

Emergency Treatment and Active Labor Act (EMTALA)

KRISTY M. KIMBALL

March 20, 2025

Disclaimer

This presentation is designed to provide general information on pertinent legal topics. The information is provided for educational purposes only. Statements made or information included do not constitute legal or financial advice, nor do they necessarily reflect the views of Holland & Hart LLP or any of its attorneys other than the author.

The information contained in this presentation is not intended to create an attorney-client relationship between you and Holland & Hart LLP. Substantive changes in the law subsequent to the date of this presentation might affect the analysis or commentary. Similarly, the analysis may differ depending on the jurisdiction or circumstances. If you have specific questions as to the application of the law to your activities, you should seek the advice of your legal counsel.

Preliminaries

- This program provides an overview of the relevant laws.
- Additional laws may apply.
 - Some states have their own versions of EMTALA.
 - Courts in your jurisdiction may have interpreted EMTALA.
 - Your particular CMS Region may have additional commentary.
- Consult with qualified experts when applying info to your circumstances.
- Presentation will be recorded and available for download at www.hhhealthlawblog.com
- If you have questions, please submit them using chat line or e-mail me at KMKimball@hollandhart.com

Written Materials

- PowerPoint slides
- 42 USC 1395dd
- 42 CFR 489.20(r) and 489.24
- CMS State Operations Manual App. V (Rev'd 7/19/19) (EMTALA Interpretive Guidelines), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_v_emerg.pdf
- Stanger, *EMTALA: Guide for Exams, Treatment and Transfers*, <https://www.hollandhart.com/emtala-guide-for-exams-treatment-and-transfers>
- Stanger, *Avoiding EMTALA Penalties*, <https://www.hollandhart.com/avoiding-emtala-penalties>

EMergency Treatment and Active Labor Act of 1986

- Statute
 - 42 USC 1395dd
 - Regulations
 - 42 CFR 489.20(m), (q), (r)
 - 42 CFR 489.24
 - 42 CFR 1003.103(e)
 - 42 CFR 1003.106(d)
 - Interpretive Guidelines
 - CMS State Operations Manual App. V (Rev'd 7/19/19)
- } Part of Medicare Provider Agreement

EMTALA Application



EMTALA Overview

- EMTALA (the Emergency Medical Treatment and Labor Act) was introduced in 1985 with bipartisan support in response to a spate of “patient dumping” cases, which refers to emergency departments refusing care to patients who are indigent and have no health insurance, including patients who were in labor. President Ronald Reagan signed it into law in 1986.
- Under EMTALA, hospitals must examine and stabilize patients, regardless of insurance status, citizenship or other factors.
- The law applies to all hospitals with emergency departments that participate in Medicare (only about 1% of non-federal community hospitals don’t participate in Medicare, according to the American Hospital Association).
- The Department of Health and Human Services oversees and enforces EMTALA.
- Physicians and hospitals can be fined up to \$133,420 per incident of failing to comply with EMTALA and are at risk of exclusion from Medicare and Medicaid programs for repeated violations. Physicians’ malpractice insurance does not cover EMTALA violations.

Who Is Subject to EMTALA?

1. **HOSPITALS THAT PARTICIPATE IN MEDICARE**

A. **Hospitals with dedicated emergency dept (“DED”), i.e.,**

- Licensed as an emergency room or department;
- Held out to the public as place that provides emergency care without appointment, *e.g.*, provider-based urgent care center or labor and delivery department; or
- During prior calendar year, provided at least 1/3 of outpatient visits for emergency conditions on urgent basis without prior appointment.

B. **Hospitals with specialized capabilities, e.g., specialty hospitals.**

2. **PHYSICIANS RESPONDING TO POTENTIAL EMERGENCY MEDICAL CONDITIONS, including on-call services.**

(42 USC 1395dd; 42 CFR 489.24(b))

EMTALA: When Is It Triggered?

- **FOR HOSPITALS WITHOUT A DED (E.G., SPECIALTY HOSPITAL), EMTALA is triggered if:**
 1. Hospital participates in Medicare,
 2. Hospital has specialized capabilities, and
 3. Hospital receives request for transfer from another facility.

(42 CFR 489.24)

EMTALA: When Is It Triggered?

- **FOR HOSPITALS WITH A DED, EMTALA is triggered if:**
 1. **Person “comes to the emergency department”**
 - Includes hospital property outside of DED.
 2. **Requests exam or treatment for a medical condition or a potential emergency condition.**
 - If unable to speak, prudent layperson would believe the person needs exam or treatment for a medical condition, and
 3. **Person is not already a patient at the hospital.**

(42 CFR 489.24)

1. “Comes to the ED”

- **“Comes to the emergency department” =**
 - Main campus of hospital, including parking lot, sidewalk, and driveway.
 - Area within 250 yards of hospital that is owned by the hospital, *e.g.*, provider-based department.
 - Off-campus facility with DED (*e.g.*, free-standing ED).
- **Not considered part of hospital for purposes of EMTALA:**
 - Areas or structures that are not part of the hospital, *e.g.*, physician offices, RHCs, SNFs, or that do not operate under the hospital’s provider number.
 - Off-campus facility without DED.

(42 CFR 489.249(b); Guidelines 489.24(a))

2. Request for Emergency Care

- **Person presents at DED and:**
 - Request for exam or treatment of a medical condition.
 - If unable to speak, prudent layperson would believe the person needs exam or treatment for a medical condition.
- **Person presents on hospital property outside DED and:**
 - Request for exam or treatment for potential emergency condition.
 - If unable to speak, prudent layperson would believe person needs exam or treatment for potential emergency medical condition.

