
CMS Manual System

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Department of Health &
Human Services (DHHS)
Centers for Medicare &
Medicaid Services (CMS)

Transmittal 60

Date: July 16, 2010

SUBJECT: Revisions to Appendix V-Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases.

I. SUMMARY OF CHANGES: Appendix V, Regulations and Interpretive Guidelines for the Emergency Medical Treatment and Labor Act (EMTALA) is updated to include revisions to the regulations from the FY2010 Inpatient Prospective Payment System (IPPS).

NEW/REVISED MATERIAL - EFFECTIVE DATE*: July 16, 2010

IMPLEMENTATION DATE: July 16, 2010

The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual not updated.)

(R = REVISED, N = NEW, D = DELETED) – (Only One Per Row.)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	Appendix V/Table of Contents
R	Appendix V/§489.24(a)(2)(i-ii)/Tag A-2406/C-2406

III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

IV. ATTACHMENTS:

	Business Requirements
x	Manual Instruction
	Confidential Requirements
	One-Time Notification
	One-Time Notification -Confidential
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

State Operations Manual

Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases

(Rev.60, 07-16-10)

Transmittals for Appendix V

Part II - Interpretive Guidelines - Responsibilities of Medicare Participating Hospitals in Emergency Cases

§489.24(a) – *Applicability of Provisions of this Section*

Tag A-2406/C-2406

(Rev.60, Issued: 07-16-10, Effective: 07-16-10, Implementation: 07-16-10)

§489.24(a) - Applicability of Provisions of this Section

- (1) In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) “comes to the emergency department”, as defined in paragraph (b) of this section, the hospital must—**
 - (i) Provide an appropriate medical screening examination 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 exists. The examination must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations and who meets the requirements of [§482.55](#) of this chapter concerning emergency services personnel and direction; and**

Interpretive Guidelines §489.24(a)(1)(i)

A “hospital with an emergency department” is defined in [§489.24\(b\)](#) as a hospital with a dedicated emergency department. An EMTALA obligation is triggered for such a hospital when an individual comes by him or herself, with another person, to a hospital’s **dedicated emergency department** (as that term is defined above) and a request is made by the individual or on the individual’s behalf, or a prudent layperson observer would conclude from the individual’s appearance or behavior a need, for examination or treatment of a **medical condition**. In such a case, the hospital has incurred an obligation to provide an appropriate medical screening examination (MSE) for the individual and stabilizing treatment or an appropriate transfer. The purpose of the MSE is to determine whether or not an emergency medical condition exists.

If an individual who is not a hospital patient comes elsewhere on **hospital property** (that is, the individual comes to the hospital but not to the dedicated emergency department), an EMTALA obligation on the part of the hospital may be triggered if either the individual requests examination or treatment for an **emergency** medical condition or if a prudent layperson observer would believe that the individual is suffering from an **emergency** medical condition. The term “hospital property” means the entire main hospital campus as defined in [§413.65\(a\)](#), including the parking lot, sidewalk and driveway or hospital departments, including any building owned by the hospital that are within 250 yards of the hospital).

If an individual is registered as an outpatient of the hospital and they present on hospital property but not to a dedicated emergency department, the hospital does not incur an obligation to provide a medical screening examination for that individual if they have begun to receive a scheduled course of outpatient care. Such an individual is protected by the hospital Conditions of Participation (CoPs) that protect patient’s health and safety and to ensure that quality care is

furnished to all patients in Medicare-participating hospital. If such an individual experiences an EMC while receiving outpatient care, the hospital does not have an obligation to conduct an MSE for that patient. As discussed in greater detail below, such a patient has adequate protections under the Medicare CoPs and state law.

