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<p>SCOPE: All Company facilities including, but not limited to, the following hospital departments and hospital-based entities:</p> <table border="0"> <tr> <td>Administration</td> <td>Hospital-Based Entities</td> </tr> <tr> <td>Admitting/Registration</td> <td>Hospital Departments on and off campus</td> </tr> <tr> <td>All Clinical Departments</td> <td>Hospital-Owned Emergency Vehicles</td> </tr> <tr> <td>Ambulatory Care Facilities</td> <td>Hospital-Owned Medical Office Buildings</td> </tr> <tr> <td>Ancillary Services</td> <td>Nursing</td> </tr> <tr> <td>Employed Physicians</td> <td>Patient Account Services/Parallon</td> </tr> <tr> <td>Dedicated Emergency Departments</td> <td>Risk Management</td> </tr> <tr> <td>Emergency Department Physicians (ED Physicians)</td> <td>Urgent Care Centers/Clinics</td> </tr> <tr> <td>Quality Management</td> <td>Off-Campus Provider-Based Emergency Departments</td> </tr> <tr> <td>Finance</td> <td>Security Departments</td> </tr> <tr> <td>Patient Logistics Centers (PLC)</td> <td>Hospitalists</td> </tr> <tr> <td>On-Call Physicians</td> <td></td> </tr> <tr> <td>Contracted Emergency Physician Groups</td> <td></td> </tr> </table> <p>This policy reflects guidance under the Emergency Medical Treatment and Labor Act (“EMTALA”) 42 U.S.C. § 1395dd and associated State laws only. It does not reflect any requirements of The Joint Commission or other regulatory entities. Each facility should ensure it has policies and procedures to address such additional requirements.</p>		Administration	Hospital-Based Entities	Admitting/Registration	Hospital Departments on and off campus	All Clinical Departments	Hospital-Owned Emergency Vehicles	Ambulatory Care Facilities	Hospital-Owned Medical Office Buildings	Ancillary Services	Nursing	Employed Physicians	Patient Account Services/Parallon	Dedicated Emergency Departments	Risk Management	Emergency Department Physicians (ED Physicians)	Urgent Care Centers/Clinics	Quality Management	Off-Campus Provider-Based Emergency Departments	Finance	Security Departments	Patient Logistics Centers (PLC)	Hospitalists	On-Call Physicians		Contracted Emergency Physician Groups	
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<p>PURPOSE: To require, in conjunction with state-specific policies, that an acute care or specialty hospital with an emergency department provide an appropriate medical screening examination and any necessary stabilizing treatment to any individual, including every infant who is born alive, at any stage of development, who comes to the Emergency Department and requests such examination, as required by EMTALA and all Federal regulations and interpretive guidelines promulgated thereunder.</p>																											
<p>POLICY: The hospital with an emergency department must provide to any individual, including every infant who is born alive, at any stage of development, who “comes to the emergency department” an appropriate Medical Screening Examination (“MSE”) within the capability of the hospital’s emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (“EMC”) exists, regardless of the individual’s ability to pay. The EMTALA obligations are triggered when there has been a request for medical care by an individual within a dedicated emergency department (“DED”), when an individual requests emergency medical care on hospital property, other than in a DED, or when a prudent layperson would recognize that an individual on hospital property requires emergency treatment or examination, though no request for treatment is made. If an EMC is determined to exist, the hospital must provide either: (i) further medical examination and any necessary stabilizing treatment within the capabilities of the staff and facilities available at the hospital; or (ii) an</p>																											

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appropriate transfer to another medical facility. The Chief Executive Officer of the Hospital, the executive officer responsible for the emergency department, and the Emergency Department Director are responsible for implementing the EMTALA policies outlined herein.

In addition to implementing the Company’s EMTALA policy, each facility must develop and implement state-compliant, facility-specific policies regarding the screening and treatment of patients with emergency conditions. These governing policies must support compliance with applicable federal and state regulations. The [EMTALA Model Facility Policies](#) are available on the Company’s Intranet.

Exception for Registered Outpatients and Inpatients. EMTALA obligations do not apply to individuals who have been registered and are receiving outpatient services who then have an EMC while receiving the outpatient services. EMTALA also is not generally applicable to inpatients.* Existing Medicare Hospital Conditions of Participation (“CoP”) and relevant state laws protect individuals who are already patients of a hospital and who experience EMCs. However, if an individual comes to the emergency department and is retained for observation status, EMTALA does apply.

