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CENTERS FOR MEDICARE & MEDICAID SERVICES

Acentra HEALTH

EMTALA

Know it. Practice it.

"It ain't what you don't know that gets you into trouble. It's what you know for sure that just ain't so." – Mark Twain

Ari Lapin, MD - Medical Director, EMTALA
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Housekeeping

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Presenter

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The Role of the BFCC-QIO in EMTALA

- Through a contract with the Centers for Medicare & Medicaid Services (CMS), **Acentra Health** serves as the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for 29 states across 5 CMS regions.
- **5-Day Advisory Review:** Conducted at CMS's request when a possible EMTALA violation involves clinical questions. An independent physician peer review is provided to inform the compliance determination.
- **60-Day Review**: Mandated upon referral to the Office of Inspector General (OIG) for possible civil monetary penalty or exclusion sanction.
- **Physician Reviewers Assess**:
  - Was there an emergency medical condition (EMC)?
  - Was the medical screening examination (MSE) appropriate?
  - Was stabilizing treatment appropriate within the hospital's capability?
  - Was the transfer appropriate?
- **QIO Assesses Clinical Facts Only:** Determining whether EMTALA was violated is the exclusive authority of CMS.

EMTALA stands for Emergency Medical Treatment and Labor Act

Today’s Agenda

- EMTALA Unpacked
- Deep Dive: MSE Pitfalls
- Deep Dive: Stabilization Pitfalls
- Deep Dive: Transfer Pitfalls
- Key Takeaways

SECTION 1

EMTALA Unpacked

What every clinician and administrator must know

What is EMTALA?

Emergency Treatment and Labor Act

What is EMTALA? Emergency Medical Treatment and Labor Act

1986

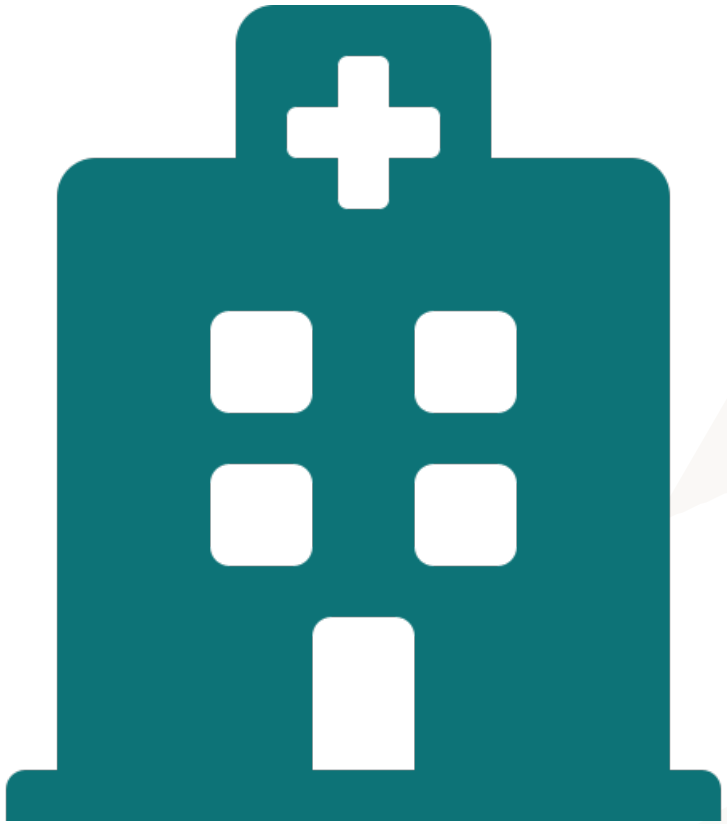
Enacted as part of COBRA

Response to "patient dumping" - Hospitