a violation of the screening requirement did not occur.

It is not impermissible under EMTALA for a hospital to follow normal registration procedures for individuals who come to the emergency department. For example, a hospital may ask the individual for an insurance card, so long as doing so does not delay the medical screening examination. In addition, the hospital may seek other information (not payment) from the individual's health plan about the individual such as medical history. And, in the case of an individual with an emergency medical condition, once the hospital has conducted the medical screening examination and has initiated stabilizing treatment, it may seek authorization for all services from the plan, again, as long as doing so does not delay the implementation of the required MSE and stabilizing treatment.

A hospital that is not a managed care plan's network of designated providers cannot refuse to screen and treat (or appropriately transfer, if the medical benefits of the transfer outweigh the risks or if the individual requests the transfer) individuals who are enrolled in the plan who come to the hospital if that hospital participates in the Medicare program.

Once an individual has presented to the hospital seeking emergency care, the determination of whether an EMC exists is made by the examining physician(s) or other qualified medical personnel of the hospital.

Medicare participating hospitals that provide emergency services must provide a medical screening examination to any individual regardless of diagnosis (e.g., labor, AIDS), financial status (e.g., uninsured, Medicaid), race, and color, national origin (e.g. Hispanic or Native American surnames), and/or disability, etc.

A hospital, regardless of size or patient mix, must provide screening and stabilizing treatment within the scope of its abilities, as needed, to the individuals with emergency medical conditions who come to the hospital for examination and treatment.

"Labor" is defined to mean the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman experiencing contractions is in true labor, unless a physician, certified nurse-midwife, or other qualified medical person acting within his or her scope of practice as defined in hospital medical staff bylaws and State law, certifies that, after a reasonable time of observation, the woman is in false labor.

An infant that is born alive is a "person" and an "individual" under 1 U.S.C. 8(a) and the screening requirement of EMTALA applies to "any individual" who comes to the emergency department. If an infant was born alive in a dedicated emergency department, and a request was made on that infant's behalf for screening for a medical condition (or if a prudent layperson would conclude, based on the infant's appearance or behavior, that the infant needed examination or treatment for a medical condition), the hospital and physician could be liable for violating EMTALA for failure to provide such a medical screening examination.

If an infant is born alive elsewhere on the hospital's campus (i.e., not in the hospital's dedicated emergency department) and a prudent layperson observer would conclude, based on the born-alive infant's appearance or behavior, that the infant was suffering from an emergency medical condition, the hospital and its medical staff are required to perform a medical screening examination on the infant to determine whether or not an emergency medical condition exists. Whether in the DED or elsewhere on the hospital's campus, if the physician or other authorized qualified medical personnel performing the medical screening examination determines that the infant is suffering from an emergency medical condition, the hospital has an obligation under EMTALA to provide stabilizing treatment or an appropriate transfer. If the hospital admits the infant, its obligation under EMTALA ends.

A minor (child) can request an examination or treatment for an EMC. The hospital is required by law to conduct the examination if requested by an individual or on the individual's behalf to determine if an EMC exists. Hospital personnel should not delay the MSE by waiting for parental consent. If after screening the minor, it is determined than no EMC is present, the staff can wait for parental consent before proceeding with further examination and treatment.

On-campus provider-based entities (such as rural health clinics or physician offices) are not subject to EMTALA, therefore it would be inappropriate to move individuals to these facilities for a MSE or stabilizing treatment under this Act.

If an individual is not on hospital property (which includes a hospital owned and operated ambulance), this regulation is not applicable. Hospital property includes ambulances owned and operated by the hospital, even if the ambulance is not on the hospital campus. An individual in a non-hospital owned ambulance, which is on hospital property is considered to have come to the hospital's emergency department. An individual in a non- hospital owned ambulance not on the hospital's property is not considered to have come to the hospital's emergency department when the ambulance personnel contact "Hospital A" by telephone or telemetry communications. If an individual is in an ambulance, regardless of whether the ambulance is owned by the hospital, a hospital may divert individuals when it is in "diversionary" status because it does not have the staff or facilities to accept any additional emergency patients at that time. However, if the ambulance is owned by the hospital, the diversion of the ambulance is only appropriate if the hospital is being diverted pursuant to community-wide EMS protocols. Moreover, if any ambulance (regardless of whether or not owned by the hospital) disregards the hospital's instructions and brings the individual on to hospital campus, the individual has come to the hospital and the hospital has incurred an obligation to conduct a medical screening examination for the individual.

Hospitals that deliberately delay moving an individual from an EMS stretcher to an emergency department bed do not thereby delay the point in time at which their EMTALA obligation begins. Furthermore, such a practice of "parking" patients arriving via EMS, refusing to release EMS equipment or personnel, jeopardizes patient health and

adversely impacts the ability of the EMS personnel to provide emergency response services to the rest of the community. Hospitals that "park" patients may also find themselves in violation of 42 CFR 482.55, the Hospital Condition of Participation for Emergency Services, which requires that hospitals meet the emergency needs of patients in accordance with acceptable standards of practice.

On the other hand, this does not mean that a hospital will necessarily have violated EMTALA and/or the hospital CoPs if it does not, in every instance, immediately assume from the EMS provider all responsibility for the individual, regardless of any other circumstances in the ED. For example, there may be situations when a hospital does not have the capacity or capability at the time of the individual's presentation to provide an immediate medical screening examination (MSE) and, if needed, stabilizing treatment or an appropriate transfer. So, if the EMS provider brought an individual to the dedicated ED at a time when ED staff was occupied dealing with multiple major trauma cases, it could under those circumstances be reasonable for the hospital to ask the EMS provider to stay with the individual until such time as there were ED staff available to provide care to that individual. However, even if a hospital cannot immediately complete an appropriate MSE, it must still assess the individual's condition upon arrival to ensure that the individual is appropriately prioritized, based on his/her presenting signs and symptoms, to be seen by a physician or other QMP for completion of the MSE. The hospital should also assess whether the EMS provider can appropriately monitor the individual's condition.

Should a hospital, which is not in diversionary status, fail to accept a telephone or radio request for transfer or admission, the refusal could represent a violation of other Federal or State requirements (e.g., Hill-Burton). If you suspect a violation of related laws, refer the case to the responsible agency for investigation.

The following two circumstances will not trigger EMTALA:

- The use of a hospital's helipad by local ambulance services or other hospitals for the transport of individuals to tertiary hospitals located throughout the State does not trigger an EMTALA obligation for the hospital that has the helipad on its property when the helipad is being used for the purpose of transit as long as the sending hospital conducted the MSE prior to transporting the individual to the helipad for medical helicopter transport to a designated recipient hospital. The sending hospital is responsible for conducting the MSE prior to transfer to determine if an EMC exists and implementing stabilizing treatment or conducting an appropriate transfer. Therefore, if the helipad serves simply as a point of transit for individuals who have received a MSE performed prior to transfer to the helipad, the hospital with the helipad is not obligated to perform another MSE prior to the individual's continued travel to the recipient hospital. If, however, while at the helipad, the individual's condition deteriorates, the hospital at which the helipad is located must provide another MSE and stabilizing treatment within its capacity **if requested** by medical personnel accompanying the individual.

- If as part of the EMS protocol, EMS activates helicopter evacuation of an individual with a potential EMC, the hospital that has the helipad does not have an EMTALA obligation if they are not the recipient hospital, **unless a request** is made by EMS personnel, the individual or a legally responsible person acting on the individual's behalf for the examination or treatment of an EMC.

Hospitals are not relieved of their EMTALA obligation to screen, provide stabilizing treatment and/or an appropriate transfer to individuals because of prearranged community or State plans that have designated specific hospitals to care for selected individuals (e.g., Medicaid patients, psychiatric patients, pregnant women). Hospitals located in those States which have State/local laws that require particular individuals, such as psychiatric or indigent individuals, to be evaluated and treated at designated facilities/hospitals may violate EMTALA if the hospital disregards the EMTALA requirements and does not conduct an MSE and provide stabilizing treatment or conduct an appropriate transfer prior to referring the individual to the State/local facility. If, after conducting the MSE and ruling out an EMC (or after stabilizing the EMC) the sending hospital needs to transfer an individual to another hospital for treatment, it may elect to transfer the individual to the hospital so designated by these State or local laws. Hospitals are also prohibited from discharging individuals who have not been screened or who have an emergency medical condition to non-hospital facilities for purposes of compliance with State law. The existence of a State law requiring transfer of certain individuals to certain facilities is not a defense to an EMTALA violation for failure to provide an MSE or failure to stabilize an EMC therefore hospitals must meet the federal EMTALA requirements or risk violating EMTALA.

If a screening examination reveals an EMC and the individual is told to wait for treatment, but the individual leaves the hospital, the hospital did not "dump" the individual unless:

- The individual left the emergency department based on a "suggestion" by the hospital;

- The individual's condition was an emergency, but the hospital was operating beyond its capacity and did not attempt to transfer the individual to another facility, or

- If an individual leaves a hospital Against Medical Advice (AMA) or LWBS, on his or her own free will (no coercion or suggestion) the hospital is not in violation of EMTALA.

Hospital resources and staff available to inpatients at the hospital for emergency services must likewise be available to individuals coming to the hospital for examination and treatment of an EMC because these resources are within the capability of the hospital. For example, a woman in labor who presents at a hospital providing obstetrical services must be treated with the resources available whether or not the hospital normally provides unassigned emergency obstetrical services.

The MSE must be conducted by an individual(s) who is determined qualified by hospital by-laws or rules and regulations and who meets the requirements of §482.55 concerning emergency services personnel and direction. The designation of the qualified medical personnel (QMP) should be set forth in a document approved by the governing body of the hospital. If the rules and regulations of the hospital are approved by the board of trustees or other governing body, those personnel qualified to perform the medical screening examinations may be set forth in the rules and regulations, or the hospital by-laws. It is not acceptable for the hospital to allow informal personnel appointments that could frequently change.

(ii) If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment, as defined in paragraph (d) of this section, or an appropriate transfer as defined in paragraph (e) of this section. If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under this section ends, as specified in paragraph (d)(2) of this section.

Interpretive Guidelines §489.24(a)(1)(ii)
Refer to Tag A-2407/C-2407 for stabilizing treatment and inpatients, and Tag A-2409/C-2409 for an appropriate transfer for EMTALA.

EMTALA does not apply to hospital inpatients. The existing hospital CoPs protect individuals who are already patients of a hospital and who experience an EMC. Hospitals that fail to provide treatment to these patients may be subject to further enforcement actions.

If the surveyor discovers during the investigation that a hospital did not admit an individual in good faith with the intention of providing treatment (i.e., the hospital used the inpatient admission as a means to avoid EMTALA requirements), then the hospital is considered liable under EMTALA and actions may be pursued.

§489.24(a)(2)

(i) When a waiver has been issued in accordance with Section 1135 of the Act that includes a waiver under Section 1135(b)(3) of the Act, sanctions under this section for an inappropriate transfer or for the direction or relocation of an individual to receive medical screening at an alternate location, do not apply to a hospital with a dedicated emergency department if the following conditions are met:

(A) The transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period.

(B) The direction or relocation of an individual to receive medical screening at an alternate location is pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan.

(C) The hospital does not discriminate on the basis of an individual's source of payment or ability to pay.

(D) The hospital is located in an emergency area during an emergency period, as those terms are defined in Section 1135(g)(1) of the Act.

(E) There has been a determination that a waiver of sanctions is necessary.

(ii) A waiver of these sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect until the termination of the applicable declaration of a public health emergency, as provided under Section 1135(e)(1)(B) of the Act.

Interpretive Guidelines: §489.24(a)(2)

What can be Waived Under Section 1135?

In accordance with Section 1135(b)(3) of the Act, hospitals and CAHs operating under an EMTALA waiver will not be sanctioned for:

- *Redirecting an individual who "comes to the emergency department," as that term is defined at §489.24(b), to an alternate location for an MSE, pursuant to a State emergency preparedness plan or, as applicable, a State pandemic preparedness plan. Even when a waiver is in effect there is still the expectation that everyone who comes to the ED will receive an appropriate MSE, if not in the ED, then at the alternate care site to which they are redirected or relocated.*

- *Inappropriately transferring an individual protected under EMTALA, when the transfer is necessitated by the circumstances of the declared emergencies. Transfers may be inappropriate under EMTALA for a number of reasons.*

However, even if a hospital/CAH is operating under an EMTALA waiver, the hospital/CAH would not be exempt from sanctions if it discriminates among individuals based on their ability to pay for services, or the source of their payment for services when redirecting or relocating them for the MSE or when making inappropriate transfers.

All other EMTALA-related requirements at 42 CFR 489.20 and EMTALA requirements at 42 CFR 489.24 continue to apply, even when a hospital is operating under an EMTALA waiver. For example, the statute does not provide for a waiver of a recipient hospital's obligation to accept an appropriate transfer of an individual protected under EMTALA. (As a reminder, even without a waiver, a hospital is obligated to accept an appropriate EMTALA transfer only when that recipient hospital has specialized capabilities required by the individual and the requisite capacity at the time of the transfer request.)

Waiver of EMTALA requirements in accordance with a Section 1135 waiver does not affect a hospital's or CAH's obligation to comply with State law or regulation that may separately impose requirements similar to those under EMTALA law and regulations. Facilities are encouraged to communicate with their State licensure authorities as to the availability of waivers under State law.

When Can a Waiver Be Issued?

In accordance with Section 1135 of the Act, an EMTALA waiver may be issued only when:

- *The President has declared an emergency or disaster pursuant to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act; and*

- *The Secretary has declared a public health emergency (PHE) pursuant to Section 319 of the Public Health Service Act; and*

- *The Secretary has exercised his/her waiver authority pursuant to Section 1135 of the Act and notified Congress at least 48 hours in advance of exercising his/her waiver authority.*

In exercising his/her waiver authority, the Secretary may choose to delegate to the Centers for Medicare & Medicaid Services (CMS) the decision as to which Medicare, Medicaid, or CHIP requirements specified in Section 1135 should be temporarily waived or modified, and for which health care providers or groups of providers such waivers are necessary. Specifically, the Secretary may delegate to CMS decision-making about whether and for which hospitals/CAHs to waive EMTALA sanctions as specified in Section 1135(b)(3).