(42 CFR 489.24(b))

Request for Non-Emergency Care

- **EMTALA does not apply to requests for clearly non-emergency care, e.g.,**
 - Preventative care (e.g., immunization, flu shots, community outreach, etc.)
 - Requests to perform non-emergency test (e.g., blood pressure or x-ray).
 - Gather evidence (e.g., BAC test, sexual assault, etc.)
 - Prescheduled appointment by physician.
- **EMTALA applies if prudent layperson would believe person needs emergency care.**

(Guidelines 489.24(c))

* *Document that request is for non-emergency care.*

3. Not Already a Hospital Patient

- **EMTALA does not apply to “patients” of hospital.**
 - Medicare Conditions of Participation protect inpatients.
 - Malpractice law protects patients.
- Inpatients: EMTALA ends once the person is admitted as an inpatient in good faith, *i.e.*, admitted for bed occupancy with expectation that person will remain overnight.
- Outpatients: EMTALA does not apply if person has begun receiving outpatient services other than emergency care.
- EMTALA does not apply even if emergency arises after person’s admission or after outpatient services begin.

(42 C.F.R. 482.1 through 482.58; 42 CFR 489.24(a)-(b), (d)(2); Guidelines 489.24(a), (d))

EMTALA Requirements

- **Hospital with DED must provide:**
 1. Emergency medical screening exam,
 2. Stabilizing treatment for emergency conditions, and/or
 3. Appropriate transfer of unstabilized person.
- **Hospital with specialized capabilities must accept transfer of unstabilized person.**
- **Cannot delay exam or treatment to inquire about payment.**
- **Must post required signage.**
- **Must maintain required documentation.**
 - On-call list.
 - ED log of those who come to hospital.

(42 CFR 489.20(r) and 489.24)

EMTALA Requirements: Infants

- Birth = comes to the hospital.
- If infant is born alive at the hospital, EMTALA applies to the infant.
- Hospital must provide exam, stabilizing treatment, and/or appropriate transfer if
 - Request for exam or treatment, or
 - Prudent person would believe that infant needs exam or treatment.

(Guidelines 489.24(a))

EMTALA Requirements: Ambulances

- **If air or ground ambulance is owned and operated by your hospital:**
 - EMTALA applies to your hospital if patient is in your ambulance unless ambulance is operated:
 - Under community-wide EMS protocol that directs it to a different hospital; or
 - At direction of physician from a different hospital.
- **If ambulance is not owned and operated by your hospital:**
 - EMTALA applies to your hospital if ambulance is on your hospital property.
 - May divert inbound ambulance if you are on diversionary status.

(42 CFR 489.24(b))

EMTALA Requirements: Diversion

- **Probably cannot divert inbound ambulance unless you are on diversionary status.** (*Arrington v. Wong* (9th Cir. 2001))
- **Diversionary status = lack staff or facilities to accept additional emergency patients.**
- **Capacity depends on—**
 - Staff, equipment, and supplies
 - Number and availability of beds
 - Past practices in accommodating additional patients in excess of occupancy limits (e.g., moving patients to other units, calling in additional staff, borrowing equipment, etc.)

(42 CFR 489.24(b))

Diversion: Practical Tips

- May divert persons who are not on hospital property and who are not in an ambulance.
- Do not divert inbound ambulance unless your hospital is on diversionary status.
 - Document diversionary status, including time and bases for diversion.
- Must provide care if person comes to hospital.

EMTALA Requirements: Helipads

- **If patient is brought to your hospital for exam or treatment prior to transport to another facility:**
 - EMTALA applies to hospital.
 - Hospital must provide screening exam, stabilizing treatment, and/or appropriate transfer.
- **If other facility already examined the person and your hospital's helipad is used merely for transport, EMTALA does not apply to your hospital unless:**
 - Person's condition deteriorates while at your helipad, and
 - Request is made for exam or treatment by the person or others.

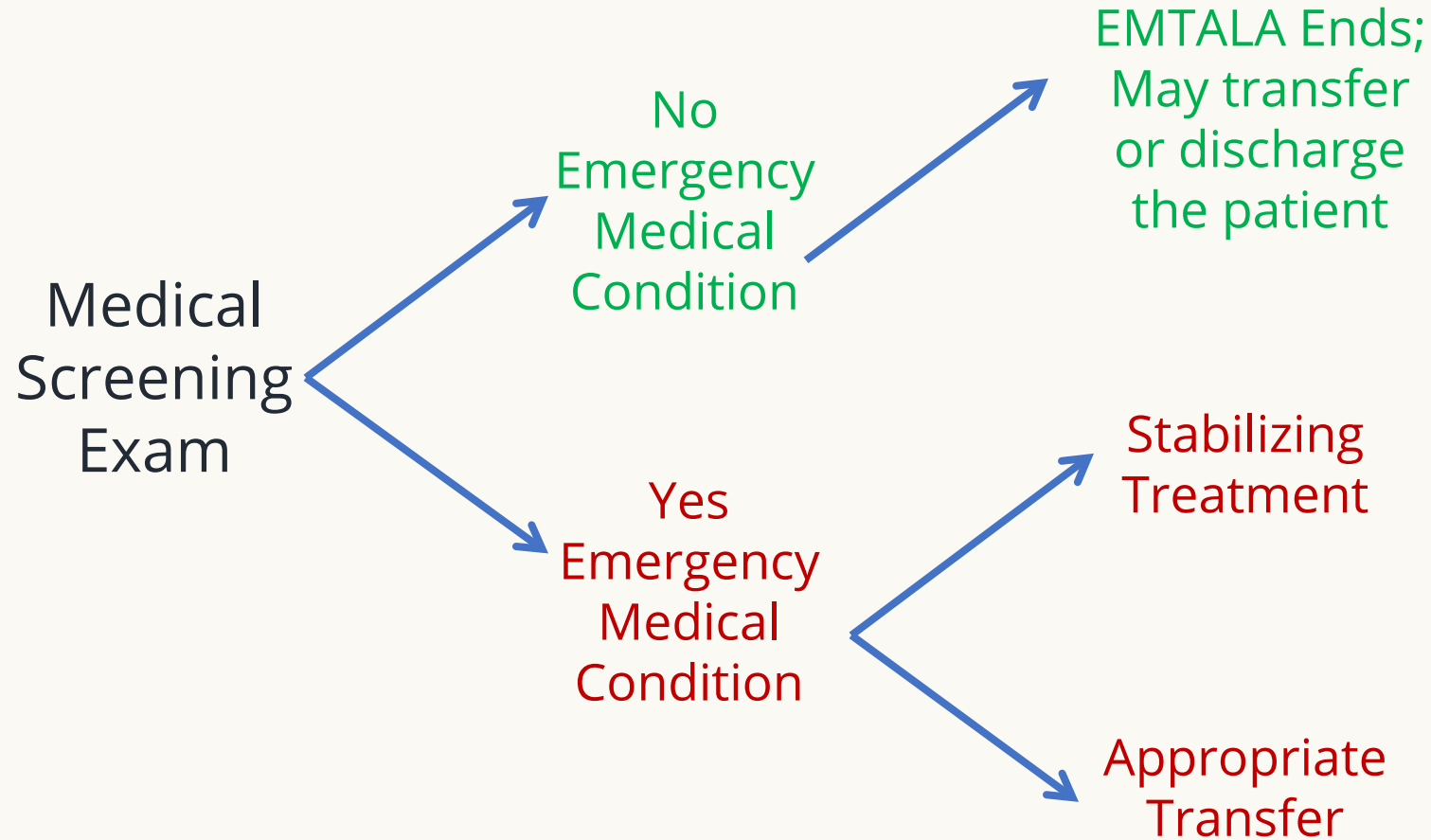
(Guidelines 489.24(a))