If an individual is initially screened in a department or facility on-campus outside of the ED, the individual could be moved to another hospital department or facility on-campus to receive further screening or stabilizing treatment without such movement being regarded as a transfer, as long as: (1) all persons with the same medical condition are moved in such circumstances, regardless of their ability to pay for treatment; (2) there is bona fide medical reason to move the individual; and (3) appropriate medical personnel accompany the individual. The same is also true for an individual who presents to the dedicated emergency department (e.g., patient with an eye injury in need of stationary ophthalmology equipment located in the eye clinic) and must be moved to another hospital-owned facility or department on-campus for further screening or stabilizing treatment. The movement of the individual between hospital departments is not considered an EMTALA transfer under this section, since the individual is simply being moved from one department of a hospital to another department or facility of the same hospital.

Hospitals should not move individuals to off-campus facilities or departments (such as an urgent care center or satellite clinic) for a MSE. If an individual comes to a hospital-owned facility or department, which is off-campus and operates under the hospital's Medicare provider number, [§1867 \(42 CFR 489.24\)](#) will not apply to that facility and/or department unless it meets the definition of a dedicated emergency department.

If, however, such a facility does not meet the definition of a dedicated ED, it must screen and stabilize the patient to the best of its ability or execute an appropriate transfer if necessary to another hospital or to the hospital on whose Medicare provider number it is operated. Hospital resources and staff available at the main campus are likewise available to individuals seeking care at the off campus facilities or departments within the capability of the hospital. Movement of the individual to the main campus of the hospital is not considered a transfer since the individual is simply being moved from one department of a hospital to another department or facility of the same hospital. In addition, a transfer from such an entity (i.e., an off-campus facility that meets the definition of a dedicated ED) to a nonaffiliated hospital (i.e., a hospital that does not own the off-campus facility) is allowed where the facility at which the individual presented cannot stabilize the individual and the benefits of transfer exceed the risks of transfer. In other words, there is no requirement under EMTALA that the individual be always transferred back to the hospital that owns and operates the off-campus dedicated ED. Rather, the requirement of EMTALA is that the individual be transferred to an appropriate facility for treatment.

If a request were made for emergency care in a hospital department **off** the hospital's main campus that does not meet the definition of a dedicated emergency department, EMTALA would not apply. However, such an off-campus facility must have policies and procedures in place as how to handle patients in need of immediate care. For example, the off-campus facility policy may direct the staff to contact the emergency medical services/911 (EMS) to take the patient to an emergency department (not necessarily the emergency department of the hospital that

operates the off-campus department, but rather the closest emergency department) or provide the necessary care if it is within the hospital's capability. Therefore, a hospital off-campus facility that does not meet the definition of a dedicated emergency department does not have an EMTALA obligation and not required to be staffed to handle potential EMC.

Medicare **hospitals** that do not provide emergency services must meet the standard of [§482.12 \(f\)](#), which requires hospitals to have written policies and procedures for the appraisal of emergencies, initial treatment within its capability and capacity, and makes an appropriate referral to a hospital that is capable of providing the necessary emergency services.

If a hospital has an EMTALA obligation, it must screen individuals to determine if an EMC exists. It is not appropriate to merely "log in" an individual and not provide a MSE. An MSE is the process required to reach, with reasonable clinical confidence, the point at which it can be determined whether the individual has an EMC or not. An MSE is not an isolated event. It is an ongoing process that begins, but typically does not end, with triage.

Triage entails the clinical assessment of the individual's presenting signs and symptoms at the time of arrival at the hospital, in order to prioritize when the individual will be seen by a physician or other qualified medical personnel (QMP).

Individuals coming to the emergency department must be provided an MSE appropriate to the individuals' presenting signs and symptoms, as well as the capability and capacity of the hospital. Depending on the individual's presenting signs and symptoms, an appropriate MSE can involve a wide spectrum of actions, ranging from a simple process involving only a brief history and physical examination to a complex process that also involves performing ancillary studies and procedures, such as (but not limited to) lumbar punctures, clinical laboratory tests, CT scans, and/or other diagnostic tests and procedures. The medical record must reflect continued monitoring according to the individual's needs until it is determined whether or not the individual has an EMC and, if he/she does, until he/she is stabilized or appropriately transferred. There should be evidence of this ongoing monitoring prior to discharge or transfer.

