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EMTALA: A Practical Primer for Risk Professionals

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EMTALA: A PRACTICAL PRIMER FOR RISK PROFESSIONALS

The Emergency Medical Treatment and Labor Act (EMTALA) was passed in 1986 under the Consolidated Omnibus Budget Reconciliation Act to address "patient dumping," discussed further below, and to ensure access to emergency services, regardless of a patient's ability to pay.[1] Compliance with EMTALA is a condition of participation in the Medicare program.[2] This primer is intended to provide an overview of EMTALA, including the relevant regulations and Conditions of Participation (CoPs), as well as practical tips for risk professionals.

EMTALA's primary objectives, as defined by courts and federal agencies tasked with enforcement, are to ensure access by all persons to emergency medical care and to prohibit discrimination in the provision of that care to persons presenting with the same, or similar, medical conditions. Hospitals are required to provide a medical screening exam (MSE) to patients seeking emergency medical care. If the patient is in labor[3] or has an emergency medical condition (EMC), stabilizing treatment without regard to ability to pay must be provided.[4]

EMTALA regulations can be found at Title 42 of the Code of Federal Regulations (CFR); Interpretive Guidelines are contained within the *State Operations Manual* at tags A-2400/C-2400 through A-2411/C-2411.[5] Additional guidance on EMTALA is available in The Office of Inspector General's (OIG) advisory bulletins and from the Centers for Medicare & Medicaid Services (CMS) program memoranda.

Some states have adopted statutes or regulations governing the provision of emergency medical care and services.[6] Hospitals are obligated to comply with such state and local laws unless they conflict with the hospital's EMTALA obligations.

ENFORCEMENT

Congress has delegated to the Secretary of Health and Human Services the responsibility for determining the CoPs[7] for providers who participate[8] in federal health care programs.[9] CMS is the division within the Department of Health and Human Services responsible for overseeing the Medicare program, the federal portion of the Medicaid program, the State Children's Health Insurance Program, the Health Insurance Marketplace and related quality assurance activities.[10] The Secretary has delegated the responsibility for implementing and enforcing CoPs to CMS. Consequently, compliance with EMTALA CoPs, as established and interpreted by CMS, is essential to a provider's continued participation in federal health care programs.

ADMINISTRATIVE LAW: AN OVERVIEW

Administrative law is the body of law that regulates the operations and procedures of governmental agencies. Congress may, and often does, grant rulemaking authority to federal agencies in order to carry out the laws enacted by Congress. Regulations issued pursuant to this authority carry the force and effect of law. The process that federal agencies must follow when making such rules is governed by law and executive order. The Administrative Procedures Act (APA) sets forth the procedures that agencies must follow and provides standards for judicial review of agency action.[11]

Judicial Deference

Judicial deference to an agency's interpretation of federal law, and its own regulations, is well established. In *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.* (1984),[12] the Supreme Court of the United States established a two-part test for when a court must defer to an agency's interpretation of a federal statute: The language of the statute must be silent or ambiguous on the issue and the agency's interpretation must be reasonable.[13] *Chevron Deference* has become one of the most important principles of administrative law. The Supreme Court extended judicial deference to an agency's interpretation of its own regulations in *Auer v. Robbins* (1997),[14] holding that courts must defer to an agency's "reasonable interpretation" of its own ambiguous regulations.

While several recent cases have limited the scope and applicability of *Chevron* and its progeny, the central tenant of judicial deference to agency action remains largely intact. The result is that courts tend to give wide deference to actions taken by agencies in furtherance of their delegated authority to carry out Congress's statutory scheme. Ultimately, unless a court of competent jurisdiction has held that CMS's interpretation of EMTALA, or the CoPs, exceeds its authority or is otherwise unlawful, the CoPs have the same force and effect as law.

Administrative Remedies and Judicial Review

Disagreement with CMS's interpretation of ETMALA or the CoPs is insufficient to seek review of CMS's actions. A provider must be subject to an adverse action by CMS, such as imposition of a monetary penalty or termination of a Medicare provider agreement, to seek review of CMS's actions. Additionally, a provider must exhaust its administrative remedies before it is entitled to judicial review. The administrative review process requires a hearing on the issues before an administrative law judge (ALJ) whose decision may then be reviewed, upon request by either party, by the Departmental Appeals Board (Board).[15] The Board's decision is binding unless the provider has a right to, and timely files a civil action seeking, judicial review in accordance with the procedures set forth in Title 42 of the Code of Federal Regulations.[16]

Risk Management Implications

Practically speaking, CoPs carry the same force and effect as the law. The cost of noncompliance can be significant and may include monetary fines and termination of the provider's Medicare agreement. Pursuit of judicial review would be time consuming, expensive and unlikely to succeed. Consequently, it is advisable for providers to make every effort to comply with the CoPs.

WHEN AND WHERE EMTALA APPLIES

EMTALA obligations are triggered under the following circumstances:[17]

- An individual presents to a dedicated emergency department for examination or treatment of a medical condition and requests examination or treatment for a medical condition; has a request made on his or her behalf for examination or treatment for a medical condition; or, a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs examination or treatment for a medical condition. A dedicated emergency department under EMTALA distinguishes between departments that the hospital represents as providing services for persons with urgent or emergent medical conditions and other departments that primarily provide scheduled care and services. A facility is determined to have a dedicated emergency department if it meets any one of the following tests:[18]
  - The department or facility is licensed as an emergency room or department by the state in which it is located.
  - The department or facility is represented to the public (by name, signs, advertising or other means) as providing emergency medical care on an urgent basis without the need to schedule an appointment.
  - At least one-third of the visits to the department in the preceding calendar year resulted in treatment for emergency medical conditions on an urgent basis.

CMS has determined that other departments within a hospital, such as labor and delivery and psychiatric units, may constitute a dedicated emergency department under certain circumstances.[19] Furthermore, CMS has rejected a request to exclude hospital urgent care centers from the EMTALA requirements. The application of EMTALA to areas outside a traditional hospital emergency room is discussed below.

- EMTALA obligations begin when an individual presents on hospital property, to other than a dedicated emergency department, and requests examination or treatment for an EMC; has a request made on their behalf for examination or treatment for an EMC; or, when a layperson would reasonably believe, based on the individual's appearance or behavior, that the individual is experiencing an EMC.[20] CMS has defined hospital property as the main hospital buildings and areas, including areas such as parking lots, driveways and sidewalks, within 250 yards of the main hospital buildings, unless CMS has approved an alternative description of the hospital property.[21] As a general rule of thumb, main hospital buildings are considered to be the main building(s) in which the hospital provides inpatient services.[22]

Patients who present with a possible EMC to an on-campus department of a hospital outside of the dedicated emergency department may be moved to the dedicated emergency department or other appropriate location after an initial screening in order to provide further screening and stabilizing treatment. Movement of a patient within departments on a hospital campus is not considered a transfer within the meaning of EMTALA.[23] However, movement of such patients within the hospital must follow the same procedures and criteria as those that would have been used if the patient had presented to and received an initial screening exam in the dedicated emergency department.[24]

Risk Management Implications

Hospitals should develop policies establishing protocols for moving patients from a dedicated emergency department. Such policies should require that all patients with the same or similar conditions be moved to a department or service regardless of their ability to pay, that such movement is predicated on the existence of a *bona fide* medical reason to move a patient and that qualified medical personnel accompany patients when they are being moved to another department or on-campus location.

Hospitals should adopt policies and procedures for responding to emergencies occurring on hospital property outside of the main hospital building. These policies and procedures should establish who is responsible for responding to on-campus emergencies, procedures for moving patients to the emergency department or calling for emergency transport, documentation standards and quality improvement review of the handling of emergency situations. It is important for hospitals to provide in-service training to all relevant personnel, not just clinical staff. For example, security personnel are often the first responders to the scene of an emergency on the hospital campus.

- EMTALA begins when an individual enters an air or ground ambulance for purposes of examination or treatment of a medical condition at the hospital's dedicated emergency department when such ambulance is owned or operated by the hospital. EMTALA does not apply to an individual in an ambulance owned or operated by a hospital in the following situations:[25]
  - Community emergency medical service protocols direct the ambulance to transport the individual to a hospital other than the hospital that owns or operates the ambulance, that is, the closest available facility.
  - A physician who is not employed or affiliated with the hospital is responsible for directing the operations of the hospital-owned ambulance.
- An individual in a nonhospital-owned ambulance is on a hospital's property for the purpose of seeking examination or treatment for a medical condition at the hospital's dedicated emergency department.[26]

Urgent Care Centers

Whether an urgent care center constitutes a dedicated emergency department is based on whether it meets the following criteria: It is represented to the public as only providing urgent care and, possibly, other services; the public is clearly advised that the urgent care center is not an emergency department and does not provide emergency medical services; and, the urgent care center does not meet EMTALA's definition of a dedicated emergency department.[27] The critical factor in determining whether an urgent care center constitutes a dedicated emergency department is how it is represented to the public.

Risk Management Implications

The broad definition of dedicated emergency department requires a hospital to evaluate its ambulatory care departments, both on- and off-campus, to identify services that meet the definition of a dedicated emergency department. The hospital should review the volume of drop-in patients who present with conditions meeting the statutory definition of an EMC, along with all information disseminated to the public regarding the types and availability of services offered.

Off-Campus Hospital Departments

Off-campus departments and facilities that do not qualify as dedicated emergency departments are not subject to EMTALA. However, these departments and facilities are subject to the Medicare CoPs, which require written policies and procedures to be established for responding to emergencies that occur on their premises.

The Interpretive Guidelines for off-campus departments require that the policies and procedures must apply to patients, staff, visitors, and others seeking or in need of emergency medical care. They also require that staff of the department or facility know how to respond to an individual seeking or in need of emergency medical services and that initial treatment and stabilization of individuals needing emergency medical care be provided in accordance with the complexity of services, types and qualifications of staff, and other resources available at the department's location.[28] CMS limits applicability of these policies and procedures to the department's or facility's normal business hours.

Such policies may direct staff in off-campus departments to call 9-1-1 for patient care management and transport to an emergency department. EMTALA does not require off-campus departments to be staffed with qualified professionals capable of managing individuals who present with an emergency medical condition.

Freestanding Emergency Departments

Freestanding emergency departments that offer emergency services at off-campus locations that are operated as provider-based departments of a hospital must meet the Medicare CoPs and requirements established by EMTALA.[29]

Labor and Delivery Departments

CMS considers a labor and delivery service to be a dedicated emergency department.[30] Therefore, the labor and delivery service must comply with all EMTALA obligations, including signage, a central log, opening of medical records and on-call coverage. Additionally, the labor and delivery service must have policies for providing an MSE, necessary stabilizing treatment, and an appropriate transfer, when required, for any individual who presents to the department seeking or in need of examination or treatment for an emergency medical condition.

The scope of the screening examination for women presenting with labor-related conditions is to determine whether the patient is experiencing contractions or has an EMC unrelated to pregnancy.[31] A registered nurse may conduct the labor screening examination, as long as the hospital has defined this as within the scope of practice for registered nurses in the standardized procedure adopted by the medical staff and the hospital board and it is in compliance with relevant state licensing agencies.[32] Such procedures should require that the patient be seen by a physician or other qualified professional in labor and delivery or be moved to the dedicated emergency department for evaluation by an emergency physician, for any nonpregnancy-related condition beyond the scope of the registered nurse.

Risk Management Implications

State surveyors will review the medical records of patients in labor to see if the MSE included ongoing evaluation of fetal heart tones, regularity and duration of uterine contractions, fetal position and station, cervical dilation and the status of membranes: ruptured, leaking or intact.[33]

Discharging Women in Labor

EMTALA regulations define an emergency medical condition in relation to a woman in labor[34] as a condition in which there is insufficient time to safely transfer the patient to another hospital before delivery, or where such transfer may pose a threat to the health and safety of the woman or the fetus.[35] The regulations define stabilized, in these cases, as the delivery of the child and placenta.[36] The Interpretive Guidelines require that the hospital must deliver the infant or undertake appropriate transfer of the woman. Transfer may only occur when requested by the patient or a person legally authorized to act on her behalf or when a physician or other qualified medical personnel certifies that the benefits of the transfer outweigh its risks.[37]

A woman having contractions is presumed to be in true labor unless a physician, certified nurse-midwife or another qualified professional, after a reasonable period of observation, certifies that the woman is in false labor.[38] There is no requirement that the consulting physician must come to the hospital to examine the patient. The Interpretive Guidelines note that telephone consultations must be documented in the medical record in accordance with the COPs for medical record entries.[39]

Risk Management Implications

The transfer of a woman in labor is a high priority for EMTALA enforcement. Review will include information such as the woman's prenatal history, condition at the time of presentation to the hospital, condition of the fetus at the time of transfer or discharge, the respective capabilities of the transferring and receiving facilities, expected delivery time and the means of transport.[40]

When a woman having contractions is discharged, other than for a certified false labor where the patient is determined not to have an EMC, the condition of the woman and fetus, the reliability of her support systems, transportation to return to the hospital and the actions of hospital staff will all be closely scrutinized.[41] It is therefore recommended that a hospital adopt policies and procedures describing the conditions and written instructions under which a woman having contractions may be sent home or referred or transferred to another facility. The policies also should designate who may perform the screening and discharge or transfer of the patient, the need for physician consultation, and requirements for countersigning determinations of false labor, when applicable. Hospitals should undertake retrospective quality improvement and risk management reviews of discharges and transfers of women having contractions to ensure they are in compliance with hospital policy.

Newborns

EMTALA requires an MSE and stabilizing treatment for infants born alive as defined under the Born-Alive Infants Protection Act.[42] The obligations apply to an infant born alive in a dedicated emergency department, including labor and delivery, if there is a request on the infant's behalf for, or a prudent layperson would conclude that the infant needs, examination, or treatment for a potential EMC. If the infant is born alive on hospital property outside of a dedicated emergency department, an MSE is required if there is a request on the infant's behalf for, or a prudent layperson would conclude that the infant needs examination, or treatment for a potential EMC.[43]

CMS guidance on application of EMTALA to the Born-Alive Infants Protection Act reaffirms that EMTALA does not apply to inpatients. Therefore, CMS has indicated that an infant considered to be an inpatient is covered by the Medicare CoPs rather than EMTALA.[44]

Risk Management Implications

Hospitals should develop and implement written policies and procedures for appraisal of newborns who have acute medical conditions.

Psychiatric Facilities

Psychiatric facilities that offer walk-in services for patients with potential psychiatric emergencies must provide emergency services within their capability or provide for an appropriate transfer in accordance with EMTALA requirements. Psychiatric hospitals that do not provide emergency or walk-in services are required to have appropriate written policies and procedures for appraisal, initial treatment and referral of patients who present with a psychiatric emergency.[45]

General acute care hospitals must provide an MSE, including medical and psychiatric assessments, within the capabilities of the hospital's emergency department, including ancillary services routinely available to the emergency department, for any patient presenting for examination of a psychiatric condition.[46]

While the Interpretive Guidelines do not define the term "psychiatric emergency," CMS considers the expression of suicidal or homicidal thoughts or gestures to constitute an EMC. Thus, CMS applies EMTALA equally to psychiatric and nonpsychiatric EMCs.[47]

EMTALA may conflict with state laws permitting detention of individuals for involuntary psychiatric evaluation and treatment, alignment of patients with local networks of designated facilities, and policies and guidance for detention and placement of psychiatric patients that may vary from state to state and county to county. Neither the EMTALA regulations nor the Interpretive Guidelines address involuntary holds.[48]

WHEN AND WHERE EMTALA DOES NOT APPLY

EMTALA does not apply under the following circumstances:[49]

- An individual presents to an off-campus department or facility of a hospital that is not a dedicated emergency department.
- An individual is receiving services on an outpatient basis in an encounter that does not trigger EMTALA obligations. If an outpatient develops an emergency condition during the course of an outpatient encounter, the hospital's response is governed by the CoPs, not EMTALA. However, EMTALA may apply if the individual was seeking or in need of examination or treatment of a potential EMC before the start, or after the completion, of the outpatient encounter.[50]
- An individual who is an inpatient, although different courts continue to rule differently on whether EMTALA applies to inpatients.
- An individual who presents to a facility or service that is not considered part of the hospital for Medicare purposes. EMTALA obligations apply only to the departments or facilities of a hospital that are billed to the Medicare program under the hospital provider number and are considered to be part of the hospital under applicable Medicare regulations. Outpatient clinics listed on and operated under the hospital's license are considered to be part of the hospital and are subject to EMTALA if they are located on hospital property.

Risk Management Implications

A review of the hospital's license and billing practices should be undertaken to determine whether its clinics are part of the hospital for billing and cost reporting purposes.