Hospital with DED: EMTALA Summary

- If person
 - comes to the hospital,
 - requests emergency exam or treatment, and
 - person is not already an inpatient or outpatienthospital must provide:
 - an appropriate medical screening exam to determine whether the person has an emergency medical condition, and if person has emergency condition,
 - stabilizing treatment or
 - appropriate transfer.

(42 CFR 489.24(a))

Treatment Flow for Hospitals w/DED



Medical Screening Exam



Medical Screening Exam

APPROPRIATE MEDICAL SCREENING EXAM =

- 1. Performed by qualified medical personnel (“QMP”).**
 - Identified in documents approved by governing body.
 - Competent to perform exam and within scope of practice under state law.
 - Privileged to perform exam.
- 2. Applied in non-discriminatory manner.**
 - Does not differ based on payment status, condition, race, national origin, disability, etc.
- 3. Sufficient to allow QMP to determine, with reasonable clinical confidence, whether emergency condition exists.**
 - Depends on presenting signs and symptoms, and hospital’s capabilities, including on-call physicians.

(Guidelines 489.24(a), (e))

Medical Screening Exam

MUST PROVIDE EXAM WITHIN CAPABILITIES OF THE HOSPITAL.

- **Capabilities =**
 - Physical space, equipment supplies and specialized services (*e.g.*, surgery, psychiatry, obstetrics, ICU, pediatrics, trauma care, etc.);
 - Level of care that hospital personnel can provide within the training and scope of their professional licenses, including the on-call roster; and
 - Whatever the hospital customarily has done to accommodate patients.

(42 CFR 489.24(b); Guidelines 489.24(d))

Medical Screening Exam

- **Screening exam is ongoing process, not isolated event.**
 - Begins with triage but goes beyond triage.
 - Continues until stabilized, admitted or transferred.
- **Should normally include—**
 - Vital signs.
 - History.
 - Documented physical exam of involved area or system.
 - If needed, ancillary tests and specialists available through hospital, *e.g.*, lab tests, diagnostic tests and procedures, CT scans or other imaging services, etc.
 - Continued monitoring.

(Guidelines 489.24(a))

Medical Screening Exam: Non-Emergent Condition

- Hospital need only perform screening exam necessary to rule out emergency medical condition based on presenting symptoms.
- If nature of the request makes it clear that medical condition is not of an emergency nature, hospital is only required to perform such screening as would be appropriate to determine that individual does not have emergency medical condition.
- In case of obvious non-emergency situation, person's statement that they are not seeking emergency care, together with brief questioning by QMP, would be sufficient to rule out emergency medical condition.

(42 CFR 489.24(c))

** Be sure to document!*

Medical Screening Exam

- If medical screening exam reveals no emergency medical condition, then EMTALA ends.
 - May transfer or discharge the person.
 - *Document determination that there is no emergency medical condition.*
- If medical screening exam reveals emergency medical condition, then hospital must provide:
 - Stabilizing treatment, or
 - An appropriate transfer.

(42 CFR 489.24(a), (d))

Medical Screening Exam

If it's not in the chart, it didn't happen.

- Appropriate exam.
- No emergency condition.
- Stable condition.
- Patient refused care or requested transfer.
- Certification that benefits of transfer > risks.



Emergency Medical Condition

- A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in
 - Placing the individual's health in serious jeopardy;
 - Serious impairment to bodily functions; or
 - Serious dysfunction of any bodily organ or part.

(42 CFR 489.24(b))

Emergency Medical Conditions: Don't Forget Mental Health and SUD

- **Psychiatric Condition:** Individual is expressing suicidal or homicidal thoughts or gestures or determined to be dangerous to self or others.
- **Substance Abuse:** “Some intoxicated individuals may meet the definition...because the absence of medical treatment may place their health in serious jeopardy.... Further, intoxicated individuals frequently have unrecognized trauma.”

(Guidelines 489.24(d); CMS Region X Q&As)

Emergency Medical Condition: Pregnancy

- In the case of pregnant woman having contractions, either—
 - Inadequate time to effect safe transfer to another hospital before delivery; or
 - Transfer may pose a threat to health or safety of woman or unborn child.
- Labor = process of childbirth beginning with latent or early labor and continuing through delivery of placenta.
- Woman experiencing contractions is presumed to be in labor unless a QMP acting within scope of practice certifies false labor after reasonable period of observation.