In addition, in order for an EMTALA waiver to apply to a specific hospital or CAH:

- *The hospital or CAH must activate its disaster protocol; and*

- *The State must have activated an emergency preparedness plan or pandemic preparedness plan in the emergency area, and any redirection of individuals for an MSE must be consistent with such plan. It is not necessary for the State to activate its plan statewide, so long as it is activated in the area where the hospital*

is located. It is also not necessary for the State plan to identify the specific location of the alternate screening sites to which individuals will be directed, although some may do so.

How Long Does an EMTALA Waiver Last?

Except in the case of waivers related to pandemic infectious disease, an EMTALA waiver is limited in duration to 72 hours beginning upon activation of the hospital's/CAH's disaster protocol. In the case of a public health emergency (PHE) involving pandemic infectious disease, the general EMTALA waiver authority will continue in effect until the termination of the declaration of the PHE. However, application of this general authority to a specific hospital/CAH or groups of hospitals and CAHs may limit the waiver's application to a date prior to the termination of the PHE declaration, since case-specific applications of the waiver authority are issued only to the extent they are necessary, as determined by CMS.

Furthermore, if a State emergency/pandemic preparedness plan is deactivated in the area where the hospital or CAH is located prior to the termination of the public health emergency, the hospital or CAH no longer meets the conditions for an EMTALA waiver and that hospital/CAH waiver would cease to be in effect as of the deactivation date. Likewise, if a hospital or CAH deactivates its disaster protocol prior to the termination of the public health emergency, the hospital or CAH no longer meets the conditions for an EMTALA waiver and that hospital/CAH waiver would cease to be in effect as of the deactivation date.

What is the Process for Seeking an EMTALA Waiver?

Section 1135 provides for waivers of certain Medicare, Medicaid, or CHIP requirements, including waivers of EMTALA sanctions, but only to the extent necessary, to ensure sufficient health care items and services are available to meet the needs of Medicare, Medicaid, and CHIP beneficiaries. The waivers also ensure that health care providers who provide such services in good faith but are unable to comply with one or more of the specified requirements may be reimbursed for such items and services and exempted from sanctions for noncompliance, absent any fraud or abuse.

When the Secretary has exercised his/her waiver authority and delegated to CMS decision-making about specific EMTALA waivers, CMS policy in exercising its authority for granting EMTALA waivers is as follows:

> ***Localized Emergency Area:*** *In the case of localized disasters, such as those related to floods or hurricanes, CMS may exercise its discretion to advise hospitals/CAHs in the affected areas that they are covered by the EMTALA waiver,* ***without requiring individual applications for each waiver.*** *However, hospitals or CAHs that activate their disaster protocol and expect to take advantage of the area-wide waiver must notify their State Survey Agency (SA) at the time they activate their disaster protocol.*

> ***Nationwide Emergency Area:*** *In the case of a nationwide emergency area, CMS may also exercise its discretion to advise hospitals/CAHs in a specific geographical area(s) that they are covered by the EMTALA waiver* ***for a time-limited period****. CMS expects to do this only if the State has activated its emergency or pandemic preparedness plan in the affected area(s), and if there is other evidence of need for the waiver for a broad group of hospitals or CAHs. CMS will rely upon SAs to advise their CMS Regional Office (RO) whether and where a State's preparedness plan has been activated, as well as when the plan has been deactivated.*

In the absence of CMS notification of area-wide applications of the waiver, hospitals/CAHs must contact CMS and request that the waiver provisions be applied to their facility. In all cases, the Act envisions that individuals protected under EMTALA will still receive appropriate MSEs somewhere (even if the MSE is not conducted not at the hospital or CAH where they present), and that individuals who are transferred for stabilization of their emergency medical condition will be sent to a facility capable of providing stabilizing services, regardless of whether a waiver is in effect.

Unless CMS advises otherwise, in cases of a public health emergency involving pandemic infectious disease, hospitals/CAHs in areas covered by time-limited, area-wide applications of the EMTALA waiver that seek to extend the waiver's application to a later date within the waiver period (that is, within the period of the PHE declaration) must submit individual requests for extension. The requests must demonstrate their need for continued application of the waiver. Such requests must be received at least three calendar days prior to expiration of the time-limited waiver. Extensions of an EMTALA waiver in emergencies that do not involve pandemic infectious disease are not available.

Waiver Request Process

Hospitals or CAHs seeking an EMTALA waiver must demonstrate to CMS that application of the waiver to their facility is necessary, and that they have activated their disaster protocol. CMS will confirm with the SA whether the State's preparedness plan has been activated in the area where the hospital or CAH is located. CMS will also seek to confirm when the hospital activated its disaster protocol, whether other measures may address the situation in a manner that does not require a waiver, and other factors important to the ability of the hospital to demonstrate that a waiver is needed.

What will CMS do in response to EMTALA complaints concerning events occurring during the waiver period?

EMTALA enforcement is a complaint-driven process. CMS will assess any complaints/allegations related to alleged EMTALA violations concerning the MSE or transfer during the waiver period to determine whether the hospital or CAH in question was operating under an EMTALA waiver at the time of the complaint, and, if so, whether

the nature of the complaint involves actions or requirements not covered by the EMTALA waiver and warrants further on-site investigation by the SA.

§489.24(c) Use of Dedicated Emergency Department for Non-emergency Services

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

Interpretive Guidelines §489.24(c)

Any individual with a medical condition that presents to a hospital's ED must receive an MSE that is appropriate for their medical condition. The objective of the MSE is to determine whether or not an emergency medical condition exists. This does not mean that all EMTALA screenings must be equally extensive. If the nature of the individual's request makes clear that the medical condition is not of an emergency nature, the MSE is reflective of the individual presenting complaints or symptoms. A hospital may, if it chooses, have protocols that permit a QMP (e.g., registered nurse) to conduct specific MSE(s) if the nature of the individual's request for examination and treatment is within the scope of practice of the QMP (e.g., a request for a blood pressure check and that check reveals that the patient's blood pressure is within normal range). Once the individual is screened and it is determined the individual has only presented to the ED for a nonemergency purpose, the hospital's EMTALA obligation ends for that individual at the completion of the MSE. Hospitals are not obligated under EMTALA to provide screening services beyond those needed to determine that there is no EMC.

For a hospital to be exempted from its EMTALA obligations to screen individuals presenting at its emergency department for nonemergency tests (e.g., individual has consulted with physician by telephone and the physician refers the individual to a hospital emergency department for a nonemergency test) the hospital must be able to document that it is only being asked to collect evidence, not analyze the test results, or to otherwise examine or treat the individual. Furthermore, a hospital may be exempted from its EMTALA obligations to screen individuals presenting to its dedicated emergency department if the individual had a previously scheduled appointment.

If an individual presents to an ED and requests pharmaceutical services (medication) for a medical condition, the hospital generally would have an EMTALA obligation. Surveyors are encouraged to ask probing questions of the hospital staff to determine if the hospital in fact had an EMTALA obligation in this situation (e.g., did the individual present to the ED with an EMC and informed staff they had not taken their medication? Was it obvious from the nature of the medication requested that it was likely that the patient had an EMC?). The circumstances surrounding why the request is being made

would confirm if the hospital in fact has an EMTALA obligation. If the individual requires the medication to resolve or provide stabilizing treatment of an EMC, then the hospital has an EMTALA obligation. Hospitals are not required by EMTALA to provide medication to individuals who do not have an EMC simply because the individual is unable to pay or does not wish to purchase the medication from a retail pharmacy or did not plan appropriately to secure prescription refills.

