



Center for Medicaid and State Operations/Survey and Certification Group

**Ref: S&C-04-10**

**DATE:** November 7, 2003

**TO:** State Survey Agency Directors

**FROM:** Director  
Survey and Certification Group

**SUBJECT:** Emergency Medical Treatment and Labor Act (EMTALA) Interim Guidance

**Letter Summary**

- **The EMTALA Final Rule is Effective November 10, 2003.**
- Hospitals are required to provide either stabilizing treatment or an appropriate transfer for patients with emergency medical conditions.
- **Attachment:** The attached interim guidance is being provided while revised Interpretive Guidelines are being developed. The attachment includes a summary of the provisions of the final rule, as well as a discussion of stabilization and the application of EMTALA to inpatients.

The purpose of this memorandum is to provide interim guidance to regional office (RO) and state survey agency (SA) personnel regarding the enforcement of the Emergency Medical Treatment and Labor Act (EMTALA) regulation, which was published in the Federal Register/Vol.68, No.174, pg. 53222 on September 9, 2003, and is effective November 10, 2003.

In 1986, Congress enacted 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 patient comes to the emergency department and a request is made for examination or treatment for a medical condition, including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide either stabilizing treatment or an appropriate transfer for patients with emergency medical conditions. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented.

To help promote consistent application of the regulations concerning the special responsibilities of Medicare participating hospitals in emergency cases, the Centers for Medicare & Medicaid Services (CMS) published the EMTALA final rule to clarify hospitals' responsibilities when treating individuals with emergency medical conditions and to address concerns about EMTALA raised by the Secretary's Advisory Committee on Regulatory Reform.

Revised Interpretative Guidelines for EMTALA are being developed at this time and will be released as soon as possible. In the meantime, the attached interim guidance is being provided to surveyors to use when conducting an investigation and assessing a hospital's compliance with EMTALA.

If you have further questions, please contact Doris M. Jackson at (410) 786-0095 or via e-mail at [Djackson@cms.hhs.gov](mailto:Djackson@cms.hhs.gov).

**Effective Date:** November 10, 2003

**Training:** This information should be distributed to all survey and certification staff, their managers and the state/RO training coordinators.

/s/  
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management (G-5)

Attachment

## INTERIM GUIDANCE FOR EMTALA FINAL RULE

### Summary of the final rule provisions relating to EMTALA:

- The rule codifies existing policy prohibiting a hospital from seeking authorization from an individual's insurance company until a medical screening exam has been provided and any necessary stabilizing treatment has been initiated. This policy appears in our State Operations Manual (SOM) and was the subject of a Joint Advisory Bulletin between CMS and the Office of the Inspector General in 1999, but had never been codified in the Code of Federal Regulations.
- The rule clarifies when a person is considered to have "come to the emergency department"; such presentation triggers a hospital's obligation under EMTALA to provide a medical screening examination (MSE).

**Dedicated Emergency Department (ED):** A hospital must provide an appropriate medical screening examination to all persons who present themselves to an area of the hospital meeting the regulation's definition of a dedicated emergency department (dedicated ED) (whether on or off the hospital's main campus), and who request, or have a request made on his or her behalf for an examination or treatment of a medical condition.

A dedicated ED is defined as meeting one of the following criteria. The entity: (1) is licensed by the State as an emergency department; or (2) holds itself out to the public as providing emergency care; or (3) during the preceding calendar year, provided at least one-third of its outpatient visits for the treatment of emergency medical conditions (EMC).

**Other locations on-campus:** Persons (including visitors) presenting themselves at an area of a hospital on the hospital's main campus other than a dedicated ED must receive a medical screening exam only if they request, or have a request made on their behalf, for examination or treatment for what may be an emergency medical condition. Where there is no verbal request, a request will nevertheless be considered to exist if a prudent layperson observer would conclude, based on the person's appearance or behavior, that the person needs emergency examination or treatment.

**Other locations off-campus:** If a request were made for emergency care in a hospital department off the hospital's main campus other than a dedicated ED, EMTALA would not apply. The off-campus facility should call the local emergency medical service (EMS) to take the individual to an emergency department (not necessarily the emergency department of the hospital that operates the off-campus department, but rather the closest emergency department) and should provide whatever assistance is within its capability. Therefore, an off-campus location that does not meet the definition of a dedicated ED is

not required to be staffed to handle potential EMC. However, under the conditions of participation (COPs) at 42 C.F.R. 482.12 (f)(3), such departments are required to have written policies and procedures for appraisal of emergencies and referrals when appropriate.