(42 CFR 489.24(b))

Pregnancy Post-*Dobbs*: EMTALA vs. State Law

TEXAS:

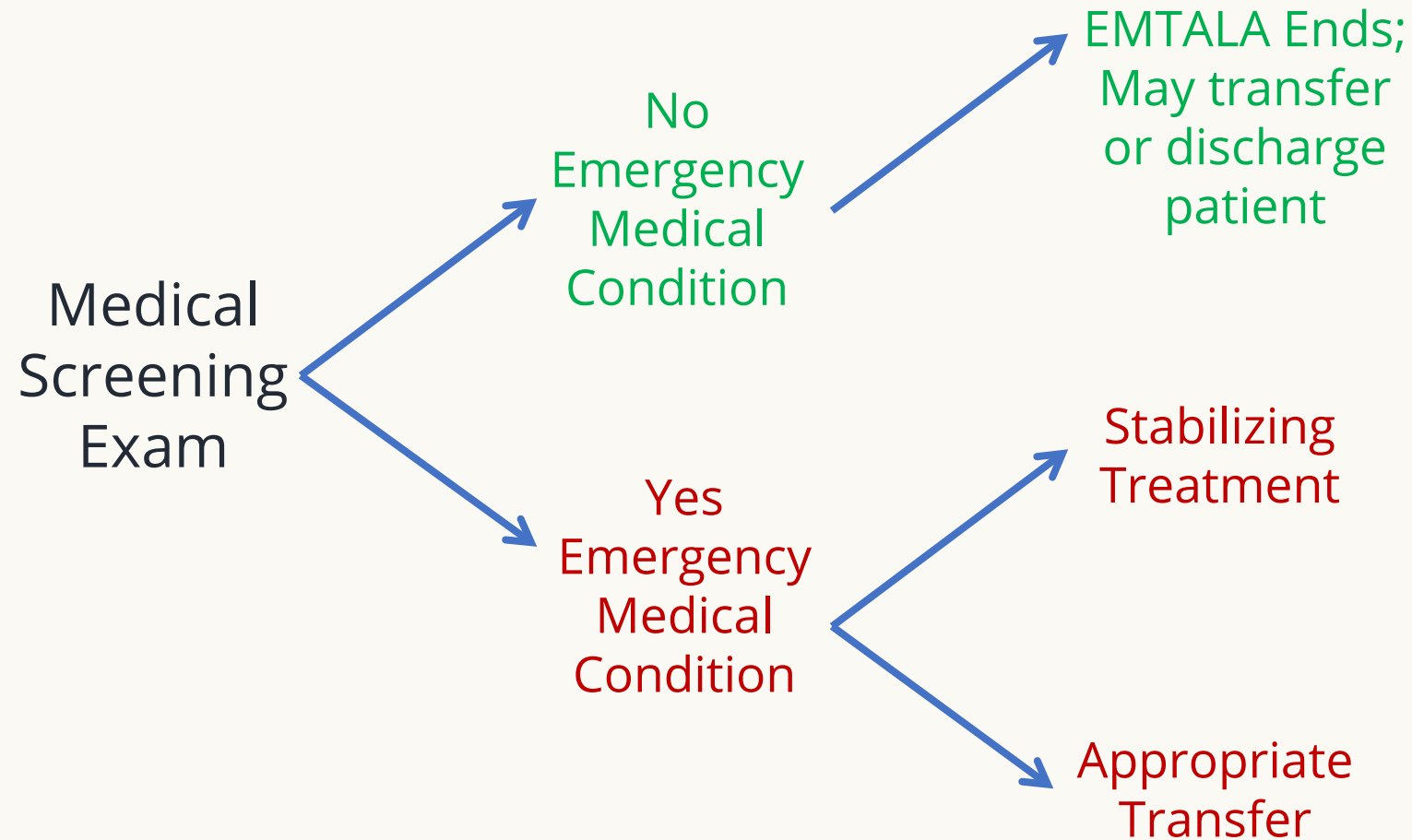
- In July of 2022, HHS and CMS issued guidance, followed by a letter, maintaining that EMTALA requires physicians to provide abortion care where necessary to preserve the health of the pregnant person if they work at a hospital receiving Medicare funds. The guidance stated that as it relates to emergency medical conditions of pregnant patients, EMTALA preempts any directly conflicting state law or mandate” and hospital staff and physicians are obligated to follow EMTALA, “even if doing so involves providing medical stabilizing treatment that is not allowed in the state in which the hospital is located.” www.cms.gov/files/document/qso-22-22-hospitals.pdf
 - Texas sued the administration over the guidance/letter (*Texas v. Becerra*, No. 5:22-CV-185-H (N.D. Tex.)), and asked a Texas District Court to block HHS from enforcing the guidance in Texas. Ultimately, after the U.S. Supreme Court refused to hear the case, the District court’s preliminary injunction, blocking enforcement of HHS’s guidance in Texas, was upheld.
 - As a result, **within Texas**, HHS is precluded from (1) enforcing the guidance/letter’s interpretation that Texas abortion laws are preempted by EMTALA; and (2) enforcing the guidance/letter’s interpretation of EMTALA—both as to when an abortion is required and EMTALA’s effect on state laws governing abortion.