SPECIFIC TYPES OF PATIENTS

Inpatients

EMTALA obligations are terminated when an individual is admitted in good faith, that is, not as a means to avoid EMTALA obligations, for inpatient[51] care in order to stabilize an EMC.[52]

While regulations apply to the interpretation and enforcement of EMTALA by CMS, they are not binding on the courts. In a 2009 decision, the Sixth Circuit Court of Appeals held that the regulation excluding inpatients from EMTALA "is contrary to the plain language" of the statute.[53] Because the case arose from an inpatient stay that occurred prior to the 2003 change in the regulations, the court did not strike the regulation down. A district court in Texas reached a similar conclusion in 2012.

In 2012, CMS confirmed in commentary that it was maintaining its current policy that EMTALA obligations end when an individual is admitted in good faith for inpatient care in order to stabilize an EMC. Inpatients are subject to the standards and protections of the Medicare CoPs.[54] The Interpretive Guidelines also clarify that emergency patients deemed to be observation status are not considered inpatients, even if they occupy a bed overnight in the observation unit. Therefore, receiving hospital obligations apply to the transfer of those patients.[55]

Patients in a Dedicated Emergency Department Waiting for an Inpatient Bed

EMTALA does not apply to individuals who are admitted as hospital inpatients, including those who are boarded in a dedicated emergency department waiting for an inpatient bed, regardless of the location of the inpatient within the hospital building.[56]

Patients Seeking Non-Emergency Services

EMTALA applies when a patient presents to a dedicated emergency department, even if the patient is requesting non-emergency services.[57] This includes patients who are referred by their primary care or other physicians to a hospital emergency department, labor and delivery department, or another department that is deemed to be a dedicated emergency department, for injections or other procedures. The hospital's obligation requires that an appropriate MSE be performed to confirm that the individual does not have an EMC.[58]

If an individual presents to an on-campus hospital service other than a dedicated emergency department, EMTALA only applies if the individual is seeking or in need of examination or treatment for a potential EMC.[59] The hospital must provide an MSE, either in the dedicated emergency department or another hospital department.

CMS has indicated that EMTALA does not apply to individuals who present to a dedicated emergency department requesting services other than examination or treatment of an EMC, including preventive care services such as immunizations, allergy shots, flu shots and routine blood pressure checks.[60] CMS implies that not all requests by patients presenting to a dedicated emergency department for medications trigger EMTALA. However, there is insufficient guidance at this time to determine the categories of medication requests that do not trigger EMTALA.[61] Therefore, best practice is to provide an MSE and other EMTALA-required services to those patients presenting for pharmaceutical services. Hospitals are not required to provide medication to patients who do not have an EMC simply because they failed to appropriately plan for refills, do not wish to have the prescription filled at a retail pharmacy or are unable to pay.[62]

Risk Management Implications

Hospitals and physicians should consider regulatory and risk management issues when deciding whether to administer medication in the absence of an MSE for patients presenting to an emergency department. Hospitals should follow their standard policies and procedures for pharmacy services requested by non-emergency patients.

Patients with Scheduled Appointments in a Dedicated Emergency Department

The Interpretive Guidelines indicate that a hospital may be exempted from EMTALA when an individual has a previously scheduled appointment in a dedicated emergency department, such as labor and delivery, an urgent care clinic or another hospital service that meets the definition of a dedicated emergency department.[63] There is no clear guidance on the types of scheduled patients presenting to an emergency department who do not trigger the EMTALA obligations.

Hospitals with emergency department appointment reservation programs that allow patients to sign up for a time slot when they may be seen in the emergency department should consult with their legal counsel regarding how the appointment program implicate EMTALA obligations.

Visitors, Vendors and Hospital Employees

EMTALA applies to any individual who is on the hospital campus for other than outpatient services and may experience an EMC, including visitors, vendors and hospital employees.[64]

Law Enforcement Requests

In general, a request by law enforcement for services that constitute the gathering of evidence for criminal law cases does not trigger EMTALA. This exception is limited to situations in which law enforcement personnel do not request examination or treatment for a medical condition and where a prudent layperson would not conclude that the individual needed such examination or treatment.[65] However, where an individual was involved in an accident or may have sustained an injury, an MSE is warranted regardless of law enforcement's failure to request examination and treatment of the injury. The Interpretive Guidelines apply these same principles to individuals presenting to a dedicated emergency department in connection with rape or sexual assault.[66]

Requests for pre-jail clearance trigger EMTALA obligations, and hospitals should provide an MSE to determine whether the individual has an EMC.[67]

Hospitals have been penalized when physicians and other medical personnel have complied with the request of law enforcement over their own professional medical judgment and experience. Courts have held that EMTALA is triggered if a prudent layperson would conclude that medical care is indicated for an individual brought to the emergency department by law enforcement requesting only a blood or urine analysis.[68] The purpose of EMTALA as interpreted by the courts is to ensure uniform treatment, including screening, of all patients who present to the emergency department, regardless of how they arrived.[69]

Persons Who Telephone a Hospital

EMTALA does not apply to a person who calls a hospital regarding the need for examination or treatment. However, the failure of a hospital to accept a call or radio request for transfer or admission may violate other federal or state law requirements.[70]

Patients in Ambulances

Hospital-Owned Ambulances

An individual in a hospital-owned ambulance being transported to the hospital for purposes of examination and treatment of a potential EMC triggers EMTALA, except when the ambulance is operating pursuant to community-wide protocols or under the direction of a physician who is not employed or affiliated with the hospital that owns the ambulance.[71]

An individual in a hospital-owned ambulance may not be diverted while en route to the hospital unless the ambulance is operating under community-wide emergency medical services (EMS) protocols. Additionally, the ambulance cannot be diverted once it arrives on hospital property.

EMTALA obligations do not apply to ambulances operated under community-wide EMS protocols that direct the ambulance to transport the individual to a hospital other than the hospital that owns the ambulance. EMTALA obligations also do not apply when a physician who is not employed or affiliated with the hospital that owns the ambulance directs the ambulance to transport the individual to another hospital.[72]

Nonhospital-Owned Ambulances

If a nonhospital-owned ambulance advises a hospital of its intent to transport an individual to the hospital, EMTALA permits the hospital to deny access if it is on diversionary status.[73] If the ambulance still brings the individual to the hospital, the hospital must accept the person and provide an MSE.[74]

Ambulance on Hospital Property to Access a Helipad

Use of a hospital helipad by local ambulance services or other hospitals to transport a patient to a tertiary or trauma hospital does not trigger EMTALA for the hospital that owns the helipad if the helipad is being used for the purpose of transit; however, the sending hospital is responsible for performing an MSE prior to transporting the patient to the helipad.[75] If the ambulance crew or patient, while at the hospital with the helipad, requests the hospital's assistance, the hospital must provide emergency services consistent with its EMTALA obligations.

EMTALA REQUIREMENTS

Medical Screening Exam

A hospital must provide an appropriate MSE within its capability and capacity to determine if an individual has an EMC.[76] Because a labor and delivery department is considered to be a dedicated emergency department, women presenting to a dedicated emergency department with labor-related conditions may be directed or otherwise moved to the labor and delivery service without an initial screening in the emergency department.[77]

The MSE requirement applies to any individual who comes to an on- or off-campus dedicated emergency department seeking or in need of examination or treatment for a medical condition or is at any other location on hospital property seeking or in need of examination or treatment for what may be an EMC. The Interpretive Guidelines define the MSE as a process required to reach a decision as to whether, within a reasonable degree of clinical confidence, an individual has an EMC. The MSE must be provided in the same manner to all individuals presenting with similar signs and symptoms.

The elements of the MSE are not defined, but will vary according to the patient's presenting complaint, history, medical condition, and the hospital's available resources.[78] Factors including non-discrimination, individual and condition-specific, continuous monitoring and contemporaneous documentation are all considered when determining whether an MSE was appropriate.[79]

The MSE must be tailored to the presenting signs and symptoms and medical history of the individual. It may range from simple to complex, and may include laboratory tests, diagnostic imaging and/or other diagnostic tests and procedures. In some cases, the MSE may require a reasonable period of observation and monitoring, or consultation with an on-call specialist, to determine whether the individual has an EMC.[80]

The patient's clinical outcome is not considered to be a determining factor as to whether an MSE was appropriate or whether the patient was provided with stabilizing treatment.[81] Furthermore, according to CMS, a misdiagnosis where a hospital used all of its resources[82] does not constitute an EMTALA violation.[83]

Triage does not qualify as an MSE because its purpose is to determine the order in which patients will be seen, rather than the presence or absence of an EMC.[84] While an MSE may begin with triage, it is ultimately an ongoing process meant to determine, within a reasonable degree of medical certainty, whether an EMC exists.