- The rule clarifies that hospitals do not have an EMTALA obligation towards an individual who has begun to receive services as part of a scheduled outpatient encounter and subsequently experiences an EMC. Such an individual is protected by the Medicare conditions of participation.
- The rule states that a hospital's EMTALA obligation ends toward an individual when the individual has been admitted for inpatient hospital services, whether or not the individual has been stabilized. The hospital COPs provide adequate protection to inpatients. A patient is considered to be "admitted" when the decision is made to admit the individual to receive inpatient hospital services with the expectation that the patient will remain in the hospital at least overnight. Typically, we would expect that this would be documented in the patient's chart and medical record as the time that the admitting physician signed and dated the admission order.
- The rule clarifies that when an individual comes to the dedicated ED for non-emergency services, and from the nature of his or her request it is clear that the individual is not making a request, or having a request made on his or her behalf, for examination or treatment for a EMC, the hospital is not obligated to conduct a comprehensive MSE. An example is an individual who presents to the dedicated ED for a minor medical complaint such as suture removal. The preamble to the regulation contemplates that a registered nurse could conduct a relatively basic MSE in this instance and direct the patient to another location other than the dedicated ED for the suture removal. Implicit in this guidance is the notion that it is permissible for a registered nurse to conduct the MSE, as long as the nurse is considered to be qualified medical personnel by (QMP) the hospital and is acting within the scope of his/her license.
- The rule eliminates EMTALA's application to off-campus outpatient clinics that do not routinely provide emergency services. This represents a change in policy from the April 7, 2000 hospital outpatient PPS final regulation, which applied EMTALA to all off-campus departments that were considered part of the hospital.
- The final rule clarifies the obligation of hospitals to maintain an "on call" list of physicians who see patients with potential emergency medical conditions in the dedicated ED. Hospitals are responsible and required to maintain such a list in a manner that best meets the needs of hospital patients receiving required EMTALA services, taking into account the services offered by the hospital and the availability of specialty physicians who take call. Although physicians are not required to take call 24/7, hospitals are expected to work with their medical staffs to develop an appropriate on call schedule. Physicians are permitted to be on call simultaneously at more than one hospital, and to schedule elective surgery or other medical procedures during on call times, without risking EMTALA sanctions, provided appropriate back up plans have been established by the hospital. These provisions of the regulation do not reflect a change in agency policy;

rather, they are intended to further clarify the agency's approach to assessing compliance with on-call requirements under EMTALA. The regulation also makes clear that if there comes a time when a hospital does not have an appropriate specialist on call, the hospital may transfer the patient to another facility if the medical benefits of doing so outweigh the risks to the patient.

- The final rule clarifies the responsibilities of hospital-owned ambulances to more fully integrate them with citywide and local community (EMS) procedures for responding to medical emergencies in a more efficient manner. Currently, if an individual is in an ambulance that is hospital-owned and operated, the hospital has an EMTALA obligation to provide a medical screening examination and possible stabilizing treatment to the individual. Under the final rule, hospital-owned ambulances, operating under the authority of community-wide EMS protocols that direct it to transport the individual to a hospital other than the hospital that owns the ambulance, are not subject to EMTALA to the extent the ambulance's operation is controlled by those protocols.

The EMTALA final rule is compatible with the current CMS enforcement process for investigating alleged violations of EMTALA. The current Interpretative Guidelines (State Operations Manual, Appendix V) will continue to be used to investigate EMTALA complaints in conjunction with the final regulation until further revisions to the Interpretative Guidelines are completed. The enforcement of EMTALA remains a complaint-driven process. The investigation of a hospital's policies and processes, and any subsequent sanctions, are initiated only by a complaint. Surveyors are encouraged to consult with the regional EMTALA contact personnel if, at any time during a survey, they have questions or concerns about the enforcement of the final rule.