Pregnancy Post-*Dobbs*: EMTALA vs. State Law

Idaho:

- In August, 2022, the Biden Administration (*United States v. Idaho*) sued the State of Idaho, arguing EMTALA requires physicians to provide abortion care where necessary to preserve the health of the pregnant person and that Idaho's total ban, with no exception for situations that threaten the health of the pregnant person, violates these requirements. A preliminary injunction, blocking enforcement of Idaho's ban where it conflicts with EMTALA, was initially granted by the District Court, but then in flux as the case moved through the appeal process. Ultimately, on 6/27/24, SCOTUS dismissed the case and reinstated the district court's preliminary injunction, blocking enforcement of Idaho's ban where it conflicts with EMTALA. However, on March 5, 2025, the Trump Administration dismissed the lawsuit.
- In January, 2024, anticipating that the Trump Administration would drop the above lawsuit, and thus, end the injunction, St. Luke's Health System sued the Trump Administration, on the same basis used in *United States v. Idaho*.
 - On 3/4/25, St. Luke's requested a temporary restraining order blocking enforcement of Idaho's ban where it conflicts with EMTALA after being informed that the federal government would be dropping its lawsuit against the state of Idaho. The district court granted the temporary restraining order the same day it was requested after which the state filed a request to modify it. Presently, decisions on the request to modify the TRO and the motion for a preliminary injunction are pending.

Medical Screening Exam



Stabilizing Treatment



Stabilizing Treatment or Transfer

IF MEDICAL SCREENING EXAM REVEALS AN EMERGENCY MEDICAL CONDITION, HOSPITAL MUST PROVIDE EITHER:

1. Stabilizing treatment within its capabilities; OR

- Such care necessary to assure, within reasonable medical probability, that no material deterioration of condition is likely to result from or occur during transfer from facility.
- Under Interpretive Guidelines, “stabilized” = emergency medical condition has resolved, even though underlying medical condition may persist.
 - For pregnant woman, delivery of child and placenta.
 - For psychiatric conditions, person is protected and prevented from harming themselves or others.
 - Restraints may temporarily stabilize.
 - Be careful when transferring psychiatric patient.

2. An appropriate transfer (*i.e.*, transfer to another facility or discharged).

EMTALA ENDS ONCE THE PATIENT IS STABILIZED, TRANSFERRED/SAFELY DISCHARGED, OR ADMITTED AS INPATIENT.

(42 CFR 489.24(b), (d))

Stable for Discharge

- Within reasonable clinical confidence, patient has reached a point where their continued care (including diagnostics or treatment) could be reasonably performed as an outpatient or later as an inpatient provided the patient is given a plan for appropriate follow-up care as part of discharge instructions.
- For psychiatric conditions, that the patient is no longer a threat to themselves or others.

(Guidelines 489.24(d))

Stable for Transfer or Discharge

DOCUMENT!
DOCUMENT!
DOCUMENT!



Stable for Transfer or Discharge: Pregnancy

- For pregnant woman in labor, “stabilized” = delivery of the child and the placenta.
- If a woman is having contractions:
 - Hospital must deliver the baby and placenta, or
 - Hospital must perform appropriate transfer, including discharge back to home.
- False labor must be certified by QMP after reasonable period of observation.

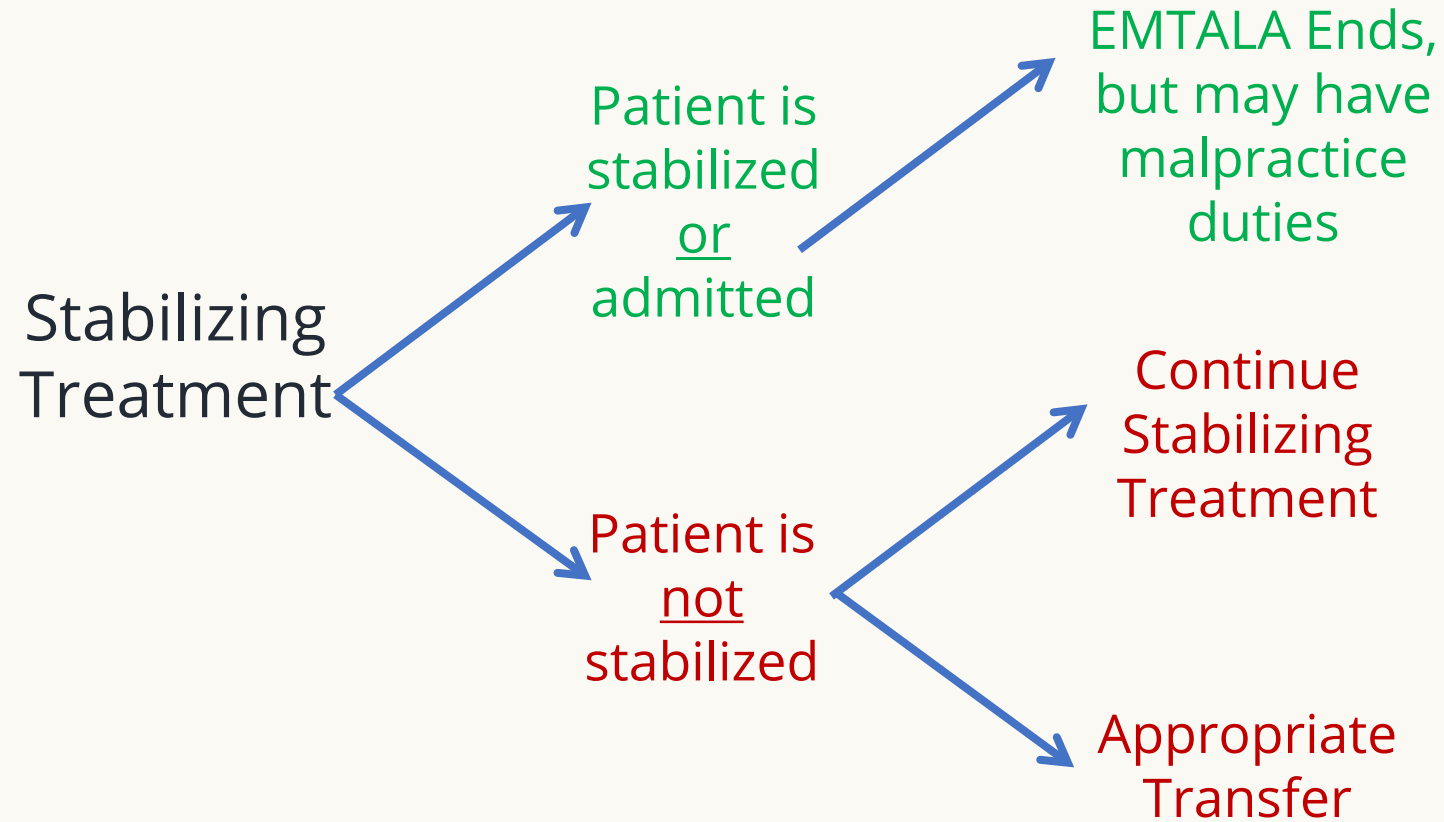
(42 CFR 489.24(d))