The MSE must be the same MSE that the hospital would perform on any individual coming to the hospital's dedicated emergency department with those signs and symptoms, regardless of the individual's ability to pay for medical care. If a hospital applies in a nondiscriminatory manner (i.e., a different level of care must not exist based on payment status, race, national origin, etc.) a screening process that is reasonably calculated to determine whether an EMC exists, it has met its obligations under EMTALA. If the MSE is appropriate and does not reveal an EMC, the hospital has no further obligation under [42 CFR 489.24](#).

Regardless of a positive or negative individual outcome, a hospital would be in violation of the anti-dumping statute if it fails to meet any of the medical screening requirements under 42 CFR 489.24. The clinical outcome of an individual's condition is not a proper basis for determining whether an appropriate screening was provided or whether a person transferred was stable. However, the outcome may be a "red flag" indicating that a more thorough investigation is needed. Do not make decisions base on clinical information that was not available at the time of

stabilizing or transfer. If an individual was misdiagnosed, but the hospital utilized all of its resources, a violation of the screening requirement did not occur.

It is not impermissible under EMTALA for a hospital to follow normal registration procedures for individuals who come to the emergency department. For example, a hospital may ask the individual for an insurance card, so long as doing so does not delay the medical screening examination. In addition, the hospital may seek other information (not payment) from the individual's health plan about the individual such as medical history. And, in the case of an individual with an emergency medical condition, once the hospital has conducted the medical screening examination and has initiated stabilizing treatment, it may seek authorization for all services from the plan, again, as long as doing so does not delay the implementation of the required MSE and stabilizing treatment.

A hospital that is not a managed care plan's network of designated providers cannot refuse to screen and treat (or appropriately transfer, if the medical benefits of the transfer outweigh the risks or if the individual requests the transfer) individuals who are enrolled in the plan who come to the hospital if that hospital participates in the Medicare program.

Once an individual has presented to the hospital seeking emergency care, the determination of whether an EMC exists is made by the examining physician(s) or other qualified medical personnel of the hospital.

Medicare participating hospitals that provide emergency services must provide a medical screening examination to any individual regardless of diagnosis (e.g., labor, AIDS), financial status (e.g., uninsured, Medicaid), race, and color, national origin (e.g. Hispanic or Native American surnames), and/or disability, etc.

A hospital, regardless of size or patient mix, must provide screening and stabilizing treatment within the scope of its abilities, as needed, to the individuals with emergency medical conditions who come to the hospital for examination and treatment.

“Labor” is defined to mean 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 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.

An infant that is born alive is a "person" and an "individual" under 1 U.S.C. 8(a) and the screening requirement of EMTALA applies to "any individual" who comes to the emergency department. If an infant was born alive in a dedicated emergency department, and a request was made on that infant's behalf for screening for a medical condition (or if a prudent layperson would conclude, based on the infant's appearance or behavior, that the infant needed examination or treatment for a medical condition), the hospital and physician could be liable for violating EMTALA for failure to provide such a medical screening examination.

If an infant is born alive elsewhere on the hospital's campus (i.e., not in the hospital's dedicated emergency department) and a prudent layperson observer would conclude, based on the born-alive infant's appearance or behavior, that the infant was suffering from an emergency medical condition, the hospital and its medical staff are required to perform a medical screening examination on the infant to determine whether or not an emergency medical condition exists. Whether in the DED or elsewhere on the hospital's campus, if the physician or other authorized qualified medical personnel performing the medical screening examination determines that the infant is suffering from an emergency medical condition, the hospital has an obligation under EMTALA to provide stabilizing treatment or an appropriate transfer. If the hospital admits the infant, its obligation under EMTALA ends.

A minor (child) can request an examination or treatment for an EMC. The hospital is required by law to conduct the examination if requested by an individual or on the individual's behalf to determine if an EMC exists. Hospital personnel should not delay the MSE by waiting for parental consent. If after screening the minor, it is determined that no EMC is present, the staff can wait for parental consent before proceeding with further examination and treatment.

On-campus provider-based entities (such as rural health clinics or physician offices) are not subject to EMTALA, therefore it would be inappropriate to move individuals to these facilities for a MSE or stabilizing treatment under this Act.