*Case law provides that EMTALA does apply to inpatients who have not been stabilized in Kentucky, Tennessee, Ohio and Michigan. *Moses v. Providence Hospital and Medical Centers, Inc. and Paul Lessem, 6th Circuit Court of Appeals, April 6, 2009.*

PROCEDURE:

HOSPITAL POLICIES

Each hospital that participates in the Medicare program and provides emergency medical services must develop policies and procedures to ensure compliance with EMTALA requirements relating to the medical screening process. Such policies should contain the following provisions:

A. General Requirements

Any hospital with an emergency department will provide to any individual who “comes to the emergency department” an appropriate MSE within the capability of the hospital’s emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an EMC exists, regardless of the individual’s ability to pay when a request is made by or on behalf of the individual for medical care, or a prudent layperson would observe that such care is needed, whether the individual is in the hospital’s DED or elsewhere on the hospital’s campus. EMTALA requires the hospital to do the following:

1. Provide an appropriate MSE to the individual within the capability of the hospital’s emergency department to determine whether or not an EMC exists.
2. If the hospital determines that an individual does have an EMC, provide necessary stabilizing treatment to the individual or provide for an appropriate transfer.

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3. Not delay examination and/or treatment in order to inquire about the individual's insurance or payment status.
4. Accept appropriate transfers of individuals with EMCs if the hospital has the specialized capabilities not available at the transferring hospital and has the capacity to treat the individuals.
5. If a patient presents to the ED and decides to leave prior to triage, prior to examination or against medical advice ("AMA") following the MSE, the hospital should obtain or attempt to obtain in writing a waiver of right to a medical examination, an informed refusal of examination, or leaving AMA. An appropriate transfer should be offered to a patient who refuses examination or treatment. The appropriate forms are located on HCA's Intranet.
6. Not take adverse action against a physician or QMP who refuses to inappropriately transfer an individual with an EMC, or against an employee who reports a violation of EMTALA requirements.
7. Maintain a list of physicians on call after the initial examination to provide further examination and/or treatment necessary to stabilize an individual,
8. Maintain a central log tracking the care of all individuals who come to the emergency department.
9. Post conspicuously in the emergency department, emergency department waiting area and other places where individuals wait for examination and treatment a sign specifying their rights to examination and treatment for an EMC and whether the hospital participates in the State Medicaid program.

B. Other EMTALA obligations

The following points, together with subject-matter and state-specific policies, more specifically define the EMTALA obligation:

1. In order for EMTALA to be triggered, hospital personnel must be aware of the individual's presence and observe the appearance or behavior, or both, of that person. This also applies to presentments at off-campus DEDs. The hospital must be on notice of the individual's existence and condition for any EMTALA obligation to begin.
2. The hospital may not establish, maintain or enforce a policy that prohibits personnel from leaving the hospital to examine and/or treat an individual in need of emergency services on the hospital campus. Furthermore, a hospital may not meet its EMTALA obligations merely by summoning emergency medical service ("EMS") personnel, but must use EMS in conjunction with hospital personnel to treat and move an individual who is already on hospital property.
3. A hospital department located **off the hospital campus**, that is **not a DED**, will not be subject to the EMTALA obligations. In off-campus hospital departments that are not DEDs, the hospital is not required to locate additional personnel or require staff at the off-campus

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department to be on call for possible emergencies. If an individual comes to a non-emergency hospital department located off campus with an EMC, it would be appropriate for the department to call the EMS if it is incapable of treating the patient, and to furnish whatever assistance it can to the individual while awaiting the arrival of EMS personnel. The governing body of a hospital must assure that the medical staff has approved written policies and procedures in effect with respect to an off-campus non-emergency hospital department(s) for appraisal of emergencies and referrals, when appropriate, as stated in 42 C.F.R. § 482.12(f)(3).

C. When the Individual Leaves Before the EMTALA Obligation is Met

1. Leaving DED Prior to Triage (“LPT”). If an individual presents to the DED and requests services for a medical condition, but the individual desires to leave prior to triage, the facility must request that the individual complete the [Sign-In Sheet](#).
 - a. Purpose of the Sign-In Sheet. For those individuals who present to the DED who are not immediately placed in a bed, the Sign-In Sheet must be completed. The [Sign-In Sheet](#) is used to document the date and time of the request for medical screening, pre-registration information, and where applicable, a release of responsibility statement by the individual.
 - b. In addition, the [Sign-In Sheet](#) also documents the facility’s responsibility to provide an MSE and indicates that the facility is ready, willing and able to do so.
 - c. If the individual leaves the facility prior to triage but the individual is not seen when he/she leaves, the form also documents the number and time of attempts to locate the individual for screening.
 - d. The [Sign-In Sheet](#) is to be placed in the permanent medical record or scanned and stored in the electronic Horizon Patient Folder or notebook if the facility does not have Horizon Patient Folder.

