

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-09-26

DATE: March 6, 2009

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: **Inpatient Prospective Payment System (IPPS) 2009 Final Rule Revisions to Emergency Medical Treatment and Labor Act (EMTALA) Regulations**

Memorandum Summary

- **EMTALA Regulations Revised:** The Fiscal Year (FY) 2009 IPPS final rule included EMTALA revisions, effective October 1, 2008.
- **On-Call Obligations:** The regulatory provisions have been revised and reorganized. Key changes include introduction of a shared community call (CCP) plan option and elimination of ambiguous language concerning on-call list criteria.
- **Emergency Waivers:** Technical corrections were made to track the statutory language.
- **Recipient Hospital Responsibilities:** A hospital with specialized capabilities is **not** required under EMTALA to accept the transfer of a hospital inpatient who presented to the admitting hospital under EMTALA.
- The Interpretative Guidelines in the State Operations Manual Appendix V that correspond to these changes are attached.

Background

The FY 2009 IPPS Final Rule (CMS-1390-F), published on August 19, 2008 (73 FR 48434) included changes in three areas of the EMTALA regulatory requirements. Some of these changes were in response to recommendations of the EMTALA Technical Advisory Group (TAG). The Interpretative Guidelines in the State Operations Manual Appendix V that correspond to these changes are attached. Section 945 of the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003 mandated the creation of the EMTALA TAG to provide advice regarding the regulations and the implementation of EMTALA. The TAG concluded its work in 2007 and made fifty-five recommendations, some of which the Centers for Medicare & Medicaid Services (CMS) has already implemented while others are currently under review.

Summary of EMTALA Clarifications

1. On-Call Provisions

a. Community Call Plan (CCP) Requirements

The IPPS FY 2009 final rule added a provision at 42 CFR.489.24(j)(2)(iii) that permits hospitals to participate in a formal CCP to share their on-call responsibilities. Participation by hospitals in a CCP is entirely voluntary. CMS is simply making this option available to hospitals that wish to pursue it.

The regulation establishes several elements that must be present in any formal CCP:

- A clear delineation of on-call coverage responsibilities; that is, when each participating hospital is responsible for on-call coverage (for a specific time period, or for a specific service, or both);
- A description of the specific geographic area to which the plan applies;
- A signature by an appropriate representative of each hospital in the plan;
- Assurances that any local and regional EMS system protocol formally includes information on community on-call arrangements;
- A statement specifying that even if an individual arrives at a hospital that is not designated as the on-call hospital, that hospital still has an obligation under 42 CFR 489.24 to provide a medical screening exam and stabilizing treatment within its capability, and that hospitals participating in the community call plan must abide by the regulations under §489.24 governing appropriate transfers; and
- An annual assessment of the community call plan by the participating hospitals.

Ideally a CCP should be integrated into a community's pre-hospital emergency services arrangements. This would facilitate the prompt delivery of specialist stabilizing treatment to individuals whose emergency medical condition (EMC) and need for specialty care can be identified while in transit to the hospital. However, it is important to note that the regulation does not relieve any hospital participating in the CCP of its EMTALA obligations to any individual that comes to the hospital's dedicated emergency department (DED), even when that hospital is not on-call for a specific specialty service under the plan. The hospital must still conduct an appropriate medical screening examination and, if the individual is determined to have an EMC, must provide stabilizing treatment within its capability to do so, or arrange for an appropriate transfer.

Under a formal EMTALA CCP, if an individual who comes to a hospital's DED requires the services of a specialist for stabilizing treatment, and another participating hospital pursuant to the plan has the responsibility for providing that service at that specific time, then a transfer to the hospital with the available on-call specialist would generally be appropriate, assuming all other transfer requirements are met. In most circumstances, it would be sufficient for a surveyor investigating the appropriateness of the transfer to confirm that the individual had an EMC that required the services of a specialist who was on the hospital's on-call list, but was providing the on-call services directly at another CCP hospital.

A CCP does not require prior review and approval from CMS before it can be implemented. Furthermore, as with other call plan options (e.g., permitting on-call physicians to perform elective surgery or take simultaneous call at two or more facilities), each hospital must also have a back-up plan when the CCP is not operational. Surveyors who investigate an EMTALA complaint at a hospital that participates in a CCP are expected to determine whether the plan complies with all of the regulatory requirements put forth in §489.24(j)(2)(iii)

b. Relocation of On-Call List Regulatory Provisions

Previously the requirement for hospitals to maintain an on-call list was located in two separate sections of the regulations: 42 CFR 489.20(r)(2), which articulates Medicare provider agreement requirements, and in 42 CFR 489.24(j)(1), which is specific to EMTALA. However, the statutory requirement for a hospital to maintain an on-call list is found at section 1866 of the Social Security Act (SSA), which governs the Medicare provider agreement, not in section 1867 of the SSA, where the EMTALA provisions are located. Thus, in order to make the regulatory framework consistent with the statutory framework, the requirement at 42 CFR 489.24(j)(1) has been revised to delete language establishing an on-call list requirement and instead cross-reference the requirement at 42 CFR 489.20(r)(2). In addition, the regulation at 42 CFR 489.20(r)(2) has been revised to reflect the addition of a community call plan option and now reads as follows:

An on-call list of 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 in accordance with §489.24(j)(2)(iii), available to provide treatment necessary after the initial examination to stabilize individuals with emergency medical conditions who are receiving services required under §489.24 in accordance with the resources available to the hospital;

This revised regulation contains two notable changes. The first revision is the addition that the on-call list includes physicians who are members of the hospital's medical staff, or who have privileges at the hospital, or who are on the medical staff or have privileges at another hospital participating in a formal community call plan. Thus, if a hospital chooses to participate in a formal EMTALA CCP, CMS expects that the hospital's on-call list will also include physicians at other hospitals participating in the plan who are, pursuant to the plan, on-call to provide specialist services for stabilizing treatment to individuals who present to the initial hospital with emergency medical conditions. The second change to the relocated regulation replaces previous wording that required hospitals to maintain an on-call list "...in a manner that best meets the needs of the hospital's patients who are receiving services ...[under EMTALA] in accordance with the resources available to the hospital, including the availability of on-call physicians." The deleted language has proven difficult to interpret and has caused confusion as to its meaning. The revised language more closely tracks the statutory language. Hospitals should not perceive the change in regulatory text as reducing their responsibility to ensure that they are providing adequate specialty on-call coverage consistent with the resources the hospital has available.