If an individual presents to a dedicated emergency department and requests services that are not for a medical condition, such as preventive care services (immunizations, allergy shots, flu shots) or the gathering of evidence for criminal law cases (e.g., sexual assault, blood alcohol test), the hospital is not obligated to provide a MSE under EMTALA to this individual.

Attention to detail concerning blood alcohol testing (BAT) in the ED is instrumental when determining if a MSE is to be conducted. If an individual is brought to the ED and law enforcement personnel request that emergency department personnel draw blood for a **BAT only** and does not request examination or treatment for a medical condition, such as intoxication and a prudent lay person observer would not believe that the individual needed such examination or treatment, then the EMTALA's screening requirement is not applicable to this situation because the only request made on behalf of the individual was for evidence. However, if for example, the individual in police custody was involved in a motor vehicle accident or may have sustained injury to him or herself and presents to the ED a MSE would be warranted to determine if an EMC exists.

When law enforcement officials request hospital emergency personnel to provide clearance for incarceration, the hospital has an EMTALA obligation to provide a MSE to determine if an EMC exists. If no EMC is present, the hospital has met its EMTALA obligation and no further actions are necessary for EMTALA compliance.

Surveyors will evaluate each case on its own merit when determining a hospital's EMTALA obligation when law enforcement officials request screening or BAT for use as evidence in criminal proceedings. This principle also applies to sexual assault cases.

Tag A-2407/C-2407

(Rev. 46, Issued: 05-29-09, Effective/Implementation: 05-29-09)

§489.24(d) Necessary Stabilizing Treatment for Emergency Medical Conditions

(1) General. Subject to the provisions of paragraph (d)(2) of this section, if any individual (whether or not eligible for Medicare benefits) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either--

(i) Within the capabilities of the staff and facilities available at the hospital, for further medical examination and treatment as required to stabilize the medical condition.

Interpretive Guidelines §489.24(d)(1)(i)

A hospital is obligated to provide the services specified in the statute and this regulation regardless of whether a hospital will be paid. After the medical screening has been implemented and the hospital has determined that an emergency medical condition exists, the hospital must provide stabilizing treatment within its capability and capacity.

Capabilities of a medical facility mean that there is physical space, equipment, supplies, and specialized services that the hospital provides (e.g., surgery, psychiatry, obstetrics, intensive care, pediatrics, trauma care).

Capabilities of the staff of a facility means the level of care that the personnel of the hospital can provide within the training and scope of their professional licenses. This includes coverage available through the hospitals on-call roster.

The capacity to render care is not reflected simply by the number of persons occupying a specialized unit, the number of staff on duty, or the amount of equipment on the hospital's premises. Capacity includes whatever a hospital customarily does to accommodate patients in excess of its occupancy limits §489.24 (b). If a hospital has customarily accommodated patients in excess of its occupancy limits by whatever mean (e.g., moving patients to other units, calling in additional staff, borrowing equipment from other facilities) it has, in fact, demonstrated the ability to provide services to patients in excess of its occupancy limits.

A hospital may appropriately transfer (see Tag A-2409/C-2409) an individual before the sending hospital has used and exhausted all of its resources available if the individual requests the transfer to another hospital for his or her treatment and refuses treatment at the sending hospital.

To comply with the MSE and stabilization requirements of §1867 all individuals with similar medical conditions are to be treated consistently. Compliance with local, State, or regionally approved EMS transport of individuals with an emergency is usually deemed to indicate compliance with §1867; however a copy of the protocol should be obtained and reviewed at the time of the survey.

If community wide plans exist for specific hospitals to treat certain EMCs (e.g., psychiatric, trauma, physical or sexual abuse), the hospital must meet its EMTALA obligations (screen, stabilize, and or appropriately transfer) prior to transferring the individual to the community plan hospital. An example of a community wide plan would be a trauma system hospital. A trauma system is a comprehensive system providing injury prevention services and timely and appropriate delivery of emergency medical treatment for people with acute illness and traumatic injury. These systems are designed so that patients with catastrophic injuries will have the quickest possible access to an established trauma center or a hospital that has the capabilities to provide comprehensive emergency medical care. These systems ensure that the severely injured patient can be rapidly cared for in the facility that is most appropriately prepared to treat the severity of injury.

Community plans (not a formal community call plan provided for under §489.24(j)(iii)) are designed to provide an organized, pre-planned response to patient needs to assure the best patient care and efficient use of limited health care resources. Community plans are designed to augment physician's care if the necessary services are not within the capability of the hospital but does not mandate patient care nor transfer patterns. Patient health status frequently depends on the appropriate use of the community plans. The matching of the appropriate facility with the needs of the patient is the focal point of this plan and assures every patient receives the best care possible. Therefore, a sending hospital's appropriate transfer of an individual in accordance with community wide protocols in instances where it cannot provide stabilizing treatment would be deemed to indicate compliance with §1867.

If an individual seeking care is a member of a managed health care plan (e.g., HMO, PPO or CMP), the hospital is obligated to comply with the requirements of §489.24 regardless of the individual's payor source or financial status. The hospitals is obligated to provide the services necessary to determine if an EMC is present and provide stabilizing treatment if indicated. This is true regardless if the individual is enrolled in a managed care plan that restricts its enrollees' choice of health care provider. EMTALA is a requirement imposed on hospitals, and the fact that an individual who comes to the hospital is enrolled in a managed care plan that does not contract with that hospital has no bearing on the obligation of the hospital to conduct an MSE and to at lease initiate stabilizing treatment. A managed health care plan may only state the services for which it will pay or decline payment, but that does not excuse the hospital from compliance with EMTALA.

Section 42 CFR 489.24(b) defines **stabilized** to mean:

> "… that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or with respect to an "emergency medical condition" as defined in this section under paragraph (2) of that definition, that a woman has delivered the child and the placenta."

The regulation sets the standard determining when a patient is stabilized.

If a hospital is unable to stabilize an individual within its capability, an appropriate transfer should be implemented. To be considered stable the emergency medical condition that caused the individual to seek care in the dedicated ED must be resolved, although the underlying medical condition may persist. For example, an individual presents to a hospital complaining of chest tightness, wheezing, and shortness of breath and has a medical history of asthma. The physician completes a medical screening examination and diagnoses the individual as having an asthma attack that is an emergency medical condition. Stabilizing treatment is provided (medication and oxygen) to alleviate the acute respiratory symptoms. In this scenario the EMC was resolved and the hospital's EMTALA obligation is therefore ended, but the underlying medical condition of asthma still exists. After stabilizing the individual, the hospital no longer has an EMTALA obligation. The physician may discharge the individual home, admit him/her to the hospital, or transfer (the "appropriate transfer" requirement under EMTALA does not apply to this situation since the individual has been stabilized) the individual to another hospital depending on his/her needs. The preceding example does not reflect a change in policy, rather it is a clarification as to when an appropriate transfer is to be implemented to decrease hospitals risk of being in violation of EMTALA due to inappropriate transfers

An individual will be deemed stabilized if the treating physician or QMP attending to the individual in the emergency department/hospital has determined, within reasonable clinical confidence, that the emergency medical condition has been resolved.