Note: The [Sign-In Sheet](#) was developed for use in the traditional Emergency Department, including any off-campus provider-based emergency department of the hospital. Modifications to the [Sign-In Sheet](#) for use in a Pediatrics ED, Labor and Delivery or a Behavioral Health Unit can be made but any modifications must be approved by the Assistant Vice President responsible for Emergency Department services in the Clinical Services Group and by Corporate Legal before the changes are implemented.

Logistics

- a. The Facility must receipt, arrive, or pre-register the individual (this process will generate a medical record number.) If an individual presents for an MSE but his or her name is unknown, register utilizing Policy SSD.PP.PTAC.217, Naming Convention for Unidentified Patients.
- b. Open a medical record; offer the individual further medical examination and treatment as

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<p>may be required to identify and stabilize an EMC.</p> <ul style="list-style-type: none"> c. Log the individual into the Central Log. d. Discuss with the individual the risks and benefits involved in leaving prior to the medical screening and document the same. e. Take all reasonable steps to secure the individual's written informed consent to refuse or withdraw from such examination and treatment by having the individual sign the Waiver of Right to Medical Screening Examination form, if possible. If the individual refuses to sign the Refusal of Treatment Form, the hospital representative who asked the individual to sign the form must document the refusal on the form and the date and time such refusal occurred. f. Document the individual's waiver of his or her right to an MSE, or the attempts to locate the individual if he or she left without notifying someone. g. Describe, in the medical record, the examination and treatment that was refused or the request for treatment that was withdrawn. h. Sign the form, adding the date and time. Note: See Sample Sign-In Sheet and Waiver of Right to Medical Screening Examination on Atlas Connect. <p>2. <u>Leaving DED after Triage but before an MSE.</u> If an individual presents to the DED and requests services for a medical condition, is triaged and then indicates a desire to leave prior to the MSE ("LPMSE"), the facility should use its best efforts to:</p> <ul style="list-style-type: none"> a. do a complete registration on the individual; b. open a medical record; c. offer the individual further medical examination and treatment as may be required to identify and stabilize an EMC; d. log the individual in the Central Log; e. discuss with the individual the risks and benefits involved in leaving prior to the medical screening and document same; f. ask the patient to sign the Waiver of Right to Medical Screening Examination form; g. if the individual refuses to sign the Waiver of Right to Medical Screening Examination form, hospital personnel should document that the waiver was provided and the individual refused to sign the form; h. document the individual's waiver of his or her right to MSE, or the attempts to locate the individual if he or she left without notifying someone; i. describe, in the medical record, the examination and treatment that was refused or the request for treatment was withdrawn; and

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<p>j. sign the form, adding date and time.</p> <p>3. <u>Leaving Hospital in Non-DED Prior to an MSE (“LPMSE”)</u>. If an individual presents to a department other than a DED and requests care for an EMC or if a prudent layperson would believe such individual required care for an EMC, the department would proceed to move the individual to the DED for an MSE. <i>If the individual refuses to have the MSE performed, the department personnel must obtain or attempt to obtain Waiver of Right to Medical Screening Examination or appropriate transfer, and such information must be captured on the Central Log in a manner determined by the individual hospital.</i> If the individual requests to be transferred to a different hospital, such transfer should occur from the hospital’s primary DED with appropriate documentation and transfer request implemented by the ED physician and nursing staff. Each Facility should review LPT and LPMSE information as part of its Performance Improvement process.</p> <p>4. <u>Leaving DED after the MSE</u>. For those individuals indicating a desire to leave the DED against medical advice (“AMA”) after receiving an MSE, the facility should use its best efforts to:</p> <ol style="list-style-type: none"> complete the registration process and open a medical record; offer the individual further medical examination and treatment as may be required to identify and stabilize an EMC; log the individual in the Central Log; discuss with the individual the risks and benefits involved in leaving against medical advice and document same; take all reasonable steps to secure the individual’s written informed consent to refuse or withdraw from such examination and treatment by having the individual sign the AMA Form, if possible; describe, in the medical record, the examination and treatment that was refused or the request for treatment was withdrawn; and sign, date and time the entry. <p>5. <u>Performance Improvement</u>. Each Facility should evaluate those situations where an individual leaves prior to an MSE or leaves against medical advice after receiving an MSE as part of its Performance Improvement process.</p> <p>D. On-Call Obligations</p> <ol style="list-style-type: none"> Each hospital that has a Medicare provider participation agreement (including both the transferring and receiving hospitals and specialty hospitals) is required to maintain a list of physician specialists who are available for additional evaluation and stabilizing treatment of individuals with EMCs.