Documentation

The determination of appropriateness of the MSE is based on documentation. Surveyors are directed to determine whether the medical record contains documentation of the screening; tests; mental status; impressions and diagnosis, as supported by a history and physical examination; laboratory tests; and other tests and procedures.[85] This documentation is critical to demonstrating that the hospital provided an appropriate MSE or other required treatment. Hospitals have been cited for failure to provide an adequate MSE or required treatment based on inadequate documentation.[86]

Nondiscrimination

An MSE must be the same for all individuals coming to the hospital's dedicated emergency department with the same or similar signs and symptoms, regardless of the individual's ability to

pay.[87] A hospital's EMTALA obligations are met when it applies a screening process that is reasonably calculated to determine whether an individual has an EMC and does so in a nondiscriminatory manner.

The tests described in the Interpretive Guidelines are generally consistent with the standards adopted by the federal courts for providing an appropriate medical screening. The Interpretive Guidelines require that the screening must be provided regardless of diagnosis, such as labor or AIDS; financial status, such as insured or Medicaid; race and color; national origin; disability; or other nonmedical factors.

Continuous Monitoring

An MSE is not an isolated event, but rather an ongoing process.[88] The medical record must reflect ongoing monitoring in accordance with the individual's needs. Monitoring must continue until it is determined that the individual does not have an EMC or until such time as the individual is admitted, stabilized or appropriately transferred or discharged. The Interpretive Guidelines state that the medical record should contain evidence of an evaluation prior to discharge or departure from the hospital or transfer to another facility.[89]

Resources Considered Available to a Dedicated Emergency Department

Resources considered to be available to a dedicated emergency department include ancillary services routinely available to the department, on-call physicians and the staff and resources of a hospital routinely available for emergency services to inpatients.[90] A hospital is not required to expand its resources or offer more services to meet its EMTALA obligations. However, surveyors will evaluate whether it appears that a hospital with a dedicated emergency department does not have adequate staff and equipment to meet the needs of its patients.[91]

Non-Emergent Conditions

When the nature of a request for examination or treatment makes it clear that the medical condition is not emergent, a hospital's obligation is limited to performing such screening as would be appropriate for any individual presenting in the same manner to determine that the individual does not have an EMC.[92]

Minors

An MSE for a minor may not be delayed by waiting for parental consent.[93] If the examination indicates that the minor does not have an EMC, a hospital may wait for consent from a parent or other responsible adult before providing further examination or treatment, although the hospital must continue to monitor the minor's condition, and if necessary, render treatment as may be appropriate to stabilize an EMC.

Risk Management Implications

Hospitals should be aware of state laws governing those services that may or must be provided to minors with or without parental consent or notification.

Who May Perform an MSE

The MSE must be conducted by an individual determined to be qualified by the hospital and medical staff. There is no requirement that the person must be a physician; however, the medical staff must establish the categories of personnel designated to perform an MSE. The categories must be listed in the medical staff bylaws or rules and regulations and be applied to each department that provides MSEs for patients.[94]

An MSE may be conducted by individuals determined qualified by hospital bylaws or medical staff rules and regulations, as set forth in a document approved by the governing body of the hospital. Surveyors are not required to accept the hospital's or medical staff's determination. Furthermore, this determination may not be delegated to the emergency services medical director or a medical staff committee.

State professional practice acts and facility licensing laws govern the process of certifying health care professionals designated to perform MSEs. Hospitals must develop screening procedures or protocols when nonphysicians perform MSEs and indicate when a physician must be contacted for consultation or take responsibility for the patient.[95]

Risk Management Implications

Hospitals should ensure that triage classifications are based on nationally or industry-recognized standards and that triage classifications for emergency patients are consistent with hospital triage policies. Policies and protocols should be established to ensure that MSEs are carried out and documented in compliance with the CoPs.

The basic qualifications for personnel designated to perform MSEs should be included in medical staff and hospital policies. Limitations on the ability of designated personnel to perform certain types of examinations should be listed in medical staff rules and regulations. The hospital should set forth training and in-service requirements for screening personnel in policies and procedures and maintain records of personnel who complete training and in-service programs. Additional standards may be required for registered nurses who perform MSEs.

Responsibility for Treatment Decisions

The physician treating a patient with a potential EMC is the responsible physician for purposes of EMTALA compliance.[96] A treating physician may be any on-site physician, including an emergency physician, an obstetrician who is attending a patient in labor, an on-call physician who assumes responsibility for the patient or any other member of the hospital medical staff who attends a patient in a dedicated emergency department.[97]

If a disagreement occurs between the treating physician and the patient's primary care or gatekeeper physician, the primary care physician or a managed care plan physician may come to the hospital and assume responsibility for the patient's continuing course of care and treatment, assuming that physician has privileges at the hospital where the patient is being treated.[98] Assumption of care by the patient's primary care or plan physician does not absolve the hospital from liability, although it may absolve the treating physician from liability under EMTALA.

TRANSFERRING PATIENTS

Un-stabilized Patients

Under EMTALA, a patient who is determined to have an EMC must be provided with further examination and necessary stabilizing treatment within the capability and capacity of the hospital's facilities and staff, including on-call physicians.[99] An un-stabilized patient may only be transferred to another appropriate facility upon an informed request by the patient or the patient's representative, or when the hospital lacks the capability to provide necessary stabilizing treatment.[100] If a hospital has exhausted its capability or is operating beyond its capacity, an appropriate transfer must be made if the EMC is not stabilized.[101] When a transfer is undertaken for medical reasons, the transferring physician must certify that the benefits reasonably expected from treatment at the receiving facility outweigh the increased risks related to the transfer.[102]

A patient's request for transfer must be in writing, signed by the patient or their representative, contain a brief statement of the hospital's ETMALA obligations, indicate the reasons for the transfer, describe the risks and benefits discussed with the patient and be included in the patient's medical record with a copy sent to the receiving hospital.[103]

A transfer based on physician certification requires a signed certification stating that, based on the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the patient, and if she is in labor, to the fetus, from effecting the transfer.[104] The certification must include a summary of the risks and benefits upon which it is based. The certification cannot be implied from the medical record but must state the reasons for the transfer; include a summary of the risks and benefits upon which it is based; be timed and dated close to the time and date of the transfer; and be included in the medical record forwarded to the receiving hospital with the patient. The Interpretive Guidelines state that the certification should not cite state law or industry practice as the basis for a transfer.[105]

The Fifth Circuit Court of Appeals has identified the ways in which a hospital or a physician may violate the certification requirement:

- Failure to obtain the physician's signature on the certification form.
- Failure by the physician to deliberate and weigh the medical risks and benefits of the transfer before signing the certification.
- Reliance by the physician on an improper consideration as a significant factor in the certification decision.
- Signing a certification despite a finding that the medical risks outweigh the medical benefits expected from the transfer.[106]

If the transferring physician is not physically present at the time of transfer, another qualified professional in consultation with the physician may determine that the benefits of the transfer outweigh the risks and, if it is determined that it is appropriate to transfer the patient, sign the certification.[107] The consulting physician must later countersign the certification.

A transfer under the foregoing conditions must meet four basic criteria:[108]

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

A timely reassessment of the patient prior to departure from the hospital must be documented. Records related to patient transfers must be maintained for a period of at least five years from the date of transfer.[109]

Stabilized Patients

Understanding the meaning of the term stabilized is critical for many reasons. It determines when a hospital has met its EMTALA obligations to a patient who has an EMC; when a hospital must follow the EMTALA standards for making an appropriate transfer of a patient; and, when a receiving hospital must accept, or may refuse to accept, a transfer of a patient with an EMC from another hospital.[110] Under EMTALA, with respect to an EMC, stabilized means that no material deterioration of the patient's condition is likely, with reasonable medical probability, to result from or occur during the transfer or discharge of the patient from the facility; or, with respect to a woman in labor who meets the criteria of an EMC under EMTALA, the baby and placenta have been delivered.[111]

Stabilized and stable are not interchangeable terms and may cause confusion among practitioners. In the *St. Anthony Hospital* decision, the court noted that the legal definition of stabilization in EMTALA is different from the medical use of the term stable to denote the status of a patient or his/her condition.[112] CMS attempted to clarify this issue stating that a patient's EMC is deemed stabilized if the treating physician or other qualified professional determines within reasonable clinical confidence that the patient's EMC has been resolved.[113] However, the term resolved does not appear in the statute or regulations and is not defined by CMS in the Interpretive Guidelines. In attempting to clarify the meaning of resolved, CMS stated that patient stabilization does not require the resolution of the underlying medical condition.[114]

Emergency Psychiatric Conditions

An individual who expresses suicidal or homicidal thoughts or gestures and who is determined to be dangerous to self or others is considered to have an EMC.[115] The definition of stabilized for medical emergencies also applies to psychiatric EMCs, and there is no distinction under the EMTALA rules between the transfer of an individual with a medical EMC or a psychiatric EMC.

