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INFORMATIONAL LETTER #2004-13

DATE: December 3, 2004

TO: ALL IDAHO HOSPITALS
ALL CRITICAL ACCESS HOSPITALS IN IDAHO

FROM: DEBBY RANSOM, R.N., R.H.I.T., Chief
Bureau of Facility Standards

SUBJECT: **STATE OPERATIONS MANUAL – APPENDIX V – INTERPRETIVE GUIDELINES – RESPONSIBILITIES OF MEDICARE PARTICIPATING HOSPITALS IN EMERGENCY CASES**

The purpose of this letter is to notify Hospitals and Critical Access Hospitals of the revised interpretive guidelines related to Emergency Medical Treatment and Labor Act (EMTALA). A copy of that document is enclosed.

If you have any questions, please contact Sylvia Creswell, Supervisor of Non Long Term Care at 208/334-6626.

Debra Ransom

DEBBY RANSOM, R.N., R.H.I.T., Chief
Bureau of Facility Standards

DR/nah
Enclosure
cc: Idaho Hospital Association

State Operations Manual

Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases (Rev. 1, 05-21-04)

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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 to 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

Tag A400

§489.20 Basic Section 1866 Commitments Relevant to Section 1867 Responsibilities

The provider agrees to the following:

§489.20(l)

(l) In the case of a hospital as defined in §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.

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 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 A400.

Tag A401

§489.20(m)

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 CFR§489.53(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 A402

§489.20(q)

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 A403

§489.20(r)

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 A404

§489.20(r)(2)

A list of physicians who are on-call for duty after the initial examination to provide further evaluation and/or treatment necessary to stabilize an individual with an emergency medical condition; and

Interpretive Guidelines: §489.20 (r)(2)

Section 1866(a)(1) 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 EMC The on-call list identifies and ensures that the emergency department is prospectively aware of which physicians, including specialists and subspecialists are available to provide care.

A hospital can meet its responsibility to provide adequate medical personnel to meet its anticipated emergency needs by using on-call physicians either to staff or to augment its emergency department, during which time the capability of its emergency department includes the services of its on-call physicians.

CMS does not have requirements regarding how frequently on-call physicians are expected to be available to provide on-call coverage Nor is there a pre-determined ratio CMS uses to identify how many days a hospital must provide medical staff on-call coverage 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.

Generally, in determining EMTALA compliance, CMS will consider all relevant factors, including the number of physicians on staff, other demands on these physicians, the frequency with which the hospital's patient typically require services of on-call physicians, and the provisions the hospital has made for situations in which a physician in the specialty is not available or the on-call physicians is unable to respond On-call coverage is a decision made by hospital administrators and the physicians who provide on-call coverage for the hospital. Each hospital has the discretion to maintain the on-call list in a manner that best meet the needs of the hospital's patients who are receiving services required under EMTALA in accordance with the resources available to the hospital, including the availability of on-call physicians. The best practice for hospitals, which offer particular services to the public, should be available through on-call coverage of the emergency department.

Physicians group names are not acceptable for identifying the on-call physician. Individual physician names are to be identified on the list.

§489.24(j) Availability of On-Call physicians

(j) Availability of on-call physicians.

(1) Each hospital must maintain an on-call list of physicians on its medical staff in a mauner that best meets the needs of the hospital's patients who are receiving services required under this section in accordance with the resources available to the hospital, including the availability of on-call physicians.

Interpretive Guidelines: §489.24(j)(1)

Hospitals have the ultimate responsibility for ensuring adequate on-call coverage. Hospitals participating in the Medicare Program must maintain a list of physicians on-call for duty after the initial examination to provide treatment necessary to stabilize an individual with an EMC Hospitals have an EMTALA obligation to provide on-call coverage for patients in need of specialized treatment if the hospital has the capacity to treat the individual.

No physician is required to be on-call at all times On-call coverage should be provided for within reason depending upon the number of physicians in a specialty. A determination about whether a hospital is in compliance with these regulations must be based on the facts in each individual case The surveyor will consider all relevant factors including the number of physicians on staff, the number of physicians in a particular specialty, other demands on these physicians, the frequency with which the hospital's patients typically require services of on-call physicians, vacations, conferences, days off and the provisions the hospital has made for situations in which a physician in the specialty is not available or the on-call physician is unable to respond.