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2. Hospitals must have procedures in place to respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control.
3. A hospital may participate in a community call plan as delineated in the model state policies provided that such plan has been approved by Legal Operations.
4. A current list of physicians who are members of the medical staff and, if applicable, physicians who participate in a community call plan must be available at all times to the emergency department and the PLC.
5. On-call physician specialists have a responsibility to provide specialty care services as needed to any individual who comes to the emergency department either as an initial presentation or upon transfer from another facility.
6. The on-call list maintained for the main hospital emergency department shall be the on-call list for the hospital, including all campuses of the hospital and any off-campus provider-based emergency departments.
7. Each hospital must have in place policies and procedures that define the responsibilities of the on-call physician to respond, examine and treat patients with an EMC. Such policies and procedures must address those situations when a physician cannot respond due to circumstances beyond his or her control or when a hospital chooses to allow simultaneous call, community call, elective procedures or exemptions due to longevity.

E. Transfer Obligations of Each Hospital

1. A hospital may transfer an individual with an EMC that has not been stabilized if the transfer is appropriate, and if:
 - a. the individual (or legally responsible person acting on the individual's behalf) requests the transfer after being informed of the hospital's obligations under EMTALA and of the risks of such a transfer. Any such request must be in writing and must indicate the reasons for the requests as well as the risks and benefits of such a transfer;
 - b. a physician certifies in writing that based on the information available at the time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman or unborn child, from being transferred. A summary of the risks and benefits upon which the decision is based must be included; or
 - c. if a physician is not physically present in the emergency department at the time of transfer, a QMP has signed a certification after a physician, in consultation with the QMP, agrees with the certification and subsequently countersigns the certification. A summary of risks and benefits upon which it is based must be included.
2. A transfer to another medical facility will be appropriate in those cases in which the receiving hospital can provide medical treatment within its capacity that can minimize the risks to the

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<p>individual's health and, in the case of a woman in labor, the health of the unborn child; and the receiving facility has available space and qualified personnel for the treatment of the individual and has agreed to provide such care.</p> <ol style="list-style-type: none"> 3. The transferring hospital must send the medical records related to the EMC along with any history, preliminary diagnosis, results of diagnostic studies or telephone reports, and other medical records pertinent to the patient's presenting EMC and the written informed consent or certification required for the transfer. Test results that become available after the individual is transferred should be telephoned to the receiving hospital, and then mailed or sent via electronic transmission consistent with HIPAA provisions on the transmission of electronic data. 4. All transfers must be effected through qualified personnel and appropriate transportation equipment including the use of necessary and medically appropriate life support measures during the transfer. The ED physician has the responsibility for medical decision-making regarding appropriate mode of transportation, equipment needed and qualified personnel for the transport. 5. The receiving facility must accept appropriate transfers of individuals with EMCs if the hospital has specialized capabilities not available at the transferring hospital and has the capacity to treat those individuals. 6. The CEO must designate in writing an administrative designee by title responsible for accepting transfers in conjunction with a receiving physician. The CEO administrative designee, in conjunction with the receiving physician, e.g., ED physician, has authority to accept the transfer if the hospital has the capability and capacity to treat the individual. 7. Hospitals may utilize a PLC to facilitate the transfer of any individual from the emergency department of the transferring facility to the receiving facility. The transferring ED physician, after discussion with the individual in need of transfer or his or her legally authorized representative, determines the appropriate receiving facility with the capability and capacity for providing the care necessary to stabilize and treat the individual's EMC. The PLC may provide to the transferring facility a listing of those facilities with the capability and capacity to treat the individual requiring specialized care. The PLC then facilitates the transfer from the transferring facility to the receiving facility selected by the transferring physician and/or the individual being transferred. The PLC does not: 1) diagnose or determine treatment for medical conditions; 2) make independent decisions regarding the feasibility of transfer; 3) make independent decisions as to where the individual will be transferred; or 4) determine how a transfer shall be effected. The ED physician and the individual to be transferred then make the decision on the receiving facility. 8. The transferring physician is responsible for determining the appropriate mode of transportation, equipment and attendants for the transfer in such a manner as to be able to effectively manage any reasonably foreseeable complication of the individual's condition that could arise during the transfer. Only qualified personnel, transportation and equipment,

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including those life support measures that may be required during transfer shall be employed in the transfer of an individual with an unstabilized EMC. If the individual refuses the appropriate form of transportation determined by the transferring physician and decides to be transported by another method, the transferring physician is to document that the individual was informed of the risks associated with this type of transport and the individual should sign a form indicating the risks have been explained and the individual acknowledges and accepts the risks. All additional requirements of an appropriate transfer are to be followed by the transferring hospital.