For those individuals whose EMCs have been resolved the physician or QMP has several options:

- **Discharge home with follow-up instructions.** An individual is considered stable and ready for discharge when, within reasonable clinical confidence, it is determined that the individual has reached the point where his/her continued care, including diagnostic work-up and/or treatment, could be reasonably performed as an outpatient or later as an inpatient, provided the individual is given a plan for appropriate follow-up care as part of the discharge instructions. The EMC that caused the individual to present to the dedicated ED must be resolved, but the underlying medical condition may persist. Hospitals are expected within reason to assist/provide discharged individuals the necessary information to secure the

necessary follow-up care to prevent relapse or worsening of the medical condition upon release from the hospital; or

- **Inpatient admission for continued care.**

Hospitals are responsible for treating and stabilizing, within their capacity and capability, any individual who presents him/herself to a hospital with an EMC. The hospital must provide care until the condition ceases to be an emergency or until the individual is properly transferred to another facility. An inappropriate transfer or discharge of an individual with an EMC would be a violation of EMTALA.

If a hospital is alleged to have violated EMTALA by transferring an unstable individual without implementing an appropriate transfer according to §489.24(e), and the hospital believes that the individual was stable (EMC resolved) the burden of proof is the responsibility of the transferring hospital. When interpreting the facts the surveyor should assess whether or not the individual was stable. Was it reasonable to believe that the transferring hospital should have been knowledgeable of the potential complications during transport? To determine whether the individual was stable and treated appropriately surveyors will request that the QIO physician review the case.
If the treating physician is in doubt that an individual's EMC is stabilized the physician should implement an appropriate transfer (see Tag A-2409/C-2409) to prevent a potential violation of EMTALA, if his/her hospital cannot provide further stabilizing treatment.

If a physician is not physically present at the time of transfer, then the qualified medical personnel (as determined by hospital bylaws or other board-approved documents) must consult with a physician to determine if an individual with an EMC is to be transferred to another facility for further stabilizing treatment.

The failure of a receiving facility to provide the care it maintained it could provide to the individual when the transfer was arranged should not be construed to mean that the individual's condition worsened as a result of the transfer.

In the case of psychiatric emergencies, if an individual expressing suicidal or homicidal thoughts or gestures, if determined dangerous to self or others, would be considered to have an EMC.

Psychiatric patients are considered stable when they are protected and prevented from injuring or harming him/herself or others. The administration of chemical or physical restraints for purposes of transferring an individual from one facility to another may stabilize a psychiatric patient for a period of time and remove the immediate EMC but the underlying medical condition may persist and if not treated for longevity the patient may experience exacerbation of the EMC. Therefore, practitioners should use great care when determining if the medical condition is in fact stable after administering chemical or physical restraints.

A hospital's EMTALA obligation ends when a physician or qualified medical person has made a decision:

- That no emergency medical condition exists (even though the underlying medical condition may persist);

- That an emergency medical condition exists and the individual is appropriately transferred to another facility; or

- That an emergency medical condition exists and the individual is admitted to the hospital for further stabilizing treatment.

(ii) For transfer of the individual to another medical facility in accordance with paragraph (e) of this section.

Interpretive Guidelines: §489.24(d)(1)(ii)

When a hospital has exhausted all of its capabilities in attempting to resolve the EMC, it must effect an appropriate transfer of the individual (see Tag A-2409/C-2409). Section 42 CFR 489.24(b) defines **transfer** to mean:

> "… the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (i) has been declared dead, or (ii) leaves the facility without the permission of any such person."

If an individual is admitted as an inpatient, EMCs must be stabilized either by the hospital to which an individual presents or the hospital to which the individual is transferred. If a woman is in labor, the hospital must deliver the baby and the placenta or transfer appropriately. She may not be transferred unless she, or a legally responsible person acting on her behalf, requests a transfer and a physician or other qualified medical personnel, in consultation with a physician, certifies that the benefits to the woman and/or the unborn child outweigh the risks associated with the transfer.

If the individual's condition requires immediate medical stabilizing treatment and the hospital is not able to attend to that individual because the emergency department is operating beyond its capacity, then the hospital should transfer the individual to a hospital that has the capability and capacity to treat the individual's EMC.

(2) Exception: Application to Inpatients.

(i) If a hospital has screened an individual under paragraph (a) of this section and found the individual to have an emergency medical condition, and admits that individual as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its special responsibilities under this section with respect to that individual

Interpretive Guidelines: §489.24(d)(2)(i)

A hospital's EMTALA obligation ends when the individual has been admitted in good faith for inpatient hospital services whether or not the individual has been stabilized. An individual is considered to be "admitted" when the decision is made to admit the individual to receive inpatient hospital services with the expectation that the patient will remain in the hospital at least overnight. Typically, we would expect that this would be documented in the patient's chart and medical record at the time that a physician signed and dated the admission order. Hospital policies should clearly delineate, which practitioners are responsible for writing admission orders.

A hospital continues to have a responsibility to meet the patient emergency needs in accordance with hospital CoPs at 42 CFR Part 482. The hospital CoPs protect individuals who are admitted, and they do not permit the hospital to inappropriately discharge or transfer any patient to another facility. The hospital CoPs that are most relevant in this case are as follows: emergency services, governing body, discharge planning, quality assurance and medical staff.
Hospitals are responsible for assuring that inpatients receive acceptable medical care upon admission. Hospital services for inpatients should include diagnostic services and therapeutic services for medical diagnosis, treatment, and care of the injured, disabled or sick persons with the intention of treating patients.
If during an EMTALA investigation there is a question as to whether an individual was admitted so that a hospital could avoid its EMTALA obligation, the SA surveyor is to consult with RO personnel to determine if the survey should be expanded to a survey of the hospital CoPs. After completion of the survey, the case is to be forwarded to the RO for violation determination. If it is determined that the hospital admitted the individual solely for the purpose of avoiding its EMTALA obligation, then the hospital is liable under EMTALA and may be subject to further enforcement action.

(ii) This section is not applicable to an inpatient who was admitted for elective (non-emergency) diagnosis or treatment.

Interpretive Guidelines: §489.24(d)(2)(ii)

Individuals admitted to the hospital for elective medical services are not protected by EMTALA. The hospital CoPs protect all classifications of inpatients, elective and emergent.

(iii) A hospital is required by the conditions of participation for hospitals under Part 482 of this chapter to provide care to its inpatients in accordance with those conditions of participation.

Interpretive Guidelines: §489.24(d)(2)(iii)

If an inpatient develops an EMC, the hospital is required to meet the patient's emergency needs in accordance with acceptable standards of practice. The hospital CoPs protects patients who are admitted, and the hospital may not discharge or transfer any patient to another facility inappropriately. The protective CoPs are found at 42 CFR Part 482. The five CoPs that are most relevant in affording patients protection in cases when patients with an EMC is admitted are as follows:

- Emergency services (§482.55)
- Governing body (§482.12)
- Discharge planning (§482.43)
- Quality assessment and performance improvement (§482.21)
- Medical staff (§482.22)

If a hospital is noncompliant with any of the above COPs, the hospital will be subject to enforcement action.