If an individual is not on hospital property (which includes a hospital owned and operated ambulance), this regulation is not applicable. Hospital property includes ambulances owned and operated by the hospital, even if the ambulance is not on the hospital campus. An individual in a non-hospital owned ambulance, which is on hospital property is considered to have come to the hospital's emergency department. An individual in a non-hospital owned ambulance not on the hospital's property is not considered to have come to the hospital's emergency department when the ambulance personnel contact "Hospital A" by telephone or telemetry communications. If an individual is in an ambulance, regardless of whether the ambulance is owned by the hospital, a hospital may divert individuals when it is in "diversionary" status because it does not have the staff or facilities to accept any additional emergency patients at that time. However, if the ambulance is owned by the hospital, the diversion of the ambulance is only appropriate if the hospital is being diverted pursuant to community-wide EMS protocols. Moreover, if any ambulance (regardless of whether or not owned by the hospital) disregards the hospital's instructions and brings the individual on to hospital campus, the individual has come to the hospital and the hospital has incurred an obligation to conduct a medical screening examination for the individual.

Hospitals that deliberately delay moving an individual from an EMS stretcher to an emergency department bed do not thereby delay the point in time at which their EMTALA obligation begins. Furthermore, such a practice of "parking" patients arriving via EMS, refusing to release EMS equipment or personnel, jeopardizes patient health and adversely impacts the ability of the EMS personnel to provide emergency response services to the rest of the community. Hospitals that "park" patients may also find themselves in violation of 42 CFR 482.55, the Hospital Condition of Participation for Emergency Services, which requires that hospitals meet the emergency needs of patients in accordance with acceptable standards of practice.

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 ED. For example, there may be situations when a hospital does not have the capacity or capability at the time of the individual's presentation to provide an immediate medical screening examination (MSE) and, if needed, stabilizing treatment or an appropriate transfer. So, if the EMS provider brought an individual to the dedicated ED at a time when ED staff was occupied dealing with multiple major trauma cases, it could under those circumstances be reasonable for the hospital to ask the EMS provider to stay with the individual until such time as there were ED staff available to provide care to that individual. However, even if a hospital cannot immediately complete an appropriate MSE, it must still assess the individual's condition upon arrival to ensure that the individual is appropriately prioritized, based on his/her presenting signs and symptoms, to be seen by a physician or other QMP for completion of the MSE. The hospital should also assess whether the EMS provider can appropriately monitor the individual's condition.

Should a hospital, which is not in diversionary status, fail to accept a telephone or radio request for transfer or admission, the refusal could represent a violation of other Federal or State requirements (e.g., Hill-Burton). If you suspect a violation of related laws, refer the case to the responsible agency for investigation.

The following two circumstances will not trigger EMTALA:

- The use of a hospital's helipad by local ambulance services or other hospitals for the transport of individuals to tertiary hospitals located throughout the State does not trigger an EMTALA obligation for the hospital that has the helipad on its property when the helipad is being used for the purpose of transit as long as the sending hospital conducted the MSE prior to transporting the individual to the helipad for medical helicopter transport to a designated recipient hospital. The sending hospital is responsible for conducting the MSE prior to transfer to determine if an EMC exists and implementing stabilizing treatment or conducting an appropriate transfer. Therefore, if the helipad serves simply as a point of transit for individuals who have received a MSE performed prior to transfer to the helipad, the hospital with the helipad is not obligated to perform another MSE prior to the individual's continued travel to the recipient hospital. If, however, while at the helipad, the individual's condition deteriorates, the hospital at which the helipad is located must provide another MSE and stabilizing treatment within its capacity **if requested** by medical personnel accompanying the individual.
- If as part of the EMS protocol, EMS activates helicopter evacuation of an individual with a potential EMC, the hospital that has the helipad does not have an EMTALA obligation if they are not the recipient hospital, **unless a request** is made by EMS personnel, the individual or a legally responsible person acting on the individual's behalf for the examination or treatment of an EMC.