9. **The PLC may utilize algorithms developed with a facility to accept a transfer on behalf of a hospital or decline a transfer request when the hospital does not provide the services needed or lacks capacity. Otherwise, a PLC may make no independent decision to accept or refuse a transfer request on behalf of a facility.**
10. Only the CEO, Administrator-on-Call (“AOC”), or a hospital leader who routinely takes administrative call has the authority to verify that the facility does not have the capability and capacity to accept a transfer. A transfer request which may be declined must first be reviewed with this individual before a final decision to refuse acceptance is made. This requirement applies to all transfer requests, regardless of whether the transfer request is facilitated by a PLC representative or the facility’s CEO designee or ED physician. Individuals qualified to serve as an AOC include the CEO, CFO, CNO, COO, CMO, ECO, VP Quality and other senior leaders reporting directly to the CEO. Other individuals who may be qualified based on experience include an ACFO, ACNO, Associate Administrator or similarly titled individuals. In general, a department director is not qualified to serve as an AOC. Additionally, a Nursing Supervisor, House Supervisor or other similarly titled position is not considered to be an equivalent of the AOC. All individuals who serve as an AOC are required to take the EMTALA Patient Transfer Training for Administrators on Call HealthStream course within 60 days of being assigned to serve as an AOC.
11. At the ED physician’s request, the PLC must facilitate a discussion between the ED physician and the on-call physician of the receiving facility. The on-call physician does not have the authority to refuse an appropriate transfer on behalf of the facility.
12. The PLC may, at the request of the transferring facility, provide information on the availability of EMS or transport options for transfer of an individual. However, the transferring physician retains the responsibility to determine the method and mode of transportation and the personnel and equipment needed. The transfer acceptance cannot be predicated upon the transferring facility using a method of transportation chosen by the receiving facility or a PLC.

F. EMTALA and National Emergencies and Disasters

1. Waivers of Sanctions. Sanctions may be waived during an emergency or disaster declared by the President of the United States or during a public health emergency declared by the Secretary of the Department of Health and Human Services for those facilities to which EMTALA applies that are located within the declared emergency or disaster area.

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- a. Such waivers are permitted for;
 - i. the inappropriate transfer arising out of the circumstances of the emergency of an individual who has not been stabilized; or
 - ii. the direction or relocation of an individual to receive an MSE at an alternate location pursuant to an appropriate and activated State emergency preparedness plan or State pandemic preparedness plan.
- b. Waiver of sanctions applies only to hospitals with DEDs that are located in an emergency area during an emergency period.

2. Hospital Responsibility.

- a. For a waiver to apply, the hospital will receive a reminder from the Regional Office that:
 - i. a hospital with a DED must activate its disaster protocols; and
 - ii. the State must have activated an emergency preparedness plan or pandemic preparedness plan in the emergency area.
- b. The waiver of sanctions will be for the 72-hour period starting with the hospital's activation of its disaster protocol.
- c. For an infectious pandemic disease, the Regional Office notice will indicate that the waiver may continue past the 72-hour period and remain in effect until termination of the declared public health emergency.
- d. Hospitals that activate their disaster protocol must notify the State Agency as soon as possible.

G. EMTALA Policies and Procedures

All EMTALA policies and related guidance are available on Atlas Connect in the Ethics & Compliance section. The EMTALA Model Facility Policies describe in greater detail the hospitals' obligations. Hospitals must review, adopt, and implement these policies for their facilities.

No facility may edit this policy in a manner that would remove existing language. However, through the use of an addendum to the policy, facilities may add language in order to indicate additional facility procedures or requirements necessary to carry out the provisions of the policy within the facility.

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DEFINITIONS:

Administrator on Call (AOC) For EMTALA purposes, the AOC is the CEO’s administrative designee who may be called upon to determine if an EMTALA transfer request should be declined because the hospital lacks capability or capacity.

Appropriate transfer occurs when: (i) the transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual’s health and, in the case of a woman in labor, the health and safety of the unborn child; (ii) the receiving facility has the available space and qualified personnel for the treatment of the individual and has agreed to accept transfer of the individual and to provide appropriate medical treatment; (iii) the transferring hospital sends to the receiving hospital all medical records (or copies thereof) related to the EMC for which the individual has presented, available at the time of transfer, including records related to the individual’s EMC, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of diagnostic studies or telephone reports of the studies, and the informed written consent for transfer or certification if applicable, name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment when requested by the ED physician to do so, and that any other records that are not readily available at the time of transfer are sent as soon as practicable after the transfer; and (iv) the transfer is effected through qualified personnel, transportation and equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.