2. Emergency Waiver Regulation Technical Changes

The FY 2008 IPPS final rules published in the Federal Register on August 22, 2007 inadvertently omitted regulatory language that was consistent with the statutory language found in section 1135. The FY 2009 IPPS final rules include the corrected regulatory text. However, S&C-08-05, issued December 4, 2007 (and revised December 14, 2007), which discussed circumstances under which EMTALA waivers could be granted during national emergencies, conformed to the statutory requirements pursuant to amendments to section 1135(b) of the Social Security Act. Thus, that guidance is consistent with the FY 2009 rule change.

In light of experience gained in several weather-related disasters in FY 2008, CMS has refined procedures that hospitals must follow when utilizing an EMTALA waiver authorized in accordance with Section 1135. Hospitals must notify their State Agency when activating their disaster plan and utilizing waivers via the process described in the S&C-08-05. The purpose of this notification is to allow CMS to track the numbers and locations of hospitals that utilize the waivers.

3. EMTALA Obligations for Hospitals with Specialized Capabilities

The FY 2009 IPPS Final Rule clarified EMTALA obligations for hospitals with specialized capabilities with the addition of the following language at §489.24(f)(2):

The provisions of this paragraph (f) do not apply to an individual who has been admitted to a referring hospital under the provisions of paragraph (d)(2)(i) of this section.

Thus, once an individual is admitted in good faith to the admitting hospital, the admitting hospital has satisfied its EMTALA obligation with respect to that individual, even if the individual remains unstabilized, **and** a hospital with specialized capabilities does **NOT** have an EMTALA obligation to accept an appropriate transfer of that individual. However, it is important to note that this rule does not apply to individuals who are protected under EMTALA and placed in observation status rather than admitted as inpatients. These individuals are outpatients.

Questions about this guidance should be addressed to Frances Jensen, M.D., at frances.jensen@cms.hhs.gov.

Effective Date: This guidance is effective immediately.

Training: The information contained in this letter should be shared with all survey and certification staff, their managers, and the State/RO training coordinators within thirty days.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management

Attachment

REVISIONS TO APPENDIX V – EMTALA
Advance Copy

Tag A-2404/C-2404

§489.20(r)

In the case of a hospital as defined in §489.24(b) (including both the transferring and receiving hospitals), to maintain—

(2) An on-call list of 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, in accordance with §489.24(j)(2)(iii), available to provide treatment necessary after the initial examination to stabilize individuals with emergency medical conditions who are receiving services under §489.24 in accordance with the resources available to the hospital;

§489.24(j) Availability of on-call physicians.

In accordance with the on-call requirements specified in §489.20(r)(2), a hospital must have written policies and procedures in place--

- (1) 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;*
- (2) To provide that emergency services are available to meet the needs of individuals with emergency medical conditions if a hospital elects to—*
 - (i) Permit on-call physicians to schedule elective surgery during the time they are on call;*
 - (ii) Permit on-call physicians to have simultaneous on-call duties;*
 - (iii) Participate in a formal community call plan. Notwithstanding participation in a community call plan, hospitals are still required to perform medical screening examinations on individuals who present seeking treatment and to conduct appropriate transfers. The formal community call plan must include the following elements:*

- (A) *A clear delineation of on-call coverage responsibilities; that is, when each hospital participating in the plan is responsible for on-call coverage.*
- (B) *A description of the specific geographic area to which the plan applies.*
- (C) *A signature by an appropriate representative of each hospital participating in the plan.*
- (D) *Assurances that any local and regional EMS system protocol formally includes information on community-call arrangements.*
- (E) *A statement specifying that even if an individual arrives at a hospital that is not designated as the on-call hospital, that hospital still has an obligation under §489.24 to provide a medical screening examination and stabilizing treatment within its capability, and that hospitals participating in the community call plan must abide by the regulations under §489.24 governing appropriate transfers.*
- (F) *An annual assessment of the community call plan by the participating hospitals.*

Interpretive Guidelines §489.20(r)(2) and §489.24(j)

On-Call List Requirements and Options

Section 1866(a)(1)(I)(iii) of the Act states, as a requirement for participation in the Medicare program, that hospitals must maintain a list of physicians who are on-call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition. *This on-call list requirement is a general provider agreement requirement for all hospitals and is thus technically an “EMTALA-related” requirement rather than a specific requirement of the EMTALA portion of the Act. When determining compliance with the on-call list requirement as part of an EMTALA survey it must be remembered that the on-call list requirement applies not only to hospitals with dedicated emergency departments, but also to hospitals subject to EMTALA requirements to accept appropriate transfers. (See discussion of §489.24(f).)* The on-call list *clearly* identifies and ensures that the *hospital’s* personnel is prospectively aware of which physicians, including specialists and subspecialists, are available to provide *stabilizing treatment for individuals with emergency medical conditions.*

The list of on-call physicians must be composed of physicians who are current members of the medical staff or who have hospital privileges. If the hospital participates in a community call plan then the list must also include the names of physicians at other hospitals who are on-call pursuant to the plan. The list must be up-to-date, and accurately reflect the current privileges of the physicians on-call. Physician group names are not acceptable for identifying the on-call physician. Individual physician names are to be identified on the list with their accurate contact information.

Hospital administrators and the physicians who provide the on-call services have flexibility regarding how to configure an on-call coverage system. Several options to enhance this flexibility are permitted under the regulations. It is crucial, however, that hospitals are aware of their responsibility to ensure that they are providing sufficient on-call services to meet the

needs of their community in accordance with the resources they have available. CMS expects a hospital to strive to provide adequate specialty on-call coverage consistent with the services provided at the hospital and the resources the hospital has available. (73 FR 48662).