Stabilized Versus Resolved

It is the treating physician's responsibility to determine whether an individual has an EMC, whether that EMC is stabilized or resolved and whether the individual's condition is stabilized for purposes of transfer or discharge.[116] In the event of disagreement, the medical judgment of the treating physician usually takes precedence.[117]

Capability and Capacity

When a hospital does not have the capability or capacity to provide a service to an individual with an unstabilized EMC, the hospital must arrange an appropriate transfer to another facility.[118] In general, EMTALA focuses on the capability and capacity of the hospital as a whole, rather than the capability of the dedicated emergency department.

EMTALA compliance is more difficult when a hospital does not have an organized service or medical specialty to treat the needs of a particular emergency patient. CMS will determine on a case-by-case basis whether a hospital has the capability to provide a service, even if the hospital is not licensed to offer that service.[119]

The EMTALA regulations define capacity as the ability to admit or treat patients based on staff, beds and equipment, as well as the "hospital's past practices of accommodating additional patients in excess of its occupancy limits."[120] CMS looks at the hospital's history of absorbing emergency patients by shifting patient room assignments or calling in additional staff. If a hospital has provided services to emergency patients in excess of its service capacity, an EMTALA violation may be alleged if the hospital denies treatment to a similar patient with an EMC.[121]

DISCHARGING PATIENTS

An individual with an EMC may be discharged when the treating physician, or other qualified professional, determines that the EMC is stabilized, defined as the point where continued care can reasonably be carried out in the outpatient setting or at a later date as an inpatient, provided the individual is given discharge instructions that contain information regarding appropriate follow-up care.[122] This criterion also applies to patients with a psychiatric emergency.

Hospitals are expected to provide discharged patients with the necessary information to secure follow-up care in order to prevent relapse or deterioration of the medical condition. CMS has interpreted this to require patients be provided with resources that are geographically and financially accessible to the patient.[123]

Homeless Patients

CMS and the EMTALA Interpretive Guidelines do not specifically address the discharge of homeless patients. However, the provisions related to providing a plan for appropriate follow-up applies equally to homeless patients.

Emergency departments are subject to the Medicare CoP for preparing a discharge summary; however, the summary is not required to be given to the patient.[124]

Risk Management Implications

Hospitals should have in place policies and procedures with clear criteria for discharge of all patients who present for evaluation or treatment of an EMC. It is essential that discharge criteria be applied objectively, without regard to a patient's insurance status, ability to pay, frequency of utilization or other factors that may be deemed discriminatory.

Hospitals should have a process to ensure all patients are provided with instructions regarding recommended follow-up care, including a list of resources that are geographically and financially accessible.

While not required, hospitals with the resources to do so should consider whether it would be prudent to undertake a process of scheduling follow-up care for patients who are unable to do so for themselves. While CMS applies a reasonableness standard to a hospital's obligation to provide patients with information to secure appropriate follow-up care, the threshold for what is reasonable is not clearly defined and may take into consideration an institution's resources. For example, if an individual does not have a telephone, it would be difficult to schedule an appointment. Therefore, providing individuals with a list of resources may be deemed insufficient to assist with the necessary information to secure follow-up care.

FINANCIAL CONSIDERATIONS

A hospital may not delay providing an MSE or other emergency services in order to inquire about an individual's insurance status or ability to pay.[125] EMTALA regulations preclude delays in emergency services to make financial or insurance inquiries and prohibit actions that discourage patients from remaining for further evaluation or treatment.[126] Certain state laws may be more restrictive; in which case, the hospital must comply with the more restrictive requirements.

A hospital may follow reasonable registration processes for patients covered by EMTALA, including requesting basic demographic information.[127] It may request insurance information, as long as the inquiry does not delay medical screening or treatment. However, a patient should not be asked to complete financial responsibility or Advance Beneficiary Notice of Noncoverage (ABN) forms or make co-payments for services prior to the provision of an MSE and any necessary stabilizing treatment.[128] Hospitals may not seek prior authorization from the patient's insurance before the MSE or commencement of stabilizing treatment for an EMC.[129]

Patient inquiries about an obligation to pay for emergency services should be responded to by a staff member trained to provide such information and who is knowledgeable about the hospital's ETMALA obligations and any relevant state laws.[130] The patient should be informed that, notwithstanding the patient's ability to pay, the hospital is ready and willing to provide an MSE and stabilizing treatment, if necessary. Patients should be encouraged to stay for an MSE and necessary stabilizing treatment and to defer further discussion of financial responsibility issues if possible, until after the medical screening has been performed.

The hospital also should respond to questions about whether the hospital accepts the patient's insurance. If the patient is a member of a noncontracted health plan, the hospital should reaffirm and document its offer to provide an MSE and encourage the patient to remain for the examination.

In the event a patient offers the insurance co-payment during the registration process prior to receiving an MSE, CMS advises that best practice is to not accept an individual's agreement for payment before stabilization.[131] If a patient insists on making the co-payment during the registration process, then it should be noted that the patient voluntarily offered the co-payment.[132]

Nothing in CMS policy prohibits giving ABNs or other financial documents, when otherwise appropriate, to patients who come to emergency care settings after they have received an MSE and are stabilized.

RECEIVING HOSPITAL OBLIGATIONS

A hospital with specialized services[133] may not refuse transfer of a patient with an unstabilized EMC who requires those specialized services, if the receiving hospital has the capacity to treat the patient.[134] This obligation applies to all hospitals participating in the Medicare program, regardless of whether they provide emergency services.

A receiving hospital must accept a patient under the following conditions:[135]

- The patient has presented for or is in need of emergency services and care and is currently in:
  - An emergency department, including an observation unit of the transferring hospital.
  - Another dedicated emergency department in the hospital, such as labor and delivery.
  - Another location on hospital property that is a part of the transferring hospital.
- The individual is not an inpatient.[136]
- The individual has been determined to have an EMC that has not been stabilized.
- The transferring hospital does not presently have the capacity and/or capability to provide further examination or treatment that is required to stabilize the individual's EMC, or the individual has made an informed request for the transfer.
- The transferring hospital has contacted the receiving hospital to arrange the transfer.
- The receiving hospital has the needed specialized services and the capacity and capability to provide those services.
- The hospital is inside the boundaries of the United States, as that term is defined for geographical purposes.[137]

Hospitals are permitted to decline a lateral transfer.[138] Therefore, in addition to determining the patient's condition and clinical needs, an accepting hospital should be able to inquire about the medical reason(s) for the transfer. However, if the transferring hospital indicates it lacks the present capability or capacity to provide the required stabilizing treatment, the receiving hospital should accept the transfer, if it has the capacity and capability to do so, to avoid the perception that the inquiries are intended to delay or discourage the transfer.

A receiving hospital may refuse to accept a transfer of a patient with an EMC from another hospital in the following circumstances:[139]

- The patient is an inpatient at the transferring hospital.
- The transferring hospital is not located in the United States.
- The patient does not have an EMC or the patient's EMC is stabilized and, consequently, EMTALA does not, or no longer, applies.

- The receiving hospital does not have the present capacity or capability to provide the required emergency medical services.
- The transferring hospital has the present capacity and capability to provide the required emergency medical services to the patient.
- The transfer is not an appropriate transfer, meaning that it is not medically appropriate to transfer the patient at that time, for example if the patient needs additional stabilizing care prior to transfer.

If a patient needs post-stabilization services at a facility providing a higher level of care, the receiving hospital may accept the patient subject to financial or insurance clearance, including obtaining prior authorization for the post-stabilization services.[140] A hospital may, however, be required to accept a patient if it has a legal or contractual obligation to do so, independent of EMTALA.