(3) Refusal to consent to treatment.

A hospital meets the requirements of paragraph (d)(1)(i) of this section with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of the examination and treatment, but the individual (or a person acting on the individual's behalf) does not consent to the examination or treatment. The medical record must contain a description of the examination, treatment, or both if applicable, that was refused by or on behalf of the individual. The hospital must take all reasonable steps to secure the individual's written informed refusal (or that of the person acting on his or her behalf). The written document should indicate that the person has been informed of the risks and benefits of the examination or treatment, or both.

Interpretive Guidelines: §489.24(d)(3)

The medical record should reflect that screening, further examination, and or treatment were offered by the hospital prior to the individual's refusal.

In the event an individual refuses to consent to further examination or treatment, the hospital must indicate in writing the risks/benefits of the examination and/or treatment; the reasons for refusal; a description of the examination or treatment that was refused; and the steps taken to try to secure the written, informed refusal if it was not secured.

Hospitals may not attempt to coerce individuals into making judgments against their interest by informing them that they will have to pay for their care if they remain but that their care will be free or at a lower cost if they transfer to another hospital.

An individual may only refuse examination, treatment, or transfer on behalf of a patient if the patient is incapable of making an informed choice for him/herself.

Tag A-2408/C-2408

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§489.24(d)(4) and (5)

(**4) Delay in Examination or Treatment.**

(i) A participating hospital may not delay providing an appropriate medical screening examination required under paragraph (a) of this section or further medical examination and treatment required under paragraph (d)(1) of this section in order to inquire about the individual's method of payment or insurance status.

(ii) A participating hospital may not seek, or direct an individual to seek, authorization from the individual's insurance company for screening or stabilization services to be furnished by a hospital, physician, or non-physician practitioner to an individual until after the hospital has provided the appropriate medical screening examination required under paragraph (a) of this section, and initiated any further medical examination and treatment that may be required to stabilize the emergency medical condition under paragraph (d)(1) of this section.

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

(iv) Hospitals may follow reasonable registration processes for individuals for whom examination or treatment is required by this section, including asking whether an individual is insured and, if so, what that insurance is, as long as that inquiry does not delay screening or treatment. Reasonable registration processes may not unduly discourage individuals from remaining for further evaluation.

Interpretive Guidelines §489.24(d)(4)(i),(ii),(iii) and (iv)

Hospitals should not delay providing a medical screening examination or necessary stabilizing treatment by inquiring about an individual's ability to pay for care. All individuals who present to a hospital and request an MSE for a medical condition (or have a request for an MSE made on their behalf) must receive that screening examination, regardless of the answers the individual may give to the insurance questions asked during the registration process. In addition, a hospital may not delay screening or treatment to any individual while it verifies the information provided.

Hospitals may follow reasonable registration processes for individuals presenting with an EMC. Reasonable registration processes may include asking whether an individual is insured and, if so, what the insurance is, as long as this inquiry do not delay screening, treatment or unduly discourage individuals from remaining for further evaluation. The registration process permitted in the dedicated ED typically consists of collecting demographic information, insurance information, whom to contact in an emergency and other relevant information.

If a managed care member comes to a hospital that offers emergency services, the hospital must provide the services required under the EMTALA statute without regard for the individual's insurance status or any prior authorization requirement of such insurance.

This requirement applies equally to both the referring and the receiving (recipient) hospital. Therefore, it may be a violation if the receiving hospital delays acceptance of the transfer of an individual with an unstabilized EMC pending receipt or verification of financial information. It would not be a violation if the receiving hospital delayed acceptance of the transfer of an individual with a stabilized EMC pending receipt or verification of financial information because EMTALA protections no longer apply once a patient is stabilized.

If a delay in screening was due to an unusual internal crisis whereby it was simply not within the capability of the hospital to provide an appropriate screening examination at the time the individual came to the hospital (e.g., mass casualty occupying all the hospital's resources for a time period), surveyors are to interview hospital staff members to elicit the facts surrounding the circumstances to help determine if there was a violation of EMTALA.

(5) Refusal to Consent to Transfer.

A hospital meets the requirements of paragraph (d)(1)(ii) of this section with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with paragraph (e) of this section and informs the individual (or a person acting on his or her behalf) of the risks and benefits to the individual of the transfer, but the individual (or a person acting on the individual's behalf) does not consent to the transfer. The hospital must take all reasonable steps to secure the individual's written informed refusal (or that of a person acting on his or her behalf). The written document must indicate the person has been informed of the risks and benefits of the transfer and state the reasons for the individual's refusal. The medical record must contain a description of the proposed transfer that was refused by or on behalf of the individual.

Interpretive Guidelines: §489.24 (d)(5)

For individuals who refuse to consent to a transfer, the hospital staff must inform the individual of the risks and benefits and document the refusal and, if possible, place a signed informed consent to refusal of the transfer in the individual's medical record.

If an individual or the individual's representative refuses to be transferred and also refuses to sign a statement to that effect, the hospital may document such refusals as they see fit.

Tag A-2409/C-2409

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§489.24(e) Restricting Transfer Until the Individual Is Stabilized

(1) General. If an individual at a hospital has an emergency medical condition that has not been stabilized (as defined in paragraph (b) of this section), the hospital may not transfer the individual unless—

(i) The transfer is an appropriate transfer (within the meaning of paragraph (e)(2) of this section); and

(ii)

(A) The individual (or a legally responsible person acting on the individual's behalf) requests the transfer, after being informed of the hospital's obligations under this section and of the risk of transfer. The request must be in writing and indicate the reasons for the request as well as indicate that he or she is aware of the risks and benefits of the transfer;

(B) A physician (within the meaning of Section 1861(r)(1) of the Act) has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman or the unborn child, from being transferred. The certification must contain a summary of the risks and benefits upon which it is based; or

(C) If a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as determined by the hospital in its bylaws or rules and regulations) has signed a certification described in paragraph (e)(1)(ii)(B) of this section after a physician (as defined in Section 1861(r)(1) of the Act) in consultation with the qualified medical person, agrees with the certification and subsequently countersigns the certification. The certification must contain a summary of the risks and benefits upon which it is based.

(2) A transfer to another medical facility will be appropriate only in those cases in which-

(i) The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(ii) The receiving facility--

(A) Has available space and qualified personnel for the treatment of the individual; and

(B) Has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(iii) The transferring hospital sends to the receiving facility all medical records (or copies thereof) related to the emergency condition which the individual has presented that are available at the time of the transfer, including available history, records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) required under paragraph (e)(1)(ii) of this section, and the name and address of any on-call physician (described in paragraph (g) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment. Other records (e.g., test results not yet

available or historical records not readily available from the hospital's files) must be sent as soon as practicable after transfer; and

(iv) The transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.

Interpretive Guidelines: §489.24(e)

The EMTALA regulations at 42 CFR 489.24(b) define "transfer" as " …the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (i) has been declared dead, or (ii) leaves the facility without the permission of any such person."

The requirements in 42 CFR 489.24(e) apply to transfers to another hospital.