Permitted On-Call Options

Community Call Plan

CMS permits hospitals to satisfy their on-call obligations through participation in a community call plan (CCP). It is strictly voluntary. Under such a community on-call plan a hospital may augment its on-call list by adding to it physicians at another hospital. There are different ways a CCP could be organized. For example, if there are two hospitals that choose to participate in community call, Hospital A could be designated as the on-call facility for the first 15 days of the month and Hospital B could be designated as the on-call facility for the remaining days of the month. Alternatively, Hospital A could be designated as on-call for cases requiring specialized interventional cardiac care, while Hospital B could be designated as on-call for neurosurgical cases.

Ideally, a CCP could allow various physicians in a certain specialty in the aggregate to be on continuous call (24 hours a day, 7 days a week) without putting a continuous call obligation at the participating hospitals on any one physician. Even if this ideal cannot be achieved, given the resources of the participating hospitals, at a minimum, hospitals choosing to participate in a CCP should be able to provide more on-call specialty coverage than they would on their own.

The plan must clearly articulate which on-call services will be provided on which dates/times by each hospital participating in the plan. Furthermore, the DED in each hospital must have specific information based on the allocation of on-call responsibilities in the plan readily available as part of the on-call list, so that personnel who are providing required services to individuals protected under EMTALA know which specialists based in which hospital(s) are available on-call to provide the necessary specialist services.

Participation in a community call plan does not mean that on-call physicians must travel from the hospital where they practice to the hospital needing their on-call services. Instead, this arrangement facilitates appropriate transfers to the hospital providing the specialty on-call services pursuant to the plan. The hospital where the individual initially presents still has an EMTALA obligation to conduct a medical screening examination, and, for individuals found to have an emergency medical condition, to provide stabilizing treatment within its capability and capacity. However, when the individual is appropriately transferred pursuant to a CCP for further stabilizing treatment, it can generally be assumed that the transferring hospital has provided treatment within its capability and capacity and that its on-call list is adequate for that specialty. For example, if an individual requires the services of a neurologist on a date when the neurologist on-call pursuant to the CCP is based at hospital B, and that neurologist is part of hospital A's on-call list, then a transfer to hospital B to obtain the services of the neurologist on-call would be in order, assuming all other transfer requirements have been met.

In those cases where, for example, hospitals A and B participate in a CCP and a physician who is a member of the medical staff or has privileges at both hospitals is on-call directly at hospital B, but only indirectly through the CCP to hospital A, there is no regulatory prohibition against the on-call physician going to hospital A to provide the stabilizing treatment, rather than transferring the individual to hospital B. The treating and on-call physician might consider which approach is in the best interests of the patient and also maintains the availability of the on-call specialist pursuant to the CCP.

The regulations establish a number of specific requirements for community call plans:

- *The plan must include the geographic parameters of the on-call coverage, indicating what patient origin areas the plan expects to service (e.g., certain communities, counties, regions, municipalities). CMS does not stipulate geographic criteria that a community call plan must meet, since the intent of the plan is to promote flexibility amongst the participating hospitals in developing a call plan that best meets the needs of their communities and utilizes the resources within the region. Similarly, there is no requirement that all hospitals within a defined geographic area must participate in the community call plan.*

Regardless of the geographic specifications of the community call plan, the existence of a CCP in a specific area does not eliminate the EMTALA obligations of hospitals with respect to making appropriate transfers. Among other things this means that:

- *hospitals participating in the community call plan are not relieved of their recipient hospital obligations to accept appropriate transfers from hospitals not participating in the plan.*
- *non-participating hospitals must accept appropriate transfers, regardless of whether the transferring hospital participates in a CCP with the recipient hospital or any other hospital.*
- *non-participating hospitals must provide stabilizing treatment within their capability and capacity before seeking to transfer an individual to another hospital, regardless of whether the recipient hospital is providing on-call services to other hospitals pursuant to a CCP.*

In other words, all Medicare-participating hospitals must fulfill their transfer responsibilities under EMTALA, notwithstanding the presence or absence of a transfer agreement and regardless of whether the transferring or recipient hospital is participating in a formal community call plan (73 FR 48667).

- *The community call plan for each participating hospital must show evidence that the duly authorized representative of each hospital has officially signed the plan. The regulations do not require that the plan be signed by an appropriate representative as part of the annual assessment but it is expected that updated signatures would be included in any subsequent revision of the CCP.*

- *The delivery of pre-hospital medical services is quite varied throughout the country and there are no specific EMTALA requirements that pertain to the development of EMS protocols. However, if there are EMS protocols in effect in part or all of the areas served by the CCP, then there must be an attestation by the CCP-participating hospitals that the CCP arrangement information has been communicated to the EMS providers and will be updated as needed so that EMS providers have the opportunity to consider this information when developing protocols. In addition, hospitals which are in the process of developing and refining their own CCPs may want to consider including input from the EMS providers that serve their DEDs so as to facilitate the efficient implementation of the CCP. For communities that do not have formalized EMS protocols, hospitals participating in a CCP would still be well-advised to inform individual EMS providers of the CCP arrangements amongst the hospitals in the geographic area specified in the plan.*
- *The formal language of the CCP must contain a statement that each hospital participating in the CCP will continue to follow the regulations requiring the provision of MSEs, and stabilizing treatment for individuals determined to have EMCs.*
- *Hospitals must conduct an annual reassessment of their CCP, including an analysis of the specialty on-call needs of the communities for which the CCP is effective (73 FR 48665). It is expected that the CCP would expand specialty coverage to the communities served by the plan and improve, within the hospitals' capabilities and capacities, the adequacy of the on-call list for the hospitals participating in the plan. CMS expects the annual assessment to support a Quality Assurance/Performance Improvement approach to the functioning of the CCP, and that hospitals would, as necessary and feasible, adjust the CCP based on the annual reassessment. Hospitals participating in the CCP have flexibility to determine how to design and implement the assessment.*

Simultaneous Call

Hospitals are permitted to allow physicians to be on-call simultaneously at two or more facilities. Hospitals are also permitted to adopt a policy that does not allow physicians to take simultaneous call at more than one hospital. If a hospital permits simultaneous call, then it must have written policies and procedures to follow when the on-call physician is not available to respond because he/she has been called to another hospital. All hospitals where the physician is on-call need to be aware of the details of the simultaneous call arrangements for the physician and have back-up plans established.