PATIENT REFUSAL OF CARE

Patient Refuses Stabilizing Treatment

Competent patients have the right to refuse further examination and stabilizing treatment, as well as a transfer to another facility. A hospital has met its EMTALA obligations if it offers the patient further examination and stabilizing treatment or transfer to another facility and informs the patient of the risks and benefits of the examination and treatment or transfer, but the patient refuses to consent.[141]

In addition to informing the patient of the risks and benefits of further examination and treatment or transfer, the hospital must take all reasonable steps to obtain the patient's written informed refusal.[142] The discussion of the risks and benefits should be documented in the patient's medical record, along with the patient's refusal.[143] The medical record also must contain a description of the proposed examination, treatment or transfer that was offered and refused. If the patient refuses to sign an informed refusal, the steps taken to secure the signed refusal should be documented as well.[144]

If an individual leaves against medical advice (AMA) or without being seen, of their own free will without coercion or suggestion by the hospital, then the hospital has not violated its EMTALA obligations.[145]

Risk Management Implications

Hospitals should develop quality management measures that track patient departures and implement actions to reduce unacceptable rates of elopement. Registration and other emergency staff should be trained about the need to document patient departures and elopements and, for patients refusing MSE, to communicate the hospital's willingness to provide an MSE and encourage those patients to stay. For patients refusing further examination or stabilizing treatment, hospitals should ensure that physicians and emergency department staff are aware of the documentation requirements set forth above. Hospitals may wish to implement follow-up protocols for those patients who leave without being seen or during the MSE or subsequent evaluation and treatment to encourage the patient to return to an emergency department or inform them of options for seeking care on an outpatient basis.

Patient Elopement

If a patient elopes or leaves the hospital without advising personnel of the reasons for leaving, the hospital should document the circumstances of the patient's departure, to the extent possible.[146] Hospitals may wish to establish follow-up call programs where they telephone eloped patients within a certain period of time to inquire about their reasons for leaving the hospital and ascertain their present medical status.

Risk Management Implications

Hospital staff should be educated to handle these situations by encouraging the patient to stay and by documenting the circumstances and reasons for the patient's decision to refuse further care.

OTHER REQUIREMENTS

Medical Records

A medical record must be opened for every patient who presents to the hospital for emergency medical services. Even if a patient leaves the hospital after triage and before receiving an MSE, the hospital must open a medical record for the patient and record the results of the visit. Records must be retained in accordance with applicable state laws and hospital policies, but in no event less than five years from the date of service. In addition, prior medical record information on a patient must be available to the emergency department.[147]

Central Log

Every hospital must maintain a central log that records the names of all individuals who present to a dedicated emergency department or another location or in a manner that triggers the hospital's EMTALA obligations.[148] The central log must list the name of each person who comes to the dedicated emergency department and whether the person refused treatment; were refused treatment by the hospital; were transferred, admitted and treated; or stabilized and transferred or discharged.[149]

Although the Interpretive Guidelines do not prescribe a timeframe for completion of entries in the central Log,[150] hospitals should ensure they are done in a timely manner. Hospitals also should be aware that some states have enacted regulations that require additional information to be entered into the central Log.[151]

Signage

Hospitals must post conspicuous signs in the dedicated emergency department, and other places where emergency patients may present, that set forth the rights of individuals under EMTALA to receive examination and treatment for EMCs; the rights of women in labor; and whether the hospital participates in the Medicaid program.[152] CMS has established specific requirements for this signage. Some states have adopted additional requirements for signage relating to emergency care.

ON-CALL PHYSICIANS

Responsibilities

Hospitals that have a dedicated emergency department must maintain a list of on-call physicians who will come to the hospital and provide stabilizing treatment to an individual with an EMC.[153] Some states also have licensing regulations requiring emergency departments to have on-call rosters.

The on-call list must meet the needs of emergency patients in accordance with the resources available to the hospital, including the availability of on-call physicians.[154] On-call physicians are considered resources available to a dedicated emergency department that must be used to provide emergency services for an individual who has or may have an EMC.

The scope of on-call physicians should reflect services available to the public. However, CMS has declined to require that every medical and surgical specialty represented on the hospital medical staff be on-call.[155] The on-call requirement applies to all hospital departments that are dedicated emergency departments, including labor and delivery services, psychiatric services and urgent care centers.

This obligation also applies to hospitals that must accept appropriate transfers of individuals with EMCs, even if the receiving hospital does not have a dedicated emergency department.[156] Some states also have adopted regulations that address requirements for on-call coverage.

There is no bright-line test under EMTALA for determining when coverage must be full-time for specialties that are not required to have full-time coverage under state law or other contractual obligations. CMS has explicitly rejected the longstanding misconception that call coverage must be full-time if there are three or more physicians in a particular specialty.[157] Hospitals are required to have written policies and procedures for addressing situations when a particular specialty is not available and other unexpected circumstances.[158]

An on-call physician may respond in some cases by directing a qualified, nonphysician practitioner to provide the requested assessment or consultation for an emergency patient.[159] However, if the emergency or other physician disagrees with the on-call physician about sending a nonphysician and requests that the on-call physician appear in person, the Interpretive Guidelines require the on-call physician to come to the hospital.[160] There is no prohibition against a treating physician consulting on a case with another physician, regardless of whether that other physician is on the hospital's on-call list.[161]

Risk Management Implications

A hospital should have policies and procedures that provide guidance to dedicated emergency department personnel if an on-call physician refuses to accept a patient or fails to come to the hospital to consult or evaluate the patient when obligated to do so.

PATIENT DUMPING

Reporting Requirements

EMTALA obligates a hospital to report to CMS or the state surveying agency when it has reason to believe an individual transferred in an unstable EMC from another hospital constitutes an EMTALA violation. Such reports must be made within 72 hours, and failure to file such report is grounds for termination of the receiving hospital's Medicare provider agreement.[162] Some states have additional requirements for reporting patient-dumping violations.

EMTALA does not require a hospital to report a violation that it has or may have committed. However, hospital staff or physicians who report a suspected EMTALA violation are protected under anti-retaliation laws.[163]

If a hospital believes it violated EMTALA, it should consider self-reporting. If a hospital self-reports before another hospital or person files a complaint with CMS or the state survey agency, and the hospital has immediately addressed and corrected the condition that led to the violation, CMS may limit the scope of its investigation. Furthermore, the Office of the Inspector General (OIG) may consider self-reporting as a mitigating factor when setting the amount of civil money penalties for an EMTALA violation.[164]

ENFORCEMENT AND PENALTIES

EMTALA is a condition of the Medicare provider agreement, and CMS may terminate a provider upon confirmation that a violation occurred.[165] CMS and the OIG are charged with enforcing compliance with EMTALA obligations. Enforcement of EMTALA is a complaint-driven process. CMS has the authority to conduct complaint and enforcement surveys and to terminate a hospital's Medicare provider agreement upon confirming an EMTALA violation.[166] The OIG has the authority to impose civil money penalties against hospitals and physicians and/or to exclude a physician from the Medicare and Medicaid programs for EMTALA violations that are "gross and flagrant or repeated."[167] The regional quality improvement organization (QIO) is responsible for assisting CMS and OIG in reviewing medical matters pertaining to the delivery of emergency care and services.[168]

A notice of suspension or termination is 23 days for violations that constitute immediate jeopardy and 90 days for violations that do not constitute immediate jeopardy.[169] All confirmed EMTALA violations are submitted to the OIG for determination of whether a civil money penalty should be imposed.

Between 2005 and 2014, there were 4,772 investigations of potential EMTALA violations. Forty-four percent of those investigations resulted in citations for EMTALA deficiencies at 62% of the hospitals investigated. During that period, investigations occurred at nearly half of all hospitals with Medicare provider agreements, and more than 25% of those hospitals were cited for violations. Only 12 of those hospitals had their provider agreements terminated.[170] Although the number of emergency department encounters is increasing, the trend is toward fewer EMTALA investigations and citations per capita and per hospital over time.