If a staff physician is on-call to provide emergency services or to consult with an emergency room physician in the area of his or her expertise, that physician would be considered to be available at the hospital. A determination as to whether the on-call physician must physically assess the patient in the emergency department is the decision of the treating emergency physician. His or her ability and medical knowledge of managing that particular medical condition will determine whether the on-call physician must come to the emergency department.

When a physician is on-call for the hospital and seeing patients with scheduled appointments in his 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 by the treating emergency physician. If, however, if it is medically appropriate to do so, the treating emergency physician may send an individual needing the services of the on-call physician to the physician's office if it is part of a hospital-owned facility (department of the hospital sharing the same Medicare provider number as the hospital) and on the hospital campus. In determining if a hospital has appropriately moved an individual from the hospital to the on-call physician's office, surveyors may consider whether (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 patient; and (3) appropriate medical personnel accompany the patient.

If a physician who is on-call does not come to the hospital when called, but rather repeatedly or typically directs the patient to be transferred to another hospital where the physician can treat the individual, the physician may have violated EMTALA. Surveyors are to assess all facts of the case prior to making a recommendation to the RO as to whether the physician violated EMTALA. Surveyors are to consider the individual needs and the physician circumstances, which may have an impact upon the case. Each case is to be viewed on its own merit and specific facts

For physicians taking call simultaneously at more than one hospital, the hospitals must have policies and procedures to follow when the on-call physician is not available to respond because he has been called to the other hospital to evaluate an individual. Hospital policies may include, but are not limited to procedures for back up on-call physicians, or the implementation of an appropriate EMTALA transfer according to 42 CFR §489.24(e). The policies and procedures a hospital adopts to meet its EMTALA obligation is at the hospital's discretion, as long as they meet the needs of the individuals who present for emergency care taking into account the capability of the hospital and the availability of on-call physicians

The decision as to whether the on-call physician responds in person or directs a non-physician practitioner (physician assistant, nurse practitioner, orthopedic tech) as his or her representative to present to the dedicated ED is made by the responsible on-call physician, based on the individual's medical need and the capabilities of the hospital and applicable State scope of practice laws, hospital bylaws, and rules and regulations The

on-call physician is ultimately responsible for the individual regardless of who responds to the call

On-call physicians may utilize telemedicine (telehealth) services for individuals in need of further evaluation and/or treatment necessary to stabilize an EMC Individuals are eligible for telemedicine services **only** when, because of the **individual's geographic location,** it is possible for the on-call physician to physically assess the patient. Permissible situations under which on-call physicians may access telemedicine include the case of an individual who presents to an **originating hospital located in a rural health professional shortage area (HPSA) or in a county outside of a metropolitan statistical area (MSA).** The RO is to consult with Health Resources Service Administration (HRSA) personnel (1-888-275-4722, option 2 for shortage designation) located in the Division of Shortage Designation (Bureau of Primary Health Care) or RO staff working with rural health issues to determine if a hospital is located in a rural HPSA or MSA to be eligible for telemedicine services and therefore not be in violation of EMTALA on-call requirements

Reimbursement for such telemedicine services are limited, therefore it is in the best interest of the provider to be knowledgeable concerning coverage and payment for Medicare telehealth services. (See Medicare Benefit Policy Manual, Pub. 100-2, Chapter 18, §270.)

Physicians that refuse to be included on a hospital's on-call list but take calls selectively for patients with whom they or a colleague at the hospital have established a doctor-patient relationship while at the same time refusing to see other patients (including those individuals whose ability to pay is questionable) may violate EMTALA. If a hospital permits physicians to selectively take call while the hospital's coverage for that particular service is not adequate, the hospital would be in violation of its EMTALA obligation by encouraging disparate treatment.

If a physician on-call does not fulfill his obligation to the hospital, but the hospital arranges for another staff physician in that specialty to assess the individual, and no other EMTALA requirements are violated, then the hospital may not be in violation of the regulation. However, in this circumstance, the physician who has agreed to take call and does not come to the hospital when called may have violated the regulation.

CMS allows hospitals flexibility in the utilization of their medical personnel. Allowing exemptions to medical staff members (senior physicians) would not by itself violate EMTALA.