Born Alive Infant Protection Act of 2002 refers to Section 8 of the United States Code, Title 1, Chapter 1 which defines “person,” “human being,” “child,” or “individual” to include an infant of the species homo sapien who is born alive at any stage of development. “Born alive” refers to an infant that has been completely expelled or extracted from the mother and who, after such expulsion or extraction, breathes or has a beating heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, regardless of whether the umbilical cord has been cut, and regardless of whether the expulsion or extraction occurs as a result of natural or induced labor, cesarean section, or induced abortion. Infants who are born alive as such have all the rights extended by the U.S. Code, including the rights provided under EMTALA.

Capabilities of a medical facility or main hospital provider means the physical space, equipment, supplies and services (e.g., trauma care, surgery, intensive care, pediatrics, obstetrics, burn unit, neonatal unit or psychiatry), including ancillary services available at the hospital. The capabilities of the hospital’s staff mean the level of care that the hospital’s personnel can provide within the training and scope of their professional licenses, including coverage available through the hospital’s on-call roster. The hospital is responsible for treating the individual within the capabilities of the hospital as a whole, not necessarily in terms of the particular department at which the individual presented. The hospital is not required to locate additional personnel or require staff at off-campus departments to be on call for possible emergencies.

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Capacity means the ability of the hospital to accommodate the individual requesting examination or treatment of the transferred individual. Capacity encompasses the number and availability of qualified staff, beds, equipment and the hospital’s past practices of accommodating additional patients in excess of its occupancy limits, including if the hospital has customarily accommodated patients by, for example, moving patients to other units, calling in additional staff, or borrowing equipment from other facilities.

Central Log is a log that a hospital is required to maintain on each individual who “comes to the emergency department” seeking assistance that documents whether he or she refused treatment, was refused treatment, or whether he or she was transferred, admitted and treated, stabilized and transferred or discharged. The purpose of the Central Log is to track the care provided to each individual where EMTALA is triggered. The Central Log includes, directly or by reference, logs from other areas of the hospital that may be considered DEDs, such as labor and delivery where an individual might present for emergency services or receive an MSE instead of the “traditional” emergency department; as well as individuals who seek care for an EMC in other areas located on the hospital property other than a DED.

Community Call Plan is a plan that allows a hospital to augment its on-call list by adding to it physicians from another hospital. Such a plan may be developed by two or more facilities and must meet the requirements as set forth in the [EMTALA Interpretive Guidelines](#).

Dedicated Emergency Department (“DED”) means any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements:

1. is licensed by the State in which it is located under applicable State law as an emergency room or emergency department;
2. is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for EMCs on an urgent basis without requiring a previously scheduled appointment; or
3. during the calendar year immediately preceding the calendar year in which a determination is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of EMCs on an urgent basis without requiring a previously scheduled appointment.
 - a. To meet the one-third criteria of being a DED, the hospital must include those individuals in their case count who meet all three criteria:
 - i. all outpatients
 - ii. all walk-in individuals with unscheduled appointments
 - iii. all individuals with EMCs who received stabilizing treatment
 - b. If one-third of the total cases being reviewed meet all three criteria above, the hospital has an EMTALA obligation in that department and it becomes a DED for EMTALA purposes.

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Emergency Medical Treatment and Labor Act (“EMTALA”) refers to Sections 1866 and 1867 of the Social Security Act, 42 U.S.C. § 1395dd, which obligate hospitals to provide medical screening, treatment and transfer of individuals with EMCs or women in labor. It is also referred to as the “anti-dumping” statute and COBRA.

Emergency Medical Condition (“EMC”) means:

1. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:
 - a. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
 - b. Serious impairment to bodily functions; or
 - c. Serious dysfunction of any bodily organ or part; or
2. With respect to a pregnant woman who is having contractions:
 - a. that there is inadequate time to effect a safe transfer to another hospital before delivery; or
 - b. that transfer may pose a threat to the health or safety of the woman or the unborn child; or
3. With respect to an individual with psychiatric symptoms:
 - a. that acute psychiatric or acute substance abuse symptoms are manifested; or
 - b. that the individual is expressing suicidal or homicidal thoughts or gestures and is determined to be a danger to self or others.