Scheduled Elective Surgery

Hospitals are permitted to allow physicians to perform elective surgery or other procedures while they are on-call. Hospitals are also permitted to adopt a policy that does not allow physicians to perform elective surgery or other procedures while they are on-call. (Critical

Access Hospitals (CAHs) should be aware that if they reimburse physicians for being on-call, there are Medicare payment policy regulations, outside the scope of EMTALA requirements that the CAH might want to consider before making a decision to permit on-call physicians to schedule elective procedures.)

When a physician has agreed to be on-call at a particular hospital during a particular period of time, but also has scheduled elective surgery *or an elective diagnostic or therapeutic procedure* during that time *as permitted by hospital policy*, that physician and the hospital *must* have planned back-up in the event *the physician* is called while performing elective surgery and is unable to respond *to an on-call request in a reasonable time*.

Medical Staff Exemptions

There is no EMTALA *or Medicare provider agreement requirement for* all physicians on the medical staff and/or *having hospital privileges* to take call. *A hospital policy* allowing exemptions to medical staff members (e.g., senior physicians) would not in of itself violate EMTALA-related *Medicare provider agreement* requirements. *However*, if a hospital permits physicians to selectively take call *only* for their own established patients who present to the ED for evaluation, *then* the hospital *must be careful to assure that it maintains adequate on-call services, and that the selective call policy is not a substitute for the on-call services required by the Medicare provider agreement*.

Other On-call List Regulatory Requirements

A hospital must have written on-call policies and procedures and must clearly define the responsibilities of the on-call physician to respond, examine and treat patients with an EMC. *Among other things, the policies and procedures must address the steps to be taken if a particular specialty is not available or the on-call physician cannot respond due to circumstances beyond his/her control (e.g., transportation failures, personal illness, etc.). The policies and procedures must also ensure that the hospital provides emergency services that meet the needs of an individual with an EMC if the hospital chooses to employ any of the on-call options permitted under the regulations, i.e., community call, simultaneous call, or elective procedures while on-call. In other words, there must be a back-up plan to these optional arrangements. For instance, some hospitals may employ the use of “jeopardy” or back-up call schedules to be used only under extreme circumstances. The hospital must be able to demonstrate that hospital staff is aware of and able to execute the back-up procedures.*

Assessment of On-call List Adequacy by Surveyors

CMS expects that a hospital should strive to provide adequate on-call coverage consistent with the services provided at the hospital and the resources the hospital has available, including the availability of specialists. (42 FR 48662). CMS does not have specified requirements regarding how frequently on-call physicians are expected to be available to provide on-call coverage. However, CMS recognizes that in order to supply safe and effective care it would not be prudent

for a hospital to expect one physician to be on-call every day of the week, every week of the year. There is also no pre-determined ratio CMS uses to identify how many days a hospital must provide medical staff on-call coverage for a particular specialty based on the number of physicians on staff for that particular specialty. In particular, CMS has no rule stating that whenever there are at least three physicians in a specialty, the hospital must provide 24-hour/7-day coverage in that specialty.

If a hospital participates in a community call plan, its on-call list must reflect this. The plan does not have to be pre-approved or require formal authorization by CMS or any local, State or Federal agency, in order to be instituted. However, during a complaint investigation, the design and implementation of the CCP will come under review.

Generally, in determining a hospital's on-call list compliance, CMS will consider all relevant factors in a case-specific manner, including the number of physicians on the medical staff/holding hospital privileges, other demands on these physicians, the frequency with which individuals with EMCs typically require the stabilizing services of the hospital's on-call physicians, and the provisions the hospital has made for situations in which a physician on-call is not available or is unable to respond due to circumstances beyond his/her control.

For instance, if the hospital under investigation performs a significant amount of interventional cardiac catheterizations and holds itself out to the public through various advertising methods as a center of excellence in providing this specialized procedure to the community, it would be reasonable to expect that there would be adequate on-call coverage by a physician who is able to perform an emergent interventional cardiac procedure on individuals who present to that hospital's DED in need of such an intervention or who are appropriately transferred to that hospital for such an intervention. On the other hand, it may not be reasonable to expect a CAH to have an interventional radiologist on call if that service is not routinely provided at the CAH or in the local vicinity of the CAH, unless the CAH participates in a community call plan that provides for this service.

On-call Physician Appearance Requirements

Although the on-call list requirement is found in Section 1866, which is the provider agreement section of the Act, Section 1867, the EMTALA section of the Act, provides for enforcement actions against both a physician and a hospital when a physician who is on the hospital's on-call list fails or refuses to appear within a reasonable period of time after being notified to appear. Hospitals would be well-advised to make physicians who are on-call aware of the hospital's on-call policies and the physician's EMTALA obligations when on call.

If a physician is listed as on-call and requested to make an in-person appearance to evaluate and treat an individual, that physician must respond in person in a reasonable amount of time. If an individual presents to Hospital A with an EMC that requires the specialty services provided by Hospital B pursuant to the CCP, then the physician who is based at Hospital B is required to report to Hospital B to provide the stabilizing treatment for the individual who presented to Hospital A and was subsequently transferred to Hospital B.