Stabilizing Treatment

- Hospital must provide stabilizing treatment within its capabilities.
 - Physical facilities, equipment, and services.
 - Staff, including on-call staff.
- If patient is stabilized, hospital may admit, discharge or transfer.
 - EMTALA ends once patient is stabilized.
 - *Document that patient is stabilized.*
- If hospital is unable to stabilize the patient, hospital must make an appropriate transfer.

(Guidelines 489.24(d))

Stabilizing Treatment



Appropriate Transfers



Transfers

- If patient is not stabilized, hospital may not transfer or discharge the patient unless:
 - Either one of the following—
 - Person or representative requests transfer, or
 - Physician certifies that benefits outweigh risks; and
 - Transfer is “appropriate” under regulations.
- Transfer = Movement outside hospital at direction of hospital personnel, including discharge.
 - Not if person leaves the hospital without permission.
 - Not movement within or between the same hospital.

(42 CFR 489.24(b), (d)(e); Guidelines 489.24(a))

Transfers: Patient Request

- Patient or their legally authorized representative may request transfer.
- Hospital must inform patient regarding:
 - EMTALA rights; and
 - Risks of transfer.
- Patient should complete written request for transfer that documents:
 - Reason for requested transfer, and
 - Patient is aware of risks and benefits of transfer.

(42 CFR 489.24(e)(ii))

Transfer: Physician Certification

- Hospital may transfer patient if:
 - Physician signs written certification:
 - Summarize the reason, risks and benefits of transfer;
 - State that, based on info available at time, the medical benefits outweigh risk; and
 - Sign the certification form.
 - Certification may not be backdated.
 - If physician not present in emergency department,
 - QMP may consult with physician and sign the certification; and
 - Physician must countersign within time required by bylaws or policies.

(42 CFR 489.24(e); Guidelines at 489.24(e))

Appropriate Transfer

- Transfers of unstable patients must be “appropriate,” *i.e.*,
 - Transferring hospital provides treatment within its capability to minimize risk of harm to patient.
 - Transferring hospital contacts receiving facility to confirm that receiving facility has available space and qualified personnel, and facility agrees to accept the transfer.
 - Identify person with authority to accept for receiving facility.
 - Transferring hospital sends:
 - Relevant records available at the time.
 - Name on-call physician who failed to respond, if any.
 - Additional records as soon as practicable.
 - Transfer effected through qualified personnel with proper equipment, including life support measures.

(42 CFR 489.24(e)(2))

Appropriate Transfer

- Hospital is not required to maintain EMS to transfer patients.
- Beware sending patient by private car.
 - Document that method of transport is appropriate, or that you offered appropriate transportation.
 - Ensure patient is accompanied by appropriate family member, friend or other.
 - Give appropriate instructions, e.g., go directly to other facility.
 - Document patient's refusal to accept ambulance transport.

Patients Who Refuse Exam, Treatment, or Transfer



Patients Who Refuse Exam, Treatment, or Transfer

- Hospital must—
 - Offer exam, treatment or transfer.
 - Document the exam, treatment or transfer that was refused.
 - Document that risks and benefits were explained to patient.
 - Document basis for refusal of transfer.
 - Take reasonable steps to secure written informed refusal.
 - If patient refuses to sign, document refusal.

(42 CFR 489.24(d)(3), (5))

Patients Refuse Care

- Hospital may not coerce persons into refusing care or leaving hospital by, *e.g.*, informing them that they will have to pay for their care if they remain but that their care will be free or at lower cost if they transfer to another hospital.

(Guideline 489.24(d)(3))

- Be careful in discussions with patient.
 - May honestly respond to queries.
 - Remind patient that law entitles them to certain care even if they cannot pay.

Prompt Examination or Treatment



Do Not Delay or Discourage Exam or Treatment

- Cannot delay exam or treatment to inquire about payment.
- Cannot seek preauthorization from insurer until after you have conducted exam and initiated stabilizing treatment.

(42 CFR 489.24(d)(4); Guideline 489.24(a), (d)(4))

- Do not suggest to patient that:
 - They should leave.
 - They could obtain services elsewhere at less cost.
 - Insurance may not cover treatment.

(Guideline 489.24(a), (d)(4))

Do Not Delay or Discourage Exam or Treatment

- So long as it does not delay or discourage exam or treatment, hospital may
 - Follow reasonable registration process (*e.g.*, obtain demographics, obtain insurance information or card, identify emergency contact, etc.).
 - Not condition treatment on payment.
 - Contact primary physician or health plan to obtain history or identify needs.
 - Not seek preauthorization.
 - Have knowledgeable person answer questions about payment.

(Guideline 489.24(a))

Transfer to Hospital with Specialized Capabilities



Recipient Hospital Responsibilities

- Participating hospital with “specialized capabilities” must accept transfer if it has capacity, *e.g.*,
 - Specialized equipment or personnel (mental health, NICU, burn unit, trauma, regional referral center, etc.).
 - Special circumstances at transferring facility (“serious capacity problem”, mechanical failure, no beds, no call coverage for specialty, etc.).
- May refuse transfers if:
 - Transferring hospital has similar capabilities (but be careful).
 - Transferring hospital admitted the patient as inpatient.
 - Transfer from outside the United States.