Hospitals are not relieved of their EMTALA obligation to screen, provide stabilizing treatment and/or an appropriate transfer to individuals because of prearranged community or State plans that have designated specific hospitals to care for selected individuals (e.g., Medicaid patients,

psychiatric patients, pregnant women). Hospitals located in those States which have State/local laws that require particular individuals, such as psychiatric or indigent individuals, to be evaluated and treated at designated facilities/hospitals may violate EMTALA if the hospital disregards the EMTALA requirements and does not conduct an MSE and provide stabilizing treatment or conduct an appropriate transfer prior to referring the individual to the State/local facility. If, after conducting the MSE and ruling out an EMC (or after stabilizing the EMC) the sending hospital needs to transfer an individual to another hospital for treatment, it may elect to transfer the individual to the hospital so designated by these State or local laws. Hospitals are also prohibited from discharging individuals who have not been screened or who have an emergency medical condition to non-hospital facilities for purposes of compliance with State law. The existence of a State law requiring transfer of certain individuals to certain facilities is not a defense to an EMTALA violation for failure to provide an MSE or failure to stabilize an EMC therefore hospitals must meet the federal EMTALA requirements or risk violating EMTALA.

If a screening examination reveals an EMC and the individual is told to wait for treatment, but the individual leaves the hospital, the hospital did not “dump” the individual unless:

- The individual left the emergency department based on a “suggestion” by the hospital;
- The individual’s condition was an emergency, but the hospital was operating beyond its capacity and did not attempt to transfer the individual to another facility, or
- If an individual leaves a hospital Against Medical Advice (AMA) or LWBS, on his or her own free will (no coercion or suggestion) the hospital is not in violation of EMTALA.

Hospital resources and staff available to inpatients at the hospital for emergency services must likewise be available to individuals coming to the hospital for examination and treatment of an EMC because these resources are within the capability of the hospital. For example, a woman in labor who presents at a hospital providing obstetrical services must be treated with the resources available whether or not the hospital normally provides unassigned emergency obstetrical services.

The MSE must be conducted by an individual(s) who is determined qualified by hospital by-laws or rules and regulations and who meets the requirements of §482.55 concerning emergency services personnel and direction. The designation of the qualified medical personnel (QMP) should be set forth in a document approved by the governing body of the hospital. If the rules and regulations of the hospital are approved by the board of trustees or other governing body, those personnel qualified to perform the medical screening examinations may be set forth in the rules and regulations, or the hospital by-laws. It is not acceptable for the hospital to allow informal personnel appointments that could frequently change.

- (ii) **If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment, as defined in paragraph (d) of this section, or an appropriate transfer as defined in paragraph (e) of this section. If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under this section ends, as specified in paragraph (d)(2) of this section.**

Interpretive Guidelines §489.24(a)(1)(ii)

Refer to Tag A-2407/C-2407 for stabilizing treatment and inpatients, and Tag A-2409/C-2409 for an appropriate transfer for EMTALA.

EMTALA does not apply to hospital inpatients. The existing hospital CoPs protect individuals who are already patients of a hospital and who experience an EMC. Hospitals that fail to provide treatment to these patients may be subject to further enforcement actions.

If the surveyor discovers during the investigation that a hospital did not admit an individual in good faith with the intention of providing treatment (i.e., the hospital used the inpatient admission as a means to avoid EMTALA requirements), then the hospital is considered liable under EMTALA and actions may be pursued.

§489.24(a)(2)

- (i) *When a waiver has been issued in accordance with Section 1135 of the Act that includes a waiver under Section 1135(b)(3) of the Act, sanctions under this section for an inappropriate transfer or for the direction or relocation of an individual to receive medical screening at an alternate location, do not apply to a hospital with a dedicated emergency department if the following conditions are met:*
 - (A) *The transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period.*
 - (B) *The direction or relocation of an individual to receive medical screening at an alternate location is 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 a State pandemic preparedness plan.*
 - (C) *The hospital does not discriminate on the basis of an individual's source of payment or ability to pay.*
 - (D) *The hospital is located in an emergency area during an emergency period, as those terms are defined in Section 1135(g)(1) of the Act.*

(E) There has been a determination that a waiver of sanctions is necessary.