When a physician is on-call for the hospital and seeing patients with scheduled appointments in his/her private office, it is generally not acceptable to refer emergency cases to his or her office for examination and treatment of an EMC. The physician must come to the hospital to examine the individual if requested to do so by the treating physician. If, however, it is medically indicated, the treating physician may send an individual needing the specialized services of the on-call physician to the physician's office if it is *a provider-based* part of *the* hospital (i.e., department of the hospital sharing the same CMS certification number as the hospital) *It must be clear that this transport is not done for the convenience of the specialist but that there is a genuine medical reason to move the individual, that all individuals with the same medical condition, regardless of their ability to pay, are similarly moved to the specialist's office, and that the appropriate medical personnel accompany the individual to the office.*

If it is permitted under the hospital's policies, an on-call physician has the option of sending a representative, i.e., directing a licensed non-physician practitioner as his or her representative to appear at the hospital and provide further assessment or stabilizing treatment to an individual. This determination should be based on the individual's medical need and the capabilities of the hospital and the applicable State scope of practice laws, hospital by-laws and rules and regulations. *There are some circumstances in which the non-physician practitioner can provide the specialty treatment more expeditiously than the physician on-call. It is important to note, however, that the designated on-call physician is ultimately responsible for providing the necessary services to the individual in the DED, regardless of who makes the in-person appearance. Furthermore, in the event that the treating physician disagrees with the on-call physician's decision to send a representative and requests the actual appearance of the on-call physician, then the on-call physician is required under EMTALA to appear in person.* Both the hospital and the on-call physician who fails or refuses to appear in a reasonable period of time may be subject to sanctions for violation of the EMTALA statutory requirements.

There is no EMTALA prohibition against the treating physician consulting on a case with another physician, who may or may not be on the hospital's on-call list, by telephone, video conferencing, transmission of test results, or any other means of communication. CMS is aware that it is increasingly common for hospitals to use telecommunications to exchange imaging studies, laboratory results, EKGs, real-time audio and video images of patients and/or other clinical information with a consulting physician not on the hospital's premises. Such practices may contribute to improved patient safety and efficiency of care. In some cases it may be understood by the hospitals and physicians who establish such remote consulting arrangements that the physician consultant is not available for an in-person assessment of the individual at the treating physician's hospital. However, if a physician:

- is on a hospital's on-call list;
- has been requested by the treating physician to appear at the hospital; and
- fails or refuses to appear within a reasonable period of time;

then the hospital and the on-call physician may be subject to sanctions for violation of the EMTALA statutory requirements.

It is an entirely separate issue, outside the scope of EMTALA enforcement, whether or not insurers or other third party payers, including Medicare, will provide reimbursement to physicians who provide remote consultation services. Hospitals and/or physicians interested in Medicare reimbursement policy for telemedicine or telehealth services should consult Medicare Benefit Policy Manual, Pub. 100-2, Chapter 18, §270.

If a physician who is on-call, either directly, or indirectly pursuant to a CCP, refuses or fails to appear at the hospital where he/she is directly on call in a reasonable period of time, then that physician as well as the hospital may be found to be in violation of EMTALA. Likewise, if a physician who is on-call typically directs the individual to be transferred to another hospital instead of making an appearance as requested, then that physician as well as the hospital may be found to be in violation of EMTALA. While CMS' enforcement of the EMTALA section of the Act and regulations and the EMTALA-related provisions of the provider agreement section of the Act and regulations are directed solely against hospitals, it is important to note that Section 1867 of the Act also provides for the Office of the Inspector General (OIG) to levy civil monetary penalties or take other actions against hospitals or physicians for EMTALA violations. CMS refers cases it has investigated to the OIG when CMS finds violations that appear to fall within the OIG's EMTALA jurisdiction. Section 1867(d)(1)(C) of the Act specifically provides for penalties against both a hospital and the physician when a physician who is on-call either fails to appear or refuses to appear within a reasonable period of time. Thus, a hospital would be well-advised to establish in its on-call policies and procedures specific guidelines-- e.g., the maximum number of minutes that may elapse between receipt of a request and the physician's appearance - for what constitutes a reasonable response time and to make sure that its on-call physicians and other staff are aware of these time-sensitive requirements.

If a physician on-call does not fulfill his/her on-call obligation, but the hospital arranges in a timely manner for another of its physicians in that specialty to assess/stabilize an individual as requested by the treating physician in the DED, then the hospital would not be in violation of CMS' on-call requirements. However, if a physician on-call does not fulfill his/her on-call obligation and the individual is, as a result, transferred to another hospital, then the hospital may be in violation of CMS's requirements and both the hospital and the on-call physician may be subject to enforcement action by the OIG under the Act.

Tag A-2406/C-2406

§489.24(a) (2) Nonapplicability of provisions of this section. Sanctions under this section for an inappropriate transfer during a national emergency or for the direction or relocation of an individual to receive medical screening at an alternate location *pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency that involves a pandemic infectious disease, pursuant to State pandemic preparedness plan* do not apply to a hospital, with a dedicated emergency department located in an emergency area *during an emergency period*, as specified in section 1135(g)(1)

of the Act. A waiver of these sanctions is limited to a 72 hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect until the termination of the applicable declaration of a public health emergency, as provided for by section 1135(e)(1)(B) of the Act.

Interpretive Guidelines: §489.24(a) (2)

Pursuant to section 1135(b) of the Social Security Act (Act), under certain emergency circumstances EMTALA sanctions may be waived. Specifically, waivers of sanctions are permitted with respect to:

- The inappropriate transfer of an individual who has not been stabilized. Pursuant to the Act the inappropriate transfer must arise out of the circumstances of the emergency; or
- The direction or relocation of an individual to receive a medical screening examination (MSE) at an alternate location pursuant to an appropriate State emergency preparedness plan or State pandemic preparedness plan. If a State emergency preparedness plan or pandemic preparedness plan has been activated in the emergency area, then the direction or relocation of individuals for MSEs is considered to be pursuant to a State plan.

Section 1135(g)(1) of the Act defines an “emergency area” as a geographical area in which, and an “emergency period” as the period during which, there exists:

- An emergency or disaster declared by the President 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 pursuant to section 319 of the Public Health Service Act.

In addition, the Secretary must notify Congress at least 48 hours prior to exercising his waiver authority pursuant to Section 1135 of the Act. The Secretary may, at his discretion, make the waiver’s effect retroactive to a point prior to the date/time he exercises his waiver authority.