(42 CFR 489.24(f))

Reporting Improper Transfers

- Receiving hospital must report to CMS or state surveyors if it has reason to believe that it has received improper transfer of patient.
 - Other hospital “dumped” the patient.
 - Other hospital refused care.
 - Other hospital sent unstabilized patient without an appropriate transfer.

(42 CFR 489.20(m))

- Liable for EMTALA penalties if fail to timely report.
- CMS Interpretive Guidelines require report within 72 hours.

(Guideline 489.20(m))

- *Investigate facts before reporting!*

On-Call Responsibilities



On-Call Responsibilities

- Hospital must maintain on-call list of medical staff members available to provide screening exam and stabilizing treatment.
 - Applies to all participating hospitals.

(42 CFR 489.20(r))

- Hospitals have flexibility in establishing call coverage.
 - Not required to have 24/7 coverage.
 - Not required to have coverage for all specialties.
- “CMS expects a hospital to strive to provide adequate specialty on-call coverage consistent with the services provided at the hospital.”
 - CMS will consider circumstances regarding call coverage.

(42 CFR 489.20(r); Guideline 489.20(r))

On-Call Responsibilities

- Hospital must have written policies and procedures to:
 - Respond if specialty or on-call physician is not available.
 - Implement proper transfers.
 - Transfer agreements.
 - Notice to EMS.
 - Provide backup plan if hospital permits on-call physicians to:
 - Schedule elective surgery or other procedures while on call. (*CAHs: Beware Medicare reimbursement.*)
 - Take simultaneous call coverage at different hospitals.

(42 CFR 489.24(j))

On-Call Responsibilities

- Not all medical staff members are required to take call.
- Maintain on-call list by individual, not by group.
- Require physicians to respond within set time (*e.g.*, 30 minutes).
- May use telemedicine.
- On-call physician should come to hospital, not have patient sent to his office.
- If polices permit, on-call physician may send midlevel, but on-call physician remains responsible.
- If treating physician determines that on-call physician should respond in person, on-call physician should do so.
- Beware informal call list.

(Guidelines 489.20(r))

On-Call Responsibilities

- If on-call physician fails to respond to call, hospital and on-call physician may be subject to EMTALA penalties.
- If hospital transfers patient because on-call physician failed to respond, hospital must send on-call physician's name to receiving facility.
- To be safe:
 - Establish call coverage policies.
 - Address call coverage requirements in bylaws and policies.
 - Train and re-train medical staff.
 - Enforce call coverage requirements.

Community Call Plan

- Hospitals may establish a community call plan by which hospitals divide call responsibilities.
- Plan must:
 - Delineate call coverage responsibilities.
 - Describe geographic area to which plan applies.
 - Signed by participating hospitals.
 - Coordinate with local EMS protocols.
 - Annual assessment of the plan.
- Must provide screening exam, treatment and/or transfer if patient shows up at hospital despite plan.

(42 CFR 489.24(j))

Documentation

IT'S THE LAW

If you have a medical emergency or are in labor you have the right to receive, within the capabilities of this hospital's staff and facilities:

- an appropriate medical **SCREENING EXAMINATION**
- necessary **STABILIZING TREATMENT** (including treatment for an unborn child) and if necessary
- an appropriate **TRANSFER** to another facility

even if

- **YOU CANNOT PAY** or
- **DO NOT HAVE MEDICAL INSURANCE** or
- **YOU ARE NOT ENTITLED TO MEDICARE OR MEDICAID**

This Hospital does participate in the Medicaid Program.

EMTALA Sign

- Hospitals with DED must post EMTALA sign:
 - Sign must:
 - Advise patients of EMTALA rights.
 - State whether hospital participates in Medicaid.
 - Be written in clear and simple terms.
 - Be in languages understandable by population served by hospital.
 - Post sign where it will likely be seen by:
 - Persons entering emergency department.
 - Persons waiting for exam and treatment.
(entrance, admitting area, waiting room, treatment area)

(42 CFR 489.20(q); Guidelines 489.20(q))

Emergency Department Log

- Hospital must maintain central log on each individual who comes to DED seeking assistance, including:
 - Whether patient refused treatment.
 - Whether patient was refused treatment.
 - Whether patient was treated, stabilized, admitted, transferred or discharged.
- Hospital has flexibility in manner in which it maintains log.
- Central log may include records from other areas, *e.g.*, pediatrics, labor & delivery, etc.

(42 CFR 489.20(r)(3); Guidelines 489.20(r)(3))

Records

- Hospitals must maintain records regarding individuals transferred to or from hospital for 5 years from date of transfer.
 - Must retain original or legally reproducible form.
 - May maintain hard copy, microfilm, fiche, disk, computer file, etc.

(42 CFR 489.20(r); Guidelines 489.20(r))

Avoiding Penalties



Penalties

- Amount of penalties depends on following factors:
 - Degree of culpability, i.e., whether hospital had policies in place and provided training, but rogue employee violated policies.
 - Seriousness of patient's condition.
 - Existence of prior violations.
 - Hospital's financial condition.
 - Nature and circumstances of incident, *e.g.*, patient left AMA despite your efforts to provide services.
 - Other factors as justice requires, *e.g.*,
 - Implemented corrective action plan.
 - Took immediate corrective against persons who violated EMTALA.

(42 CFR 1003.106(d))

Avoiding Penalties

- Do what is in the best interest of the patient.
- Document, document, document!
 - Appropriate medical screening exam, including:
 - Performed by QMP.
 - Addressed presenting symptoms.
 - Ongoing monitoring.
 - Whether patient had emergency medical condition.
 - Stabilizing treatment.
 - Whether patient was stabilized.
 - Patient received appropriate transfer, including physician certification of risks and benefits.
 - Patient left AMA.