If CMS determines that a hospital has violated EMTALA, it has three options. It may advise the hospital of the violation but take no further enforcement action if there have been no further violations. It may terminate the hospital's provider agreement on a 90-day notice if it determines that the violation is a threat to patient health and safety.[171] It may terminate the hospital's provider agreement on a 23-day notice if it determines that the violation constitutes imminent jeopardy to patient health and safety.[172]

If CMS determines that a hospital has violated EMTALA, the hospital will receive a transmittal letter and a Statement of Deficiencies, Form CMS 2567, advising the hospital whether CMS intends to seek termination of the hospital's Medicare provider agreement on a 23- or 90-day notice.[173] The notice also states when the plan of correction must be submitted to CMS and the date on which CMS will publish the notice of termination in the local newspaper if an acceptable plan of correction has not been submitted to CMS in a timely manner.[174]

In response to a Statement of Deficiencies, a hospital must submit a plan of correction that complies with CMS requirements. Submission of a plan of correction does not constitute an admission by the hospital of an EMTALA violation. A hospital may wish to include a statement on the plan of correction that its submission is not an admission of or agreement with the facts or conclusions contained in the Statement of Deficiencies. Because the scope of the re-survey is not limited to the issues cited in the Statement of Deficiencies, the hospital should review EMTALA compliance in areas that were not the focus of the original survey or in other locations of the hospital that were not visited by the surveyors at the time of the original survey. The hospital also should review the medical records copied by the surveyors to determine potential liability for civil money penalties or litigation.

Confirmed EMTALA violations may subject the hospital or physician to administrative penalties including fines and, although rare, termination of participation in the Medicare program.[175] Physicians are particularly concerned about a civil monetary fine because it is not covered by malpractice insurance. However, physicians should be reassured that it is exceedingly rare for the OIG to impose a monetary fine on an individual physician. While approximately 7.6% of emergency physicians face a malpractice claim each year, only 1.4% result in payment to a plaintiff. By comparison, fewer than two individual physicians are subject to monetary penalties for EMTALA violations in a given year.[176]

States may also impose penalties on hospitals and physicians, through their respective state medical board, for violations of EMTALA or state laws governing the provision of emergency medical services.

In addition to administrative penalties, patients may file civil suits against hospitals for EMTALA violations in addition to medical malpractice claims.[177] EMTALA creates an entirely separate cause of action that is distinct from the traditional state law based medical malpractice claims that hospitals typically encounter. However, the private right of action created under the statute is only applicable to hospitals and not individual physicians.[178]

Although EMTALA limits financial recovery to the damages recoverable for state medical malpractice claims, other state tort reform laws may not apply to EMTALA claims. Courts have suggested that some reforms, such as shorter statutes of limitations and protections of peer review proceedings, do not apply to claims arising under EMTALA.[179]

PUBLIC HEALTH EMERGENCIES

EMTALA sanctions may be waived for an inappropriate transfer of an individual with an unstabilized EMC during a public health emergency, as defined in a presidential declaration. Furthermore, regulations preclude the imposition of sanctions for an inappropriate transfer during a national emergency by a hospital located in an emergency area.[180]

The Project Bioshield Act of 2004 permits certain EMTALA requirements to be waived during emergency periods in a designated emergency area. It authorized the temporary waiver or modification of EMTALA standards regarding transfer of an individual who has not been stabilized

to receive an MSE at an alternate location if the transfer is required by the circumstances of a declared emergency in the emergency area during the emergency period in accordance with an appropriate state emergency preparedness plan.[181]

In response to the COVID-19 pandemic and public health emergency, CMS partially waived enforcement of Section 1867(a) of the Act, allowing hospitals, psychiatric hospitals and critical access hospitals to screen patients at offsite locations to help prevent the spread of COVID-19, as long as such screening is not inconsistent with a state's emergency preparedness or pandemic plan.[182]

Risk Management Implications

Hospitals should have a policy mandating compliance with EMTALA and provide comprehensive education about EMTALA to all staff members who have responsibility for carrying out its obligations.

EMTALA also should be part of a hospital's compliance program. Noncompliance should be viewed as potentially exposing the hospital to administrative actions, liability for patient claims, and public criticism. In addition to the foregoing, the time and resources required to respond to a CMS investigation and Statement of Deficiencies are not insignificant.

Hospitals should have in place a process for routinely auditing emergency department practices to ensure they comply with EMTALA, as well as any state laws governing the provision of emergency services. A recent survey revealed five primary causes of noncompliance with EMTALA obligations among hospitals: ignorance of EMTALA requirements, high referral burden at receiving hospitals, receiving hospital reluctance to report potential EMTALA violations for fear of risking relationships with other hospitals, financial pressures, and conflicting priorities between hospitals and physicians.[183] It is advisable for hospitals to undertake an in-depth review of potential causes of noncompliance and proactively address any areas of weakness identified.

Although physicians can be held independently liable for an EMTALA violation, hospitals also may be liable for physicians who fail to comply. An effective method of reducing the likelihood of EMTALA violations is a robust physician education program, centered on reducing exposure in high-risk areas.

Areas that present the greatest risk of violating EMTALA include MSEs, lack of documentation of hospitals to design comprehensive educational programs that include focusing on the basics.

RESOURCES

California Hospital Association. (2018). EMTALA Manual: A guide to patient anti-dumping laws. California Hospital Association. (While not directly cited, the CHA EMTALA manual provided guidance on the organization of and approach to this topic.).

REFERENCES

1 The Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S. Code § 1395dd (2018).

2 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24 (2020).

3 The criteria for determining when "labor" constitutes a medical emergency is discussed infra.

4 EMTALA, 42 U.S.C. § 1395dd(a)-(b) (2018).

5 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

6 See, e.g., California Health & Safety Code §§ 1317-1317.9a and 1799.111.

7 The Conditions of Participation are published in Title 42 of the Code of Federal Regulations, beginning at Part 482. CMS's interpretation and guidelines for enforcement of the COPs are published in the *State Operations Manual*.

8 To "participate" means to receive payment or funding from the Medicare and/or Medicaid programs.

9 Authorization of appropriations, 42 U.S.C. § 301 (2018); Consultation with state agencies and other organizations to develop conditions of participation for providers of services, 42 U.S.C. § 1395z (2018).

10 U.S. Department of Health and Human Services. (n.d.). *HHS Agencies & Offices*. HHS.gov. Retrieved October 1, 2020, from https://www.hhs.gov/about/agencies/hhs-agencies-and-offices/index.html

11 The Freedom of Information Improvement Act of 2016, 5 U.S.C. § 552 (2018); Administrative Procedure Act, 5 U.S.C. § 702 (2018).

12 Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc., 68 U.S. 837 (1984).

13 Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc., 68 U.S. 837(1984).

14 Auer v. Robbin, 519 U.S. 452 (1997).

15 U.S. Department of Health and Human Services. (n.d.). *Guidelines — Appellate review of decisions of administrative law judges affecting a provider's participation in the Medicare and Medicaid programs*. HHS.gov. Retrieved October 1, 2020, from https://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/participation/index.html

16 Effect of Departmental Appeals Board decision, 42 C.F.R. § 498.90 (2020); Extension of time for seeking judicial review, 42 C.F.R. § 498.95 (2020).

17 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(b) (2020).

18 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(b) (2020).

19 Medicare program; Clarifying policies related to the responsibilities of Medicare-participating hospitals in treating individuals with emergency medical conditions, 68 F.R. 53229, 53231 (2003).

20 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(b) (2020).

21 Centers for Medicare & Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

22 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(b) (2020).

23 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(b) (2020).

24 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

25 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(b) (2020).

26 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(b) (2020).

27 Medicare program; Clarifying policies related to the responsibilities of Medicare-participating hospitals in treating individuals with emergency medical conditions, 68 F.R. 53228-53229 (2003).

28 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

29 Centers for Medicare and Medicare Services. (2008, January 11). *Requirements for provider-based off-campus emergency departments and hospitals that specialize in the provision of emergency services*. HHS.gov. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/CMS1207239

30 Medicare program; Clarifying policies related to the responsibilities of Medicare-participating hospitals in treating individuals with emergency medical conditions, 68 F.R. 53228-53229 (2003).

31 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24 (2020).

32 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

33 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

34 CMS defines "labor" as "the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta" (42 C.F.R. §489.24(a)(1)(i) (2020).).

35 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(b)(2) (2020).

36 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(b) (2020).

37 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

38 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24 (a(1)(i) (2020).

39 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(c)(1) (2020).

40 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

41 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

42 The Born-Alive Infants Protection Act of 2002, 1 U.S.C. § 8 (2018).

43 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

44 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf.

45 Condition of participation: Governing body, 42 C.F.R. § 482.12(f) (2020).

46 EMTALA, 42 U.S. Code § 1395dd(a) (2018).

47 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

48 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf.

49 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(b) (2020).