- (ii) 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 under Section 1135(e)(1)(B) of the Act.*

Interpretive Guidelines: §489.24(a)(2)

What can be Waived Under Section 1135?

In accordance with Section 1135(b)(3) of the Act, hospitals and CAHs operating under an EMTALA waiver will not be sanctioned for:

- Redirecting an individual who “comes to the emergency department,” as that term is defined at §489.24(b), to an alternate location for an MSE, pursuant to a State emergency preparedness plan or, as applicable, a State pandemic preparedness plan. Even when a waiver is in effect there is still the expectation that everyone who comes to the ED will receive an appropriate MSE, if not in the ED, then at the alternate care site to which they are redirected or relocated.*
- Inappropriately transferring an individual protected under EMTALA, when the transfer is necessitated by the circumstances of the declared emergencies. Transfers may be inappropriate under EMTALA for a number of reasons.*

However, even if a hospital/CAH is operating under an EMTALA waiver, the hospital/CAH would not be exempt from sanctions if it discriminates among individuals based on their ability to pay for services, or the source of their payment for services when redirecting or relocating them for the MSE or when making inappropriate transfers.

All other EMTALA-related requirements at 42 CFR 489.20 and EMTALA requirements at 42 CFR 489.24 continue to apply, even when a hospital is operating under an EMTALA waiver. For example, the statute does not provide for a waiver of a recipient hospital’s obligation to accept an appropriate transfer of an individual protected under EMTALA. (As a reminder, even without a waiver, a hospital is obligated to accept an appropriate EMTALA transfer only when that recipient hospital has specialized capabilities required by the individual and the requisite capacity at the time of the transfer request.)

Waiver of EMTALA requirements in accordance with a Section 1135 waiver does not affect a hospital’s or CAH’s obligation to comply with State law or regulation that may separately impose requirements similar to those under EMTALA law and regulations. Facilities are encouraged to communicate with their State licensure authorities as to the availability of waivers under State law.

When Can a Waiver Be Issued?

In accordance with Section 1135 of the Act, an EMTALA waiver may be issued only when:

- The President has declared an emergency or disaster pursuant to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act; and*
- The Secretary has declared a public health emergency (PHE) pursuant to Section 319 of the Public Health Service Act; and*
- The Secretary has exercised his/her waiver authority pursuant to Section 1135 of the Act and notified Congress at least 48 hours in advance of exercising his/her waiver authority.*

In exercising his/her waiver authority, the Secretary may choose to delegate to the Centers for Medicare & Medicaid Services (CMS) the decision as to which Medicare, Medicaid, or CHIP requirements specified in Section 1135 should be temporarily waived or modified, and for which health care providers or groups of providers such waivers are necessary. Specifically, the Secretary may delegate to CMS decision-making about whether and for which hospitals/CAHs to waive EMTALA sanctions as specified in Section 1135(b)(3).

In addition, in order for an EMTALA waiver to apply to a specific hospital or CAH:

- The hospital or CAH must activate its disaster protocol; and*
- The State must have activated an emergency preparedness plan or pandemic preparedness plan in the emergency area, and any redirection of individuals for an MSE must be consistent with such plan. It is not necessary for the State to activate its plan statewide, so long as it is activated in the area where the hospital is located. It is also not necessary for the State plan to identify the specific location of the alternate screening sites to which individuals will be directed, although some may do so.*

How Long Does an EMTALA Waiver Last?

Except in the case of waivers related to pandemic infectious disease, an EMTALA waiver is limited in duration to 72 hours beginning upon activation of the hospital's/CAH's disaster protocol. In the case of a public health emergency (PHE) involving pandemic infectious disease, the general EMTALA waiver authority will continue in effect until the termination of the declaration of the PHE. However, application of this general authority to a specific hospital/CAH or groups of hospitals and CAHs may limit the waiver's application to a date prior to the termination of the PHE declaration, since case-specific applications of the waiver authority are issued only to the extent they are necessary, as determined by CMS.