The final rule clarifies previous interpretations of the EMTALA requirements as explained in a number of the survey and certification EMTALA policy letters. Listed below are the survey and certification letters clarifying CMS policies regarding EMTALA which are located on CMS' website [www.cms.hhs.gov/medicaid/survey-cert/letters.asp](http://www.cms.hhs.gov/medicaid/survey-cert/letters.asp):

- S&C # 02-34 On-Call Requirements-EMTALA (June 13, 2002)
- S&C # 02-35 Simultaneously On-Call (June 13, 2002)
- S&C # 02-14 Certification of False Labor-EMTALA (January 16, 2002)
- S&C # 02-06 Hospital Capacity-EMTALA (November 29, 2001)
- S&C # 02-02 Question and Answer Relating to Bioterrorism and the Emergency Medical Treatment and Labor Act (EMTALA) (November 8, 2001)
- S&C Letter- Policy Clarification Hospital Owned and Operated Ambulance Participating in Emergency Medical Services (EMS) (September 13, 2000)

The forthcoming interpretative guidelines will clarify CMS enforcement policies in more detail. This interim guidance provides RO and SA personnel the necessary tools to determine if a hospital violated EMTALA. However, CMS would like to take this opportunity to clarify its

policy regarding when a patient is *stabilized* and the hospital's EMTALA obligation to *inpatients*.

### **Stabilized**

The final regulation contains provisions intend to address uncertainty on the part of hospitals regarding when a patient is stabilized, when the hospital's EMTALA obligation ends, and enforcement.

The EMTALA regulation sets forth the standard for determining when a patient is stabilized. 42 C.F.R. 489.24 (b) defines "stabilized" to mean

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

The SOM, Appendix V, pg. V-24 further clarifies the regulation by providing that the attending physician or QMP determines when a patient is stabilized.

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

To be considered stable, a patient's emergency medical condition must be resolved, even though the underlying medical condition may persist. For example, an individual presents to a hospital complaining of chest tightness, wheezing, and shortness of breath and has a medical history of asthma. A physician completes a medical screening examination and diagnoses the individual as having an asthma attack which is an emergency medical condition. Stabilizing treatment is provided (medication and oxygen) to alleviate the acute respiratory symptoms. In this scenario the EMC was resolved, but the underlying medical condition of asthma still exists. After stabilizing the patient, the hospital no longer has an EMTALA obligation. The physician may discharge the patient home, admit him/her to the hospital, or transfer (the "appropriate transfer" requirement under EMTALA does not apply to this situation since the patient has been stabilized) the patient to another hospital depending on his/her needs or request.

CMS is aware that hospital staff may be unclear on how to implement an appropriate transfer under EMTALA according to §489.24, outlined in the SOM, Appendix V, pg. V-24. Under EMTALA, a hospital is responsible for treating and stabilizing, within its capacity and capability, any individual who presents himself or herself to a hospital with an emergency medical condition. Moreover, the hospital must provide such care until the condition ceases to be an emergency, or until the patient is properly transferred to another facility.

For transfers between medical facilities, the SOM provides that

**"A patient is stable for transfer if the patient is transferred from one facility to a second facility and the treating physician attending to the patient has determined, within reasonable clinical confidence, that the patient is expected to leave the hospital"**

*and be received at the second facility with no material deterioration in his/her medical condition, and the treating physician reasonably believes the receiving facility has the capability to manage the patient's medical condition and any reasonably foreseeable complication of that condition.*

Hospitals that transfer patients to recipient hospitals when the patients are considered stable “for transfer,” but whose EMCs have not been resolved, are still required to perform an appropriate transfer. An inappropriate transfer of an individual with an EMC would be a violation of the hospital’s EMTALA obligation.

### **Inpatients**

The rule states that a hospital’s EMTALA obligation ends toward an individual when the individual has been admitted for inpatient hospital services whether or not the individual has been stabilized. The hospital continues to have a responsibility to meet the patient emergency needs in accordance with hospital COPs. The hospital COPs protects patients who are admitted, and they do not permit the hospital to inappropriately discharge or transfer any patient to another facility. The hospital COPs are located at 42 C.F.R. Part 482.

Hospitals are responsible for assuring that inpatients receive acceptable medical care upon admission. If during an EMTALA investigation, there is a question as to whether a patient was admitted so that a hospital could avoid its EMTALA obligation, the SA surveyor should consult with RO personnel to determine if the survey should be expanded to a hospital survey. After completion of the survey, the case is to be forwarded to the RO for violation determination. If it is determined that the hospital admitted the patient for the purpose of avoiding its EMTALA obligation, then the hospital is liable under EMTALA and may be subject to further enforcement action.

Finally, a hospital’s EMTALA obligation ends when a physician or qualified medical person had made a decision:

- That no emergency exists;
- That an emergency exists which requires transfer to another facility, or the patient requests transfer to another facility (the EMTALA obligation rests with the transferring hospital until arrival at the receiving hospital); or
- That an emergency exists and the patient is admitted to the hospital for further stabilizing treatment.