50 Medicare defines an "encounter" as "direct personal contact between a patient and a physician, or other person who is authorized by State licensure and, if applicable, by hospital or staff bylaws, to order or furnish hospital services for diagnosis or treatment of the patient" (42 C.F.R. § 410.2 (2020).).

51 "Inpatient" is a "a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services" (42 C.F.R. § 489.24(b) (2020).).

52 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

53 Moses v. Providence Hospital and Medical Centers, 561 F.3d 573 (6th Cir. 2009).

54 Medicare program; Emergency Medical Treatment and Labor Act (EMTALA): Applicability to hospital inpatients and hospitals with specialized capabilities, 77 F.R. 5213 (2012).

55 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

56 Medicare program; Clarifying policies related to the responsibilities of Medicare-participating hospitals in treating individuals with emergency medical conditions, 68 F.R. 53247 (2003).

57 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(a) (2020).

58 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(a)(1)(i) (2020).

59 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

60 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(c) (2020).

61 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

62 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(c) (2020).

63 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

64 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

65 Medicare program; Clarifying policies related to the responsibilities of Medicare-participating hospitals in treating individuals with emergency medical conditions, 68 F.R. 53228-53229 (2003).

66 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

67 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

68 Kraft v. Laney, CIV S-04-0129 GGH (E.D. Cal. Aug. 24, 2005).

69 Malcolm, K.E., Malcolm, J.G., Wu, D.T., Spainhour, K.A. & Race, K.P. (2017). Cops and docs: The challenges for ED physicians balancing the police, state laws, and EMTALA. *Journal of Healthcare Risk Management*, 37(2), 29-35. https://doi.org/10.1002/jhrm.21280

70 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

71 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(b)(3) (2020).

72 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(b) (2020).

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

74 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(b) (2020).

75 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

76 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(a) (2020).

77 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

78 ETMALA, 42 U.S. Code § 1395dd(a) (2018).

79 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

80 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

81 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

82 CMS implies an obligation beyond the statutory language; however, the SOM does not elaborate on what criteria will be used in determining whether a hospital used "all of its resources."

83 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

84 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

85 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

86 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

87 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(a)(1) (2020).

88 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

89 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

90 "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." (Centers for Medicare and Medicaid Services. (2019, July Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf).

91 Conditions of participation: Emergency services, 42 C.F.R. § 482.55 (2020).

92 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(c) (2020).

93 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

94 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

95 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

96 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

97 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

98 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

99 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(a)(1)(ii) and (d) (2020).

100 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(d) (2020).

101 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(d)-(e) (2020).

102 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(e) (2020).

103 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

104 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(e)(1)(ii)(B) (2020).

105 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

106 Burditt v. U.S. HHS, 934 F.2d 1362 (5th Cir. 1991).

107 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(e)(1)(ii)(C) (2020).

108 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(e)(1)(ii)(B) (2020).

109 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

110 EMTALA does not obligate hospitals to accept transfers from non-hospital entities; however, EMTALA is triggered if a patient from a non-hospital entity presents to a hospital with a DED for purposes of examination and treatment.

111 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(b) and (d) (2020).

112 St. Anthony Hospital v. U.S. Department of Health and Human Services, 309 F.3d 680 (10th Cir. 2002).

113 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

114 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

115 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

116 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(b) and (e)(1)(ii)(B) (2020).

117 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

118 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(e) (2020).

119 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

120 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(b) (2020).

121 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

122 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

123 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

124 Condition of participation: Discharge planning, 42 C.F.R. § 482.43 (2020).

125 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(d)(4) (2020).

126 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(d)(4) (2020).

127 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

128 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

129 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(d)(4)(ii) (2020).

130 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

131 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

132 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

133 A Medicare participating hospital is considered to have specialized capabilities or facilities if it has the capability and capacity to provide a service the transferring hospital does not (Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf).

134 Lulla, A. & Svancarek, B. (2020, November 21). EMS USA Emergency Medical Treatment and Active Labor Act. *StatPearls* [Internet]. StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK539798/

135 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(f) (2020).

136 For EMTALA purposes, a patient who has been admitted to the transferring hospital but is boarded in the emergency department pending the assignment to an available bed is considered an inpatient (42 C.F.R. §489.24(d)(2)(ii)(2020).).

137 '"United States," when used in a geographical sense, means the States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa." (42 U.S.C. § 410(i)).

138 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

139 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

140 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

141 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(d)(3) and (5) (2020).

142 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(d)(3) and (5) (2020).

143 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

144 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

145 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

146 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

147 Basic commitments, 42 C.F.R. § 489.20(r)(1) (2020).

148 Basic commitments, 42 C.F.R. § 489.20(r)(3) (2020).

149 Basic Commitments, 42 C.F.R. § 489.20(r)(3) (2020).

150 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

151 See, e.g., Title 22, California Code of Regulations, §§ 70413(h), 70453(h) and 70651(h).

152 Basic commitments, 42 C.F.R. § 489.20(q) (2020).

153 Basic commitments, 42 C.F.R. § 489.20(r)(2) (2020).

154 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(j) (2020).

155 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

156 Basic commitments, 42 C.F.R. § 489.20(r)(2) (2020).

157 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

158 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(j) (2020).

159 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

160 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

161 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

162 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

163 EMTALA, 42 U.S. Code § 1395dd(i) (2018).

164 Medicare and state health care programs: Fraud and abuse; Revisions to the Office of Inspector General's civil monetary penalty rules, 81 F.R. 88338-88339 (2016).

165 Termination by CMS, 42 C.F.R. § 489.53 (2020).

166 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(g) (2020).

167 EMTALA, 42 U.S. Code § 1395dd(d)(1) (2018).

168 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(h) (2020).

169 EMTALA, 42 U.S. Code § 1395dd(d)(3) (2018).

170 Terp, S., Seabury, S.A., Arora, S., Eads, A., Lam, C.N. & Menchine, M. (2017). Enforcement of the Emergency Medical Treatment and Labor Act, 2005 to 2014. Annals of Emergency Medicine, 69(2), 155-162. https://doi.org/10.1016/j.annemergmed.2016.05.021

171 EMTALA, 42 U.S. Code § 1395dd(d)(3) (2018).

172 EMTALA, 42 U.S. Code § 1395dd(d)(3) (2018).

173 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf.

174 Centers for Medicare and Medicaid Services. (2019, July 19). Appendix V: Responsibilities of Medicare participating hospitals in emergency cases. In *State Operations Manual*. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

175 Hsuan, C., Horwitz, J.R., Ponce, N.A., Hsia, R.Y. & Needleman, J. (2018). Complying with the Emergency Medical Treatment and Labor Act: Challenges and solutions. *Journal of Healthcare Risk Management*, 37(3): 31-41. https://doi.org/10.1002/jhrm.21288

176 Terp, S., Seabury, S.A., Arora, S., Eads, A., Lam, C.N. & Menchine, M. (2017). Enforcement of the Emergency Medical Treatment and Labor Act, 2005 to 2014. *Annals of Emergency Medicine*, 69(2), 155-162. https://doi.org/10.1016/j.annemergmed.2016.05.021

177 EMTALA, 42 U.S. Code § 1395dd(d)(2) (2018).

178 Malcolm, K.E., Malcolm, J.G., Wu, D.T., Spainhour, K.A. & Race, K.P. (2017). Cops and docs: The challenges for ED physicians balancing the police, state laws, and EMTALA. *Journal of Healthcare Risk Management*, 37(2), 29-35. https://doi.org/10.1002/jhrm.21280

179 Hsuan, C., Horwitz, J.R., Ponce, N.A., Hsia, R.Y. & Needleman, J. (2018). Complying with the Emergency Medical Treatment and Labor Act (EMTALA): Challenges and solutions. *Journal of Healthcare Risk Management*, 37(3), 31-41. https://doi.org/10.1002/jhrm.21288 8

180 Special responsibilities of Medicare hospitals in emergency cases, 42 C.F.R. § 489.24(a)(2) (2020).

181 Project BioShield Act of 2004, , Pub. L. No. 108-276, 118 Stat. 135 (2004).

182 Centers for Medicare and Medicaid Services. (2020, December 1). *COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers*. https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

183 Hsuan, C., Horwitz, J.R., Ponce, N.A., Hsia, R.Y. & Needleman, J. (2018). Complying with the Emergency Medical Treatment and Labor Act (EMTALA): Challenges and solutions. *Journal of Healthcare Risk Management*, 37(3), 31-41. https://doi.org/10.1002/jhrm.21288 8

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