The waiver of sanctions applies only to hospitals:

- With dedicated emergency departments; **and**
- Located in an emergency area during an emergency period.

When all of the above requirements are met, CMS Central Office will inform the Regional Office (RO) that the Secretary is permitting an EMTALA waiver, including whether it takes effect retroactively. The RO should then issue an advisory notice that, for a limited period of time during the emergency period, as discussed below, hospitals with dedicated emergency departments in the emergency area will not, be subject to EMTALA sanctions for:

- Redirecting individuals seeking an MSE when a State emergency preparedness plan or a pandemic preparedness plan has been activated in the emergency area; or
- Inappropriate transfers arising out of the circumstances of the emergency.

The RO will remind hospitals that in order for the waiver to apply:

- *The hospital must activate its disaster protocol and;*
- *The State must have activated an emergency preparedness plan or pandemic preparedness plan in the emergency area.*

In accordance with the regulatory language, the RO notice will also indicate that the waiver of sanctions will be for the 72-hour period starting with each hospital's activation of its hospital disaster protocol. In the case of an infectious pandemic disease, however, the RO notice will indicate that the waiver may continue past the 72-hour period and remain in effect until termination of the declaration of public health emergency as described in Section 1135(e)(1)(B) of the Act. However, the 72-hour period (or longer in the case of an infectious pandemic disease) may not in any case start before the effective date *specified in* the Secretary's *waiver*.

Hospitals that activate their disaster protocol and EMTALA waiver must notify their SA that they have done so as soon as possible. The SA will advise the RO on a regular basis as to which hospitals are utilizing an EMTALA waiver.

EMTALA complaints alleging violations by a hospital in an emergency area during an emergency period related to failure to provide an MSE or to an inappropriate transfer must first be reviewed by the RO to determine whether a waiver of sanctions was in effect. The review may require some preliminary investigation, usually by telephone. If the review indicates a waiver was in effect for that hospital at the time of the complaint, then the RO will not authorize the State Agency to conduct an EMTALA investigation of the complaint.

Tag A-2409/C-2409

(Rev.)

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

(1) General. If an individual at a hospital has an emergency medical condition that has not been stabilized (as defined in paragraph (b) of this section), the hospital may not transfer the individual unless—

(i) The transfer is an appropriate transfer (within the meaning of paragraph (e)(2) of this section); and

(ii)

(A) The individual (or a legally responsible person acting on the individual's behalf) requests the transfer, after being informed of the hospital's obligations under this section and of the risk of transfer. The request must be in writing and indicate the reasons for the request as well as indicate that he or she is aware of the risks and benefits of the transfer;

(B) A physician (within the meaning of section 1861(r)(1) of the Act) has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman or the unborn child, from being transferred. The certification must contain a summary of the risks and benefits upon which it is based; or

(C) If a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as determined by the hospital in its bylaws or rules and regulations) has signed a certification described in paragraph (e)(1)(ii)(B) of this section after a physician (as defined in section 1861(r)(1) of the Act) in consultation with the qualified medical person, agrees with the certification and subsequently countersigns the certification. The certification must contain a summary of the risks and benefits upon which it is based.

(2) A transfer to another medical facility will be appropriate only in those cases in which-

(i) The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(ii) The receiving facility--

(A) Has available space and qualified personnel for the treatment of the individual; and

(B) Has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(iii) The transferring hospital sends to the receiving facility all medical records (or copies thereof) related to the emergency condition which the individual has presented that are available at the time of the transfer, including available history, records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests and the informed written consent or

certification (or copy thereof) required under paragraph (e)(1)(ii) of this section, and the name and address of any on-call physician (described in paragraph (g) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment. Other records (e.g., test results not yet available or historical records not readily available from the hospital's files) must be sent as soon as practicable after transfer; and

(iv) The transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.

Interpretive Guidelines: §489.24(e)

The EMTALA regulations at 42 CFR 489.24(b) define “transfer” as “...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 (i) has been declared dead, or (ii) leaves the facility without the permission of any such person.”

The requirements in 42 CFR 489.24(e) apply to transfers to another hospital.

Transfer of individuals with unstabilized EMCs

*In the case of individuals found to have an EMC a hospital is required under EMTALA rules at 42 CFR 489.24(d) to provide stabilizing treatment within the capabilities of the staff and facilities available in the hospital, or to provide a transfer to another hospital as required by 42 CFR 489.24(e). Transfer of the individual to another hospital may be reasonable and permissible, but the regulations establish a number of requirements that each transfer must meet in order to comply with EMTALA. If an individual's EMC has not been stabilized, prior to transferring the individual to another hospital, the sending hospital is required under EMTALA to pursue a transfer **because either:***

- the individual requests the transfer; **or***
- the expected benefits of the transfer outweigh the increased risks of the transfer.*

In either case, the transfer must also always meet the four requirements of an “appropriate” transfer.

If an individual is moved to a diagnostic facility located at another hospital for diagnostic procedures not available at the transferring hospital, and the hospitals arrange to return the individual to the transferring hospital, the transfer requirements must still be met by the sending hospital. The recipient hospital is not obligated to meet the EMTALA transfer requirements

when implementing an appropriate transfer back to the transferring hospital. However, it is reasonable to expect the recipient hospital with the diagnostic capability to communicate (e.g., telephonic report or documentation within the medical record) with the transferring hospital its findings of the medical condition and a status report of the individual during and after the procedure.

The transfer requirements apply only to individuals who have been determined to have an EMC that has not been stabilized. The hospital has no further EMTALA obligation to an individual who has been determined not to have an EMC or whose EMC has been stabilized, or who has been admitted as an inpatient (See discussion related to the requirements of 42 CFR 489.24(d), concerning stabilizing treatment.) However, the hospital has other obligations to the individual under the Hospital Conditions of Participation.