Surveyors are to review the hospital policies or medical staff bylaws with respect to response time of the on-call physician. If a physician on the list is called by the hospital to provide emergency screening or treatment and either refuses or fails to arrive within the response time established by hospital policies or medical staff bylaws, the hospital and that physician may be in violation of EMTALA. Hospitals are responsible for ensuring that on-call physicians respond within a reasonable period of time. The

expected response time should be stated in minutes in the hospitals policies Terms such as "reasonable" or "prompt" are not enforceable by the hospital and therefore inappropriate in defining physician's response time Note the time of notification and the response (or transfer) time

(2) The hospital must have written policies and procedures in place—

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

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

The medical staff by-laws or policies and procedures must define the responsibility of the on-call physicians to respond, examine and treat patients with an EMC.

Physicians, including specialists and subspecialists (e.g., neurologists) are not required to be on-call at all times or required to be on-call in their specialty for emergencies whenever they are visiting their own patients in the hospital. The hospital must have policies and procedures (including back-up call schedules or the implementation of an appropriate EMTALA transfer) to be followed when a particular specialty is not available or the on-call physician cannot respond because of situations beyond his or her control The hospital is ultimately responsible for providing adequate on-call coverage to meet the needs of its patients.

(ii) To provide that emergency services are available to meet the needs of patients with emergency medical conditions if it elects to permit on-call physicians to schedule elective surgery during the time that they are on-call or to permit on-call physicians to have simultaneous on-call duties.

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

Physicians are not prohibited from performing surgery while on-call The only exception applies to Critical Access Hospital (CAH) staff. On-call physicians who are reimbursed for being on-call at CAHs cannot provide services at any other provider or facility However, a hospital may have its own internal policy prohibiting elective surgery by on-call physicians to better serve the needs of its patients seeking treatment for a potential emergency medical condition When a physician has agreed to be on-call at a particular hospital during a particular period of time, but has also scheduled elective surgery during that time, that physician and the hospital should have planned back-up in the event that he/she is called while performing elective surgery and is unable to respond to the situation or the implementation of an appropriate EMTALA transfer according to §489.24(e).

Physicians can be on-call simultaneously at other hospitals to maximize patient access to care. When the on-call physician is simultaneously on-call at more than one hospital in

the geographic area, all hospitals involved must be aware of the on-call schedule as each hospital independently has an EMTALA obligation The medical staff by laws or policies and procedures must define the responsibilities of the on-call physicians to respond, examine and treat individuals with emergency medical conditions, and the hospital must have policies and procedures to be followed when a particular specialty is not available or the on-call physician cannot respond because of situations beyond his or her control as the hospital is ultimately responsible for providing adequate on-call coverage to meet the needs of its individuals.

Tag A405

§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.

§489.24 Special Responsibilities of Medicare Hospitals in Emergency Cases

The provisions of this regulation apply to all hospitals that participate in Medicare and provide emergency services.

Hospitals with an emergency department are required under EMTALA to do the following:

- To 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;

- 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;

- 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

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Tag A406

§489.24(a) General

(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)

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 for the individual and stabilizing treatment or an appropriate transfer. The purpose of the medical screening examination 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 examinations 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 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 a 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) on-call, 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

Individuals coming to the emergency department must be provided a MSE beyond initial triaging. Triaging is not equivalent to a medical screening examination. Triage merely determines the "order" in which individuals will be seen, not the presence or absence of an emergency medical condition.

A MSE is the process required to reach with reasonable clinical confidence, the point at which it can be determined whether a medical emergency does or does not exist. 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) a screening process that is reasonably calculated to determine whether an EMC exists, it has met its obligations under the EMTALA.

Depending on the individual's presenting symptoms, the MSE represents a spectrum 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 diagnostic tests and procedures.

A MSE is not an isolated event. It is an ongoing process. The record must reflect continued monitoring according to the patient's needs until he/she is stabilized or appropriately transferred. There should be evidence of this evaluation 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 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 person actually caring for the patient at the treating facility

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.