Transfer of Individuals with Unstabilized EMCs

In the case of individuals found to have an EMC a hospital is required under EMTALA rules at 42 CFR 489.24(d) to provide stabilizing treatment within the capabilities of the staff and facilities available in the hospital, or to provide a transfer to another hospital as required by 42 CFR 489.24(e). Transfer of the individual to another hospital may be reasonable and permissible, but the regulations establish a number of requirements that each transfer must meet in order to comply with EMTALA. If an individual's EMC has not been stabilized, prior to transferring the individual to another hospital, the sending hospital is required under EMTALA to pursue a transfer **because either:**

- the individual requests the transfer; **or**

- the expected benefits of the transfer outweigh the increased risks of the transfer.

In either case, the transfer must also always meet the four requirements of an "appropriate" transfer.

If an individual is moved to a diagnostic facility located at another hospital for diagnostic procedures not available at the transferring hospital, and the hospitals arrange to return the individual to the transferring hospital, the transfer requirements must still be met by the sending hospital. The recipient hospital is not obligated to meet the EMTALA transfer requirements when implementing an appropriate transfer back to the transferring hospital. However, it is reasonable to expect the recipient hospital with the diagnostic capability to communicate (e.g., telephonic report or documentation within the medical record) with the transferring hospital its findings of the medical condition and a status report of the individual during and after the procedure.

The transfer requirements apply only to individuals who have been determined to have an EMC that has not been stabilized. The hospital has no further EMTALA obligation to an individual who has been determined not to have an EMC or whose EMC has been stabilized, or who has been admitted as an inpatient (See discussion related to the requirements of 42 CFR 489.24(d), concerning stabilizing treatment.) However, the hospital has other obligations to the individual under the Hospital Conditions of Participation.

These transfer requirements do not apply to an individual who is moved to another part of the hospital, because technically the patient has not been transferred. This is also the case when an individual who presents to an off-campus dedicated emergency department is found to have an EMC and is moved to the hospital's main campus for stabilizing treatment that cannot be provided at the off-campus site.

Transfer at the Request of the Individual

A transfer may be made at the request of the individual with an EMC or of a person legally responsible for that individual. The hospital must assure that the individual or legally responsible person is first informed of the hospital's obligations under EMTALA, e.g., its obligation to provide stabilizing treatment within its capability and capacity, regardless of the individual's ability to pay. The hospital must also assure that the individual has been advised of the medical risks associated with transfer. After the hospital has communicated this information, the individual's request for a transfer must be in writing. The request must include the reason(s) why the transfer is being requested and a statement that the individual is aware of the risks and benefits associated with the transfer. The individual or individual's representative must sign the written request.

Transfer with a Physician Certification

Alternatively, a transfer may be made when a physician certifies that the expected benefits of the transfer outweigh the risks. Specifically, a physician must certify that the medical benefits to the individual with the EMC that could reasonably be expected from provision of appropriate treatment at another hospital outweigh the increased risks that result from being transferred. In the case of a pregnant woman in labor, the physician must certify that the expected benefits outweigh the risk to both the pregnant woman and the unborn child. Under certain circumstances qualified medical personnel other than a physician may sign the certification. A qualified medical person (QMP) may sign the certification of benefits versus risks of a transfer only after consultation with a physician who agrees with the transfer. The physician must subsequently countersign the certification. The physician's countersignature must be obtained within the established timeframe according to hospital policies and procedures. Hospital by-laws or rules or regulations must specify the criteria and process for granting medical staff privileges to QMPs, and, in accordance with the hospital or CAH Conditions of Participation, each individual QMP must be appropriately privileged.

The date and time of the physician (or the QMP) certification should closely match the date and time of the transfer.

Section 1861(r)(i) of the Act defines **physicians** as:

> A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action. (This provision is not to be construed to limit the authority of a doctor or medicine or osteopathy to delegate tasks to other qualified health care personnel to the extent recognized under State law or a State's regulatory mechanism).

The regulation at §489.24 (e)(1) requires an express written certification. Physician certification cannot simply be implied from the findings in the medical record and the fact that the patient was transferred.

The certification must state the reason(s) for transfer. The narrative rationale need not be a lengthy discussion of the individual's medical condition reiterating facts already contained in the medical record, but it should give a complete picture of the benefits to be expected from appropriate care at the receiving (recipient) facility and the risks associated with the transfer, including the time away from an acute care setting necessary to effect the transfer. The risks and benefits certification should be specific to the condition of the patient upon transfer.

This rationale may be included on the certification form or in the medical record. In cases where the individual's medical record does not include a certification, the hospital may be given the opportunity to retrieve the certification. Certifications may not be backdated.

Women in Labor

- Regardless of practices within a State, a woman in labor may be transferred only if she or her representative requests the transfer or if a physician or other qualified medical personnel signs a certification that the benefits outweigh the risks. If the hospital does not provide obstetrical services, the benefits of a transfer may outweigh the risks. A hospital cannot cite State law or practice as the basis for transfer.

- Hospitals that are not capable of handling high-risk deliveries or high-risk infants often have written transfer agreements with facilities capable of handling high-risk cases. The hospital must still meet the screening, treatment, and transfer requirements.

Four Requirements for an Appropriate Transfer

1. **§489.24 (e)(2)(i) - The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;**

Before implementing a transfer of an individual with an unstablized EMC, a hospital is required to provide stabilizing treatment within its capability and capacity. See discussion of stabilizing treatment, 42 CFR 489.24(d). This includes treatment to minimize the transfer risk to the health of the individual and, in the case of a pregnant woman in labor, the health of the unborn child.

If Hospital A participates in a community call plan with Hospital B and an individual with an EMC requires the services of an on-call specialist who, pursuant to the community call plan, is on-call at Hospital B to respond to the specialty needs of individuals at Hospital A, then generally a transfer of the individual to Hospital B is warranted. However, Hospital A is still required to provide treatment within its on-site capability and capacity to minimize the risks of transfer, and all other transfer requirements must also be met, notwithstanding the participation in the community call plan.

2. **§489.24(e)(2)(ii) - The receiving facility--**

    (A) Has available space and qualified personnel for the treatment of the individual; and

    (B) Has agreed to accept transfer of the individual and to provide appropriate medical treatment;

    The transferring hospital must obtain permission from the receiving (recipient) hospital to transfer an individual. The transferring hospital should document its communication with the receiving (recipient) hospital, including the date and time of the transfer request and the name and title of the person accepting the transfer.

3. **§489.24 (e)(2)(iii) - The transferring hospital sends to the receiving facility all medical records (or copies thereof) related to the emergency condition which the individual has presented that are available at the time of the transfer, including available history, records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) required under paragraph (e)(1)(ii) of this section, and the name and address of any on-call physician (described in paragraph (g) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment. Other records (e.g., test results not yet available or historical records not readily available from the hospital's files) must be sent as soon as practicable after transfer;**

   Necessary medical records must accompany individuals being transferred to another hospital. If a transfer is in an individual's best interest, it should not be delayed until records are retrieved or test results come back from the laboratory. Whatever medical records are available at the time the individual is transferred should be sent to the receiving (recipient) hospital with the patient. Test results that become available after the individual is transferred should be telephoned to the receiving (recipient) hospital, and then mailed or sent via electronic transmission consistent with HIPAA provisions on the transmission of electronic data.