Encounter means a direct personal contact between a patient and a physician, or other person who is authorized by State licensure law and, if applicable, by hospital or critical access hospital (“CAH”) staff bylaws, to order or provide hospital services for diagnosis or treatment of the individual.

Hospital means a facility that has a provider agreement to participate in the Medicare Program as a hospital, including a critical access or rural primary care hospital.

Hospital-Based Entity or Provider-Based Entity means a provider of health care services, or a rural health clinic (“RHC”), that is either created by, or acquired by, a hospital for the purpose of providing health care services of a different type from those of the hospital under the name, ownership, and administrative and financial control of the hospital. A hospital-based entity may, by itself, be qualified to participate in Medicare as a provider and the Medicare CoP do apply to a hospital-based entity as an independent entity. Hospital-based entities may be located on or off the hospital campus. Examples of hospital-based entities may include inpatient psychiatric facility (distinct part unit), skilled nursing facility (“SNF”), comprehensive outpatient rehabilitation facility (“CORF”) and an RHC.

Hospital Campus (“Campus”) means the physical area immediately adjacent to the hospital’s

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main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis by the Centers for Medicare & Medicaid Services ("CMS") Regional Office to be part of the hospital's campus.

Hospital Department or Department of Hospital means a facility or organization that is either created by or acquired by a hospital for the purpose of providing health care services of the same type as those provided by the hospital under the name, ownership, and financial and administrative control of the hospital. A hospital department may not by itself be qualified to participate in Medicare as a provider and Medicare CoP do not apply to a department as an independent entity. Hospital departments may be located on or off the hospital campus.

Hospital with Emergency Department means a hospital with a DED as defined above.

Hospital Property means the entire main hospital campus, including parking lot, sidewalk, and driveway, but excluding other areas or structures of the hospital's main building that are not part of the hospital, such as physician offices, rural health centers, skilled nursing facilities, or other entities that participate separately under Medicare, or restaurants, shops or other non-medical facilities.

Individual includes every infant who is born alive, at any stage of development pursuant to the Born Alive Infants Protection Act of 2002.

Inpatient means an individual who is formally admitted to the hospital by a physician's order.

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

Medical Screening Examination ("MSE") is the process required to reach with reasonable clinical confidence, the point at which it can be determined whether or not an EMC exists or with respect to a woman who could be in labor, whether or not the woman is in labor. Screening is to be conducted to the extent necessary, by physicians and/or other QMP to determine whether an EMC exists. With respect to an individual with behavioral symptoms, an MSE consists of both a medical and behavioral health screening.

Medically Indicated Transfer means the transfer of an individual to a facility with a higher level of care or to a facility with a service that the transferring facility does not provide in order to provide further care and treatment to an individual with an EMC.

Movement from Off-Campus Department means the movement of an individual from an off-

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campus department to the main hospital campus; such movement is not considered a transfer.

National Emergency is an emergency or disaster declared by the President of the United States pursuant to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act and a public health emergency declared by the Secretary of the Department of Health and Human Services pursuant to section 319 of the Public Health Service Act.

Off-Campus Provider-Based Emergency Department means an emergency department, licensed as an emergency department by the state, operating under the Medicare Provider number of the main hospital and located no more than 35 miles from the main hospital campus. While it may sometimes incorrectly be referred to as a Free-Standing Emergency Department, operationally it is considered a provider-based department of the hospital if it operates under the same provider number as the main facility.

On-Call List refers to the list that the hospital is required to maintain that defines those physicians who are on the hospital's medical staff or who have privileges at the hospital, or who are on staff or have privileges at another hospital participating in a formal community call plan and are available to provide treatment necessary after the initial examination to stabilize individuals with EMCs. The list should be maintained in accordance with the resources available to the hospital and should include the name and direct telephone number or direct pager of each physician who is required to fulfill on-call duties. A practice group's name, answering service, and general office phone numbers are not acceptable under EMTALA. The purpose of the on-call list is to ensure that the DED is prospectively aware of which physicians, including specialists and sub-specialists, are available to provide treatment necessary to stabilize individuals with EMCs. Only physicians that are available to physically come to the ER may be included on the on-call list. A physician available via telemedicine does not satisfy the on-call requirements under EMTALA. The services included in the on-call list will be determined by the hospital administration and physicians in accordance with the resources available to the hospital. Each shall provide to the PLC, on a daily basis, an accurate list of physician specialists and sub-specialists available on-call.

Outpatient means a person who has not been admitted as an inpatient but who is registered on the hospital or CAH records as an outpatient and receives services (rather than supplies alone) directly from the hospital or CAH.