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

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

However, in the event of a national emergency or crisis (e.g. bioterrorism) State or local governments may develop community response plans that designate specific entities (hospitals, public health facilities, etc.) with the responsibility of handling certain categories of patients during these **catastrophic events**. Hospitals in the area of the national emergency would still be responsible for providing a MSE to all individuals who requested examination or treatment for a medical condition or an EMC, but the transfer or referral of these individuals in accordance with such a community plan would not result in sanctions against the hospital under EMTALA. For example: An individual who has been potentially exposed to a toxin presents at a hospital that has not been designated, pursuant to a State or local EMS plan, as a hospital where patients exposed to toxins should go. After questioning the individual and making a determination that the individual falls into the category for which the community has a specified screening site, the individual may be referred to the designated community facility without risking sanctions under 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 a individuals 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.

If a QMP other than the physician (Registered Nurse, Physician Assistant, etc.) determines a woman is in false labor; a physician must certify the diagnosis. How the physician certifies (telephone consultation, or actually examines the patient) the diagnosis of false labor is determined by the hospital and its medical staff. The hospital should have policies and procedures in place providing guidance to their QMP on how to meet this requirement If telephone consultation is the means utilized to satisfy this requirement, documentation within the patient charts must be in accordance with the hospital CoP at 42 CFR §482.24(c)(1)

(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 Guideline §489.24(a)(1)(ii)

Refer to Tag A407 for stabilizing treatment and inpatients and Tag A409 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.

(2) Nonapplicability of provisions of this section. Sanctions under this section for inappropriate transfer during a national emergency do not apply to a hospital with a dedicated emergency department located in an emergency area, as specified in section 1135(g)(1) of the Act.

Interpretive Guidelines §489.24 (a)(2)

CMS will issue guidelines as appropriate in the event of a national emergency and its impact upon the EMTALA regulations.

§489.24(c) Use of Dedicated Emergency Department for Nonemergency Services

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

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 hat 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 A407

§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 A409) 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 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

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 (1) 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 A409) 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 A409).

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 has been declared dead or leaves the facility without the permission of any such person. If discharge would result in the reasonable medical probability of material deterioration of the patient, the emergency medical condition should not be considered to have been stabilized."

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 (nonemergency) diagnosis or treatment.

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

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)(ii)

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

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Tag A408

§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 nonphysician practitioner to an individual until after the hospital has provided the appropriate medical screening examination required under paragraph (a) of this section, and initiated any further medical examination and treatment that may be required to stabilize the emergency medical condition under paragraph (d)(1) of this section.

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

(iv) Hospitals may follow reasonable registration processes for individuals for whom examination or treatment is required by this section, including asking whether an individual is insured and, if so, what that insurance is, as long as that inquiry does not delay screening or treatment. 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 A409

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

§489.24(e)(1) and (2)

(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

Interpretive Guidelines: §489.24 (e)(1)(i)

If an individual's EMC has not been resolved prior to transferring the individual to another hospital the sending hospital has an EMTALA obligation, and must meet the four requirements of an "appropriate" transfer.

These requirements are found in §489(e)(2):

- §489.24(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;
- §489.24(e)(2)(ii), the receiving facility has agreed to accept the patient, has space and qualified personnel available for the treatment;
- §489.24(e)(2)(iii), the transferring hospital sends to the receiving facility all medical records related to the emergency medical condition which are available at the time of transfer and;
- §489.24(e)(2)(iv), the transfer is effected through qualified personnel and transportation equipment

(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

Interpretive Guidelines: §489.24 (e)(1)(ii)(A) and (B)

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

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 and 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.

The certification that the benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the risk of the transfer is not required for transfers of individuals who no longer have an emergency medical condition.

The date and time of the physician certification should closely match the date and time of the transfer.

(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.

Interpretive Guidelines: §489.24 (e)(1)(ii)(C)

A QMP may sign the certification of benefits versus risks of a transfer only after consultation with the physician who authorizes the transfer. If a QMP determines that the transfer to another facility is in the best interest of the individual and signs the certification of benefits versus risks, a physician's countersignature must be obtained within the established timeframe according to hospital policies and procedures

(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;

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

This is the first requirement of an appropriate transfer

The provision of treatment to minimize the risks of transfer is merely one of the four requirements of an appropriate transfer. If the patient requires treatment, it must be sufficient to minimize the risk likely to occur or result from the transfer.