These transfer requirements do not apply to an individual who is moved to another part of the hospital, because technically the patient has not been transferred. This is also the case when an individual who presents to an off-campus dedicated emergency department is found to have an EMC and is moved to the hospital's main campus for stabilizing treatment that cannot be provided at the off-campus site.

Transfer at the request of the individual

A transfer may be made at the request of the individual with an EMC or of a person legally responsible for that individual. The hospital must assure that the individual or legally responsible person is first informed of the hospital's obligations under EMTALA, e.g., its obligation to provide stabilizing treatment within its capability and capacity, regardless of the individual's ability to pay. The hospital must also assure that the individual has been advised of the medical risks associated with transfer. After the hospital has communicated this information, the individual's request for a transfer must be in writing. The request must include the reason(s) why the transfer is being requested and a statement that the individual is aware of the risks and benefits associated with the transfer. The individual or individual's representative must sign the written request.

Transfer with a physician certification.

Alternatively, a transfer may be made when a physician certifies that the expected benefits of the transfer outweigh the risks. Specifically, a physician must certify that the medical benefits to the individual with the EMC that could reasonably be expected from provision of appropriate treatment at another hospital outweigh the increased risks that result from being transferred. In the case of a pregnant woman in labor, the physician must certify that the expected benefits outweigh the risk to both the pregnant woman and the unborn child. Under certain circumstances qualified medical personnel other than a physician may sign the certification. A qualified medical person (QMP) may sign the certification of benefits versus risks of a transfer only after consultation with a physician who agrees with the transfer. The physician must subsequently countersign the certification. The physician's countersignature must be obtained within the established timeframe according to hospital policies and procedures. Hospital by-laws or rules or regulations must specify the criteria and process

for granting medical staff privileges to QMPs, and, in accordance with the hospital or CAH Conditions of Participation, each individual QMP must be appropriately privileged. The date and time of the physician (or the QMP) certification should closely match the date and time of the transfer.

Section [1861\(r\)\(i\)](#) of the Act defines **physicians** as:

A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action. (This provision is not to be construed to limit the authority of a doctor of medicine or osteopathy to delegate tasks to other qualified health care personnel to the extent recognized under State law or a State's regulatory mechanism).

The regulation at [§489.24 \(e\)\(1\)](#) requires an express written certification. Physician certification cannot simply be implied from the findings in the medical record and the fact that the patient was transferred.

The certification must state the reason(s) for transfer. The narrative rationale need not be a lengthy discussion of the individual's medical condition reiterating facts already contained in the medical record, but it should give a complete picture of the benefits to be expected from appropriate care at the receiving (recipient) facility and the risks associated with the transfer, including the time away from an acute care setting necessary to effect the transfer. The risks and benefits certification should be specific to the condition of the patient upon transfer.

This rationale may be *included* on the certification form or in the medical record. In cases where the individual's medical record does not include a certification, the hospital may be given the opportunity to retrieve the certification. Certifications may not be backdated.

Women in Labor

- Regardless of practices within a State, a woman in labor may be transferred only if she or her representative requests the transfer *or* if a physician or other qualified medical personnel signs a certification that the benefits outweigh the risks. If the hospital does not provide obstetrical services, the benefits of a transfer may outweigh the risks. A hospital cannot cite State law or practice as the basis for transfer.
- Hospitals that are not capable of handling high-risk deliveries or high-risk infants often have written transfer agreements with facilities capable of handling high-risk cases. The hospital must still meet the screening, treatment, and transfer requirements.

Four requirements for an appropriate transfer

1. ***§489.24 (e)(2)(i) The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;***

Before implementing a transfer of an individual with an unstablized EMC a hospital is required to provide stabilizing treatment within its capability and capacity. See discussion of stabilizing treatment, 42 CFR 489.24(d). This includes treatment to minimize the transfer risk to the health of the individual and, in the case of a pregnant woman in labor, the health of the unborn child.

If Hospital A participates in a community call plan with Hospital B and an individual with an EMC requires the services of an on-call specialist who, pursuant to the community call plan, is on-call at Hospital B to respond to the specialty needs of individuals at Hospital A, then generally a transfer of the individual to Hospital B is warranted. However, Hospital A is still required to provide treatment within its on-site capability and capacity to minimize the risks of transfer, and all other transfer requirements must also be met, notwithstanding the participation in the community call plan.

2. ***§489.24(e)(2)(ii) The receiving facility--***

(A) Has available space and qualified personnel for the treatment of the individual; and

(B) Has agreed to accept transfer of the individual and to provide appropriate medical treatment;

The transferring hospital must obtain permission from the receiving (recipient) hospital to transfer an individual. The transferring hospital should document its communication with the receiving (recipient) hospital, including the date and time of the transfer request and the name *and title* of the person accepting the transfer.

3. *§489.24 (e)(2)(iii) The transferring hospital sends to the receiving facility all medical records (or copies thereof) related to the emergency condition which the individual has presented that are available at the time of the transfer, including available history, records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) required under paragraph (e)(1)(ii) of this section, and the name and address of any on-call physician (described in paragraph (g) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment. Other records (e.g., test results not yet available or historical records not readily available from the hospital's files) must be sent as soon as practicable after transfer;*

Necessary medical records must accompany individuals being transferred to another hospital. If a transfer is in an individual's best interest, it should not be delayed until records are retrieved or test results come back from the laboratory. Whatever medical records are available at the time the individual is transferred should be sent to the receiving (recipient) hospital with the patient. Test results that become available after the individual is transferred should be telephoned to the receiving (recipient) hospital, and then mailed or sent via electronic transmission consistent with HIPAA provisions on the transmission of electronic data.

4. *§489.24 (e)(2)(iv) The transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.*

Emergency medical technicians may not always be "qualified personnel" for purposes of transferring an individual under these regulations. Depending on the individual's condition, there may be situations in which a physician's presence or some other specialist's presence might be necessary. The physician at the sending hospital (not at the receiving hospital) has the responsibility to determine the appropriate mode, equipment, and attendants for transfer.

While the sending hospital is ultimately responsible for ensuring that the transfer is affected appropriately, the hospital may meet its obligations as it sees fit. These regulations do not require that a hospital operate an emergency medical transportation service.