4. **§489.24 (e)(2)(iv) - The transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.**

   Emergency medical technicians may not always be "qualified personnel" for purposes of transferring an individual under these regulations. Depending on the individual's condition, there may be situations in which a physician's presence or some other specialist's presence might be necessary. The physician at the sending hospital (not at the receiving hospital) has the responsibility to determine the appropriate mode, equipment, and attendants for transfer.

   While the sending hospital is ultimately responsible for ensuring that the transfer is affected appropriately, the hospital may meet its obligations as it sees fit. These regulations do not require that a hospital operate an emergency medical transportation service.

Tag A-2410/C-2410

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§489.24(e)(3)

(3) A participating hospital may not penalize or take adverse action against a physician or a qualified medical person described in paragraph (e)(1)(ii)(C) of this section because the physician or qualified medical person refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized, or against any hospital employee because the employee reports a violation of a requirement of this section.

Interpretive Guidelines: §489.24 (e)(3)

A "participating hospital" means a hospital that has entered into a provider agreement under §1866 of the Act.

Hospital employees reporting alleged EMTALA violations are also protected by this regulation.

Tag A-2411/C-2411

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§489.24(f) Recipient Hospital Responsibilities

A participating hospital that has specialized capabilities or facilities (including, but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive care units, or, with respect to rural areas, regional referral centers (which, for purposes of this subpart, mean hospitals meeting the requirements of referral centers found at §412.96 of this chapter)) may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual.

(1) The provisions of this paragraph (f) apply to any participating hospital with specialized capabilities, regardless of whether the hospital has a dedicated emergency department.

(2) The provisions of this paragraph (f) do not apply to an individual who has been admitted to a referring hospital under the provisions of paragraph (d)(2)(i) of this section.

Interpretive Guidelines: §489.24(f)

A Medicare-participating hospital that has specialized capabilities or facilities may not refuse to accept an appropriate transfer from another hospital of an individual with an unstabilized emergency medical condition who is protected under EMTALA and requires such specialized capabilities or facilities. This assumes that, in addition to its specialized capabilities, the recipient hospital has the capacity to treat the individual, and that the transferring, i.e. referring, hospital lacks that capability or capacity. Hospitals with specialized capabilities or facilities may include, but are not limited to, hospitals with burn units, shock trauma units, neonatal intensive care units or hospitals that are regional referral centers that serve rural areas as defined by the requirements at 42 CFR 412.96.

This requirement to accept an appropriate transfer applies to any Medicare-participating hospital with specialized capabilities, regardless of whether the hospital has a dedicated emergency department. In other words, while some obligations under EMTALA apply only to hospitals that have a dedicated emergency department, e.g., requirements related to providing a medical screening examination, the EMTALA recipient hospital obligation can also apply to hospitals that do not have a dedicated emergency department. For example, if an individual is found to have an emergency medical condition that requires specialized psychiatric capabilities, a psychiatric hospital that participates in Medicare and has capacity is obligated to accept an appropriate transfer of that individual. It does not matter if the psychiatric hospital does not have a dedicated emergency department.

The regulation states that a recipient hospital's EMTALA obligations do not extend to individuals who are inpatients of another hospital. Thus, a hospital may not be cited for violating EMTALA if it refuses to accept the transfer of an inpatient from the referring hospital.

Section 489.24(b) defines inpatient: "Inpatient means an individual who is admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services as described in §409.10(a) of this chapter with the expectation that he or she will remain at least overnight and occupy a bed even though the situation later develops that the individual can be discharged or transferred to another hospital and does not actually use a hospital bed overnight."

Individuals who are placed in observation status are not inpatients, even if they occupy a bed overnight. Therefore, placement in an observation status of an individual who came to the hospital's DED does not terminate the EMTALA obligations of that hospital or a recipient hospital toward the individual.

There is no EMTALA obligation for a Medicare-participating hospital with specialized capabilities to accept transfers from hospitals located outside the boundaries of the United States. In accordance with Section 210(i) of the Social Security Act, the term "United States," when used in a geographical sense, means the States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa. Hospitals that request transfers must recognize that the appropriate transfer of individuals with unstabilized emergency medical conditions that require specialized services should

not routinely be made over great distances, bypassing closer hospitals with the needed capability and capacity.

A hospital with specialized capabilities or facilities that has the necessary capacity to treat an individual with an emergency medical condition may not condition or attempt to condition its acceptance of an appropriate transfer of an individual protected under EMTALA on the use of a particular mode of transport or transport service. It is the treating physician at the transferring hospital who decides how the individual is transported to the recipient hospital and what transport service will be used, since this physician has assessed the individual personally. The transferring hospital is required to arrange transport that minimizes the risk to the individual who is being transferred, in accordance with the requirements of §489.24(e)(2)(B)(iv).

A hospital with specialized capabilities that delays the treatment of an individual with an emergency medical condition who arrives as a transfer from another facility could be in violation of EMTALA, depending on the circumstances of that delay. For instance, if there is evidence that the recipient hospital unreasonably delayed the treatment of certain individuals and expedited the treatment of other individuals, based on their ability to pay for the services or some other form of discrimination, then the recipient hospital may be in violation of EMTALA. Hospitals that deliberately delay moving an individual from an EMS stretcher do not thereby delay the point in time at which their EMTALA obligation begins. Furthermore, such a practice of "parking" individuals arriving via EMS, refusing to release EMS personnel or equipment, can potentially jeopardize the health and safety of the transferred individual and other individuals in the community who may need EMS services at that time. On the other hand, this does not mean that a hospital will necessarily have violated EMTALA and/or the hospital CoPs if it does not, in every instance, immediately assume from the EMS provider all responsibility for the individual, regardless of any other circumstances in the hospital.

Lateral transfers, that is, transfers between facilities of comparable resources and capabilities, are not required by §489.24(f), because the benefits of such a transfer would not be likely to outweigh the risks of the transfer, except when the transferring hospital has a serious capacity problem, a mechanical failure of equipment, or similar situations, such as loss of power or significant flooding.

Assessment of whether the transferring hospital with the requisite capabilities lacked the capacity to provide stabilizing treatment, or of whether the recipient hospital lacked the capacity to accept an appropriate transfer requires a review of the hospital's general practices in adjusting its capacity. If a hospital generally has a record of accommodating additional patients by various means, such as moving patients from one unit to another, calling in additional staff, and temporarily borrowing additional equipment from other facilities, then that hospital would be expected under EMTALA to take reasonable steps to respond to the treatment needs of an individual requiring stabilizing treatment for an emergency medical condition. The determination of a hospital's capacity would depend on the case-specific circumstances and the hospital's previous implementation of capacity management actions.

The criteria for classifying hospitals as rural regional referral centers are defined in 42 CFR 412.96. A designated rural regional referral center is obligated to accept appropriate transfers of individuals who require the hospital's specialized capabilities if the hospital has the capacity to treat the individual.

Transmittals Issued for this Appendix

Rev #	Issue Date	Subject	Impl Date	CR#
R60SOM	07/16/2010	Revisions to Appendix V,-Interpretive Guidelines-Responsibilities of Medicare Participating Hospitals in Emergency Cases	07/16/2010	N/A
R46SOM	05/29/2009	Revisions to Appendix V,-“Emergency Medical Treatment and Labor Act (EMTALA) Interpretive Guidelines	05/29/2009	N/A
R01SOM	05/21/2004	Initial Release of Pub 100-07	N/A	N/A