Avoiding Penalties

- Maintain written EMTALA policies and forms.
 - See sample policies.
- Train and re-train staff regarding EMTALA compliance.
 - Document the training.
- Post required EMTALA signs.
- Ensure QMPs are identified and qualified.
 - Identified in document approved by board.
 - Privileged to provide screening exams.
- Maintain and periodically review ED log.
 - Update as appropriate.

Avoiding Penalties

- **Know when EMTALA does/does not apply.**
 - Person on hospital property requesting care.
 - Persons in hospital or inbound ambulance.
 - Not inpatients or outpatients.
 - Not non-emergency care.
- **Apply EMTALA clinical standards even when EMTALA does not apply.**
 - Document appropriate screening exam.
 - Document stabilizing treatment.
 - Document appropriate transfer or discharge.
- **Do not delay exam or treatment.**
 - Document timely action.

Avoiding Penalties

- **Beware transfer by private car.**
 - Document that we offered alternative transport.
 - Document circumstances of transfer.
- **Beware inbound ambulances.**
 - Generally cannot turn away unless on divert.
 - May discuss treatment alternatives, but document.
- **Beware requests for transfer to your facility.**
 - Require requests to come to authorized persons.
 - Confirm your own capacity.
 - Confirm specialized capabilities.

Avoiding Penalties

- **Immediately respond to suspected violations.**
 - Gather and confirm facts, including documents and witness statements.
 - Supplement record as appropriate.
 - Impose sanctions if appropriate.
 - Provide additional training.
- **No duty to self-report your own violations.**
 - May want to self-report if another hospital will report.
 - Must report:
 - On-call physicians who failed to respond.
 - Receipt of improper transfer.

In Short . . .

- You will probably be okay if you—
 - Establish appropriate policies
 - Do what is best for the patient
 - Document your reasons and actions

Additional Resources



WWW.CMS.GOV/REGULATIONS-AND-GUIDANCE/LEGISLATION/EMTALA

Emergency Medical Treatment & Labor Act (EMTALA) - Centers for Medicare & Medicaid Services - Windows Internet Explorer provide

http://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html?redirect=/emtala/

emta interpretive guidelines 2012

Convert Select

Favorites AHLA Lists AKS CMS home CMS Stark eCFR EMTALA guidelines Gmail HIPAA Hotmail Idaho Statutes IDAPA DHW IDSOS Search MapQuest Nursing Facilities OCR HIPAA OIG Stark

Emergency Medical Treatment & Labor Act (EMT...

Home | About CMS | Newsroom Center | FAQs | Archive | Share Help Email Print

CMS.gov
Centers for Medicare & Medicaid Services

Learn about [your healthcare options](#) Search

Medicare Medicaid/CHIP Medicare-Medicaid Coordination Insurance Oversight Innovation Center **Regulations and Guidance** Research, Statistics, Data and Systems Outreach and Education

Home > Regulations and Guidance > Emergency Medical Treatment & Labor Act (EMTALA) > Emergency Medical Treatment & Labor Act (EMTALA)

Emergency Medical Treatment & Labor Act (EMTALA)

[CMS Guidance to State Survey Agency Directors](#)

[Emergency Medical Treatment and Labor Act Technical Advisory Group \(EMTALA TAG\)](#)

Emergency Medical Treatment & Labor Act (EMTALA)

In 1986, Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented.

Downloads

[CMS-1063F \[PDF, 716KB\]](#)

[State Operations Manual: Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases \[PDF, 531KB\]](#)

Related Links

[Revisions to Appendix V - Inpatient Prospective Payment System \(IPPS\) 2009 Final Rule Revisions to EMTALA Regulations \[Survey and Certification Letter 09-26\]](#)

[Policy & Memos to States and Regions](#)

[Transmittal \(05/21/2004\): Release of Basic Manual \(State Operations Manual\)](#)

[Transmittal \(11/22/2004\): Payment for Emergency Medical Treatment and Labor Act \(EMTALA\) - Mandated](#)

Done

Internet | Protected Mode: Off

5:16 AM 5/4/2013



Healthcare is a massive industry that needs specialized legal advice.

Healthcare spending represents about a fifth of US GDP. Few sectors are as complex and highly regulated. In an ultra-competitive environment, our industry-experienced team takes care of clients' legal issues so they can focus on business.

Our team provides holistic guidance on regulatory issues, including Stark, Anti-Kickback Statute, HIPAA, Medicare/Medicaid, and similar state laws. We handle provider and payor contracting; mergers, acquisitions, and joint ventures; data privacy and security; licensing, credentialing and medical staff issues; government investigations and False Claim Act litigation; antitrust and trade regulation; employment; real estate; tax; employee benefits; and administrative or civil litigation. Given our combined experience, there is not much our healthcare clients face that we haven't seen and successfully handled before.

Innovations in healthcare delivery and device and pharmaceutical design are also often top priorities for our clients. Our intellectual property and life sciences groups combine legal expertise in patent, trademark, and IP licensing, with sophisticated scientific knowledge to protect and monetize innovations and emerging technologies.

Primary Contacts



Kim Stanger

Partner

Boise, Phoenix
208.383.3913



Blaine Benard

Partner

Salt Lake City
801.799.5881



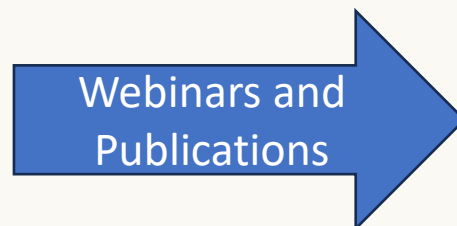
Webinar Recordings

Click here to get access to our health law webinar recordings

Publications

Click here to get access to our health law publications and more on our Health Law blog

Idaho Patient Act Timeline



Questions?



KRISTY KIMBALL

KMKimball@hollandhart.com

(801) 799-5792