Furthermore, if a State emergency/pandemic preparedness plan is deactivated in the area where the hospital or CAH is located prior to the termination of the public health emergency, the hospital or CAH no longer meets the conditions for an EMTALA waiver and that hospital/CAH waiver would cease to be in effect as of the deactivation date. Likewise, if a hospital or CAH

deactivates its disaster protocol prior to the termination of the public health emergency, the hospital or CAH no longer meets the conditions for an EMTALA waiver and that hospital/CAH waiver would cease to be in effect as of the deactivation date.

What is the Process for Seeking an EMTALA Waiver?

Section 1135 provides for waivers of certain Medicare, Medicaid, or CHIP requirements, including waivers of EMTALA sanctions, but only to the extent necessary, to ensure sufficient health care items and services are available to meet the needs of Medicare, Medicaid, and CHIP beneficiaries. The waivers also ensure that health care providers who provide such services in good faith but are unable to comply with one or more of the specified requirements may be reimbursed for such items and services and exempted from sanctions for noncompliance, absent any fraud or abuse.

When the Secretary has exercised his/her waiver authority and delegated to CMS decision-making about specific EMTALA waivers, CMS policy in exercising its authority for granting EMTALA waivers is as follows:

Localized Emergency Area: *In the case of localized disasters, such as those related to floods or hurricanes, CMS may exercise its discretion to advise hospitals/CAHs in the affected areas that they are covered by the EMTALA waiver, **without requiring individual applications for each waiver.** However, hospitals or CAHs that activate their disaster protocol and expect to take advantage of the area-wide waiver must notify their State Survey Agency (SA) at the time they activate their disaster protocol.*

Nationwide Emergency Area: *In the case of a nationwide emergency area, CMS may also exercise its discretion to advise hospitals/CAHs in a specific geographical area(s) that they are covered by the EMTALA waiver **for a time-limited period.** CMS expects to do this only if the State has activated its emergency or pandemic preparedness plan in the affected area(s), and if there is other evidence of need for the waiver for a broad group of hospitals or CAHs. CMS will rely upon SAs to advise their CMS Regional Office (RO) whether and where a State's preparedness plan has been activated, as well as when the plan has been deactivated.*

In the absence of CMS notification of area-wide applications of the waiver, hospitals/CAHs must contact CMS and request that the waiver provisions be applied to their facility. In all cases, the Act envisions that individuals protected under EMTALA will still receive appropriate MSEs somewhere (even if the MSE is not conducted not at the hospital or CAH where they present), and that individuals who are transferred for stabilization of their emergency medical condition will be sent to a facility capable of providing stabilizing services, regardless of whether a waiver is in effect.

Unless CMS advises otherwise, in cases of a public health emergency involving pandemic infectious disease, hospitals/CAHs in areas covered by time-limited, area-wide applications of the EMTALA waiver that seek to extend the waiver's application to a later date within the waiver period (that is, within the period of the PHE declaration) must submit individual requests for

extension. The requests must demonstrate their need for continued application of the waiver. Such requests must be received at least three calendar days prior to expiration of the time-limited waiver. Extensions of an EMTALA waiver in emergencies that do not involve pandemic infectious disease are not available.

Waiver Request Process

Hospitals or CAHs seeking an EMTALA waiver must demonstrate to CMS that application of the waiver to their facility is necessary, and that they have activated their disaster protocol. CMS will confirm with the SA whether the State's preparedness plan has been activated in the area where the hospital or CAH is located. CMS will also seek to confirm when the hospital activated its disaster protocol, whether other measures may address the situation in a manner that does not require a waiver, and other factors important to the ability of the hospital to demonstrate that a waiver is needed.

What will CMS do in response to EMTALA complaints concerning events occurring during the waiver period?

EMTALA enforcement is a complaint-driven process. CMS will assess any complaints/allegations related to alleged EMTALA violations concerning the MSE or transfer during the waiver period to determine whether the hospital or CAH in question was operating under an EMTALA waiver at the time of the complaint, and, if so, whether the nature of the complaint involves actions or requirements not covered by the EMTALA waiver and warrants further on-site investigation by the SA.