NOTE: The four requirements of an "appropriate" transfer are applied only if the transfer is to another medical facility. In other words, the hospital has the alternative of either (1) providing treatment to stabilize the emergency medical condition and subsequently admitting, discharging or transferring the individual, or (2) appropriately transferring an unstabilized individual to another medical facility if the emergency medical condition still exists. There is no "third" option of simply "referring" the individual away after performing step one (treatment to minimize the risk of transfer) of the four transfer requirements of an appropriate transfer.

If an individual is moved to another part of the hospital, the transfer requirements are not applicable because technically the patient has not been transferred.

If an individual is moved to a diagnostic facility located at another hospital with the intention of returning to the first hospital, an appropriate transfer (within the meaning of paragraph (e)(2) of this subsection) must still be effectuated 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 Implementing an appropriate transfer back to the sending hospital is not necessary

Surveyor Probes

After the investigation of the transferring hospital, call or go to the receiving (recipient) facility and determine whether the receiving (recipient) facility verifies the transferring hospital's information In cases of discrepancy, obtain the medical record from the transferring and receiving hospitals and the ambulance service for review. Review each hospital's information If you determine that it is necessary to conduct a complaint investigation at the receiving (recipient) hospital, notify the RO to request an extension of the investigation timeframe

Review the transfer logs for the entire hospital, not merely the emergency department. Examine the following for appropriate transfers:

- Transfers to off-site testing facilities and return;
- Death or significant adverse outcomes;
- Refusals of examination, treatment, or transfer;
- Patients leaving against medical advice (AMA);
- Returns to the emergency department within 48 hours; and
- Emergency department visits where the individual is logged in for an unreasonable amount of time before the time indicated for commencement of the medical screening examination.

(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;

Interpretive Guidelines: §489.24(e)(2)(A) and (B)

This is the second requirement of an appropriate transfer.

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 of the person accepting the transfer.

(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

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

This is the third requirement of an appropriate 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.

Surveyor Probe

Documentation in the medical records should identify the services that were performed before transfer

(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)(2)(iv)

This is the fourth requirement of an appropriate 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 (and not 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 effected 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 A410

§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 A411

§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) 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.

Interpretive Guidelines: §489.24(e)

Recipient hospitals only have to accept a patient if the patient requires the specialized capabilities of the hospital in accordance with this section and the hospital has the capacity to treat the individual. If the transferring hospital wants to transfer a patient, but the patient does not require any "specialized" capabilities, the receiving (recipient) hospital is not obligated to accept the patient unless the individual presents at the recipient hospital. If the patient required the specialized capabilities of the intended receiving (recipient) hospital, and the hospital has the capability and capacity to accept the transfer, but refused, this requirement has been violated.

Lateral transfers, that is, transfers between facilities of comparable resources, are not sanctioned by §489.24 because they would not offer enhanced care benefits to the patient except where there is mechanical failure of equipment, no ICU beds available, or similar situations. However, if the sending hospital has the capability but lacks the capacity, then the individual would most likely benefit from the transfer.

The number of patients that may be occupying a specialized unit, the number of staff on duty, or the amount of equipment on the hospital's premises do not in and of themselves reflect the capacity of the hospital to care for additional patients. If a hospital generally has accommodated additional patients by whatever means (e g , moving patients to other units, calling in additional staff, borrowing equipment from other facilities), it has demonstrated the ability to provide services to patients in excess of its occupancy limit For example, a hospital may be able to care for one or more severe burn patient without opening up a "burn unit." In this example, if the hospital has the capacity, the hospital would have a duty to accept an appropriate transfer of an individual requiring the hospital's capabilities, providing the transferring hospital lacked the specialized services to treat the individual. The provisions of this requirement are applicable only when the sending hospital is located within the boundaries of the United States Medicare participating hospitals with specialized capabilities or facilities are not obligated to accept transfers from hospitals located outside of the boundaries of the United States.

The recipient hospital has an EMTALA obligation when an individual with an EMC is transferred to its hospital.

If a hospital is found in violation of the recipient hospital responsibility requirements, obtain a copy of the patient's medical record from the transferring facility

Rural Regional Referral Centers

The criteria for classifying hospitals as rural regional referral centers are defined in 42 CFR §412.96 for the purpose of exemptions and adjustments of payment amounts under the Prospective Payment System. The criteria in 42 CFR §412.96 are applicable to the nondiscrimination provisions of §489.24 Check with the appropriate CMS RO for information as to whether the hospital is designated as a rural regional referral center 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