Patient Logistics Center (PLC) means an entity to facilitate the transfer of patients in need of services unavailable at a transferring facility, or at the request of a patient, to a receiving facility via ground or air ambulance transportation. A PLC provides staffing to facilitate making arrangements for the transfer of such individuals, while the ED physicians or other physicians in the transferring facility retain the decision-making responsibilities for determining to which receiving facility the individual is transferred and by what means, including personnel, transport type and equipment. The Patient Logistics Centers' role is to facilitate transfers between hospitals, manage bed capacity and patient placement, arrange for transportation as requested, and to be a resource for hospitals

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regarding their capability and capacity to receive transfers at any point in time.

Physician means: (i) a doctor of medicine or osteopathy; (ii) a doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State and who is acting within the scope of his/her license; (iii) a doctor of podiatric medicine to the extent that he/she is legally authorized to perform by the State; or (iv) a doctor of optometry to the extent that he/she is legally authorized to perform by the State with respect to services related to the condition of aphakia.

Physician Certification refers to written or electronically-penned certifications by the treating physician ordering the transfer prior to the patient's transfer 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 individual and, in the case of a woman in labor, to the unborn child from effecting the transfer. The certification shall include a summary of the risks and benefits upon which the certification is based and the reason(s) for the transfer. If a physician is not physically present at the time of transfer, a QMP can sign the certification as long as the QMP consults with the physician and the physician agrees with the certification, and subsequently, countersigns the certification. The date and time of such certification should closely match the date and time of the transfer.

Prudent Layperson Observer is a legal standard descriptive of a careful, attentive and diligent individual who is not a medical professional, who, theoretically, believes, based on the individual's appearance or behavior, that the individual present in a DED needs an examination or treatment for a medical condition or the individual present on hospital property, other than the DED, needs an examination or treatment for an EMC.

Qualified Medical Person or Personnel ("QMP") means an individual, in addition to a licensed physician, who is licensed or certified and who has demonstrated current competence in the performance of MSEs, for example:

- Registered Nurse in Perinatal Services, depending on State law
- Psychiatric Social Worker, depending on State law
- Registered Nurse in Psychiatric Services, depending on State law
- Psychologist
- Physician Assistant
- Advanced Registered Nurse Practitioner
- Certified Registered Nurse Midwife

The above-referenced categories are examples of professionals that may be approved by a hospital's governing board as qualified to administer one or more types of initial MSEs and complete/sign a certification for transfer in consultation with a physician when a physician is not physically present in the DED. Each hospital's governing board must make such a determination on behalf of the hospital through the hospital's by-laws or rules and regulations.

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Signage refers to the hospital requirement to post signs conspicuously in a DED or in a place or places likely to be noticed by all individuals entering the DED as well as those individuals waiting for examination and treatment in areas other than the DED located on hospital property, (e.g., outpatient departments, labor and delivery, waiting room, admitting area, entrance and treatment areas), informing individuals of their rights under Federal law with respect to examination and treatment for medical conditions, EMCs and women in labor. The sign must also state whether or not the hospital participates in the State’s Medicaid program in a State plan approved under Title XIX.

Stabilized, with respect to an EMC, means 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 the facility or in the case of a woman in labor, that the woman delivered the child and the placenta.

To Stabilize, with respect to an EMC, means to either provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility or, in the case of a woman in labor, that the woman has delivered the child and the placenta. Exception applicable to inpatients: If a hospital has screened an individual and found that the individual has an EMC and admits that individual as an inpatient in good faith in order to stabilize the EMC, the hospital has satisfied its responsibilities with respect to that individual under EMTALA.*

*Case law provides that EMTALA does apply to inpatients who have not been stabilized in Kentucky, Tennessee, Ohio and Michigan. *Moses v. Providence Hospital and Medical Centers, Inc. and Paul Lessem, 6th Circuit Court of Appeals, April 6, 2009.*

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

Triage is a sorting process to determine the order in which individuals will be provided an MSE by a physician or QMP. Triage is not the equivalent of an MSE and does not determine the presence or absence of an EMC.

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REFERENCES:

1. Social Security Act, § 1867, 42 U.S.C. § 1395dd, Examination and Treatment for Emergency Medical Conditions and Women In Labor
2. CMS Site Review Guidelines, State Operations Manual
3. 42 C.F.R. § 489.24 Special Responsibilities of Medicare Hospitals in Emergency Cases
4. 42 C.F.R. § 489.20(l)(m)(q) and (r) Basic Commitments
5. 42 C.F.R. § 413.65 Requirements for a determination that a facility or organization has provider-based status
6. [EMTALA Model Facility Policies](#)