§489.24(c) Use of Dedicated Emergency Department for Non-emergency Services

If an individual comes to a hospital's dedicated emergency department and a request is made on his or her behalf for examination or treatment for a medical condition, but the nature of the request makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition.

Interpretive Guidelines §489.24(c)

Any individual with a medical condition that presents to a hospital's ED must receive an MSE that is appropriate for their medical condition. The objective of the MSE is to determine whether or not an emergency medical condition exists. This does not mean that all EMTALA screenings must be equally extensive. If the nature of the individual's request makes clear that the medical condition is not of an emergency nature, the MSE is reflective of the individual presenting complaints or symptoms. A hospital may, if it chooses, have protocols that permit a QMP (e.g., registered nurse) to conduct specific MSE(s) if the nature of the individual's request for examination and treatment is within the scope of practice of the QMP (e.g., a request for a blood pressure check and that check reveals that the patient's blood pressure is within normal range).

Once the individual is screened and it is determined the individual has only presented to the ED for a nonemergency purpose, the hospital's EMTALA obligation ends for that individual at the completion of the MSE. Hospitals are not obligated under EMTALA to provide screening services beyond those needed to determine that there is no EMC.

For a hospital to be exempted from its EMTALA obligations to screen individuals presenting at its emergency department for nonemergency tests (e.g., individual has consulted with physician by telephone and the physician refers the individual to a hospital emergency department for a nonemergency test) the hospital must be able to document that it is only being asked to collect evidence, not analyze the test results, or to otherwise examine or treat the individual.

Furthermore, a hospital may be exempted from its EMTALA obligations to screen individuals presenting to its dedicated emergency department if the individual had a previously scheduled appointment.

If an individual presents to an ED and requests pharmaceutical services (medication) for a medical condition, the hospital generally would have an EMTALA obligation. Surveyors are encouraged to ask probing questions of the hospital staff to determine if the hospital in fact had an EMTALA obligation in this situation (e.g., did the individual present to the ED with an EMC and informed staff they had not taken their medication? Was it obvious from the nature of the medication requested that it was likely that the patient had an EMC?). The circumstances surrounding why the request is being made would confirm if the hospital in fact has an EMTALA obligation. If the individual requires the medication to resolve or provide stabilizing treatment of an EMC, then the hospital has an EMTALA obligation. Hospitals are not required by EMTALA to provide medication to individuals who do not have an EMC simply because the individual is unable to pay or does not wish to purchase the medication from a retail pharmacy or did not plan appropriately to secure prescription refills.

If an individual presents to a dedicated emergency department and requests services that are not for a medical condition, such as preventive care services (immunizations, allergy shots, flu shots) or the gathering of evidence for criminal law cases (e.g., sexual assault, blood alcohol test), the hospital is not obligated to provide a MSE under EMTALA to this individual.

Attention to detail concerning blood alcohol testing (BAT) in the ED is instrumental when determining if a MSE is to be conducted. If an individual is brought to the ED and law enforcement personnel request that emergency department personnel draw blood for a **BAT only** and does not request examination or treatment for a medical condition, such as intoxication and a prudent lay person observer would not believe that the individual needed such examination or treatment, then the EMTALA's screening requirement is not applicable to this situation because the only request made on behalf of the individual was for evidence. However, if for example, the individual in police custody was involved in a motor vehicle accident or may have sustained injury to him or herself and presents to the ED a MSE would be warranted to determine if an EMC exists.

When law enforcement officials request hospital emergency personnel to provide clearance for incarceration, the hospital has an EMTALA obligation to provide a MSE to determine if an EMC

exists. If no EMC is present, the hospital has met its EMTALA obligation and no further actions are necessary for EMTALA compliance.

Surveyors will evaluate each case on its own merit when determining a hospital's EMTALA obligation when law enforcement officials request screening or BAT for use as evidence in criminal proceedings. This principle also applies to sexual assault cases.