Tag A-2411/C-2411

§489.24(f) Recipient Hospital Responsibilities

A participating hospital that has specialized capabilities or facilities (including, but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive care units, or, with respect to rural areas, regional referral centers (*which, for purposes of this subpart, mean hospitals meeting the requirements of referral centers found at §412.96 of this chapter*))

may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual.

- (1) *The provisions of this paragraph (f) apply to any participating hospital with specialized capabilities, regardless of whether the hospital has a dedicated emergency department.*
- (2) *The provisions of this paragraph (f) do not apply to an individual who has been admitted to a referring hospital under the provisions of paragraph (d)(2)(i) of this section.*

Interpretive Guidelines: §489.24(f)

A *Medicare-participating hospital* that has specialized capabilities or facilities may not refuse to accept an appropriate transfer *from another hospital* of an individual *with an unstabilized emergency medical condition who is protected under EMTALA and* requires such specialized capabilities or facilities. This assumes that, in addition to its specialized capabilities the recipient hospital has the capacity to treat the individual, and that the transferring, *i.e. referring,* hospital lacks that capability or capacity. *Hospitals with specialized capabilities or facilities may include, but are not limited to, hospitals with burn units, shock trauma units, neonatal intensive care units or hospitals that are regional referral centers that serve rural areas as defined by the requirements at 42 CFR 412.96.*

This requirement *to accept an appropriate transfer* applies to any *Medicare-participating hospital with specialized capabilities, regardless of whether the hospital has a dedicated emergency department.* *In other words, while some obligations under EMTALA apply only to hospitals that have a dedicated emergency department, e.g., requirements related to providing a medical screening examination, the EMTALA recipient hospital obligation can also apply to hospitals that do not have a dedicated emergency department. For example, if an individual is found to have an emergency medical condition that requires specialized psychiatric capabilities, a psychiatric hospital that participates in Medicare and has capacity is obligated to accept an appropriate transfer of that individual. It does not matter if the psychiatric hospital does not have a dedicated emergency department.*

The regulation states that a recipient hospital's EMTALA obligations do not extend to individuals who are inpatients of another hospital. Thus, a hospital may not be cited for violating EMTALA if it refuses to accept the transfer of an inpatient from the referring hospital.

§489.24(b) defines inpatient: "Inpatient means an individual who is admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services as described in §409.10(a) of this chapter with the expectation that he or she will remain at least overnight and occupy a bed even though the situation later develops that the individual can be discharged or transferred to another hospital and does not actually use a hospital bed overnight."

Individuals who are placed in observation status are not inpatients, even if they occupy a bed overnight. Therefore, placement in an observation status of an individual who came to the hospital's DED does not terminate the EMTALA obligations of that hospital or a recipient hospital toward the individual.

There is no EMTALA obligation for a Medicare-participating hospital with specialized capabilities to accept transfers from hospitals located outside the boundaries of the United States. In accordance with Section 210(i) of the Social Security Act, the term "United States," when used in a geographical sense, means the States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa. Hospitals that request transfers must recognize that the appropriate transfer of individuals with unstabilized emergency medical conditions that require specialized services should not routinely be made over great distances, bypassing closer hospitals with the needed capability and capacity.

A hospital with specialized capabilities or facilities that has the necessary capacity to treat an individual with an emergency medical condition may not condition or attempt to condition its acceptance of *an appropriate transfer of an individual protected under EMTALA* on the use of a particular *mode of transport or transport service*. *It is the treating physician at the transferring hospital who decides how the individual is transported to the recipient hospital and what transport service will be used, since this physician has assessed the individual personally. The transferring hospital is required to arrange transport that minimizes the risk to the individual who is being transferred, in accordance with the requirements of §489.24(e)(2)(B)(iv).*

A hospital with specialized capabilities that delays the treatment of an individual with an emergency medical condition who arrives as a transfer from another facility could be in violation of EMTALA, depending on the circumstances *of that delay*. *For instance, if there is evidence that the recipient hospital unreasonably delayed the treatment of certain individuals and expedited the treatment of other individuals, based on their ability to pay for the services or some other form of discrimination, then the recipient hospital may be in violation of EMTALA.* Hospitals that deliberately delay moving an individual from an EMS stretcher do not thereby delay the point in time at which their EMTALA obligation begins. Furthermore, such a practice of "parking" *individuals* arriving via EMS, refusing to release EMS personnel or equipment, *can potentially jeopardize the health and safety of the transferred individual and other individuals in the community who may need EMS services at that time*. On the other hand, this does not mean that a hospital will necessarily have violated EMTALA and/or the hospital CoPs if it does not, in every instance, immediately assume from the EMS provider all responsibility for the individual, regardless of any other circumstances in the hospital.

Lateral transfers, that is, transfers between facilities of comparable resources *and capabilities*, are not required by §489.24(f), because the benefits of such *a* transfer would not be likely to outweigh the risks *of the transfer*, except *when* the *transferring* hospital has a serious capacity problem, a mechanical failure of equipment, or similar situations, *such as loss of power or significant flooding*.

Assessment of whether the transferring hospital with the requisite capabilities lacked the capacity to provide stabilizing treatment, or of whether the recipient hospital lacked the capacity to accept an appropriate transfer requires a review of the hospital's general practices in

adjusting its capacity. If a hospital generally has a record of accommodating additional patients by various means, such as moving patients from one unit to another, calling in additional staff, and temporarily borrowing additional equipment from other facilities, then that hospital would be expected under EMTALA to take reasonable steps to respond to the treatment needs of an individual requiring stabilizing treatment for an emergency medical condition. The determination of a hospital's capacity would depend on the case-specific circumstances and the hospital's previous implementation of capacity management actions.

The criteria for classifying hospitals as rural regional referral centers are defined in 42 CFR §412.96. A designated rural regional referral center is obligated to accept appropriate transfers of individuals who require the hospital's specialized capabilities if the hospital has the capacity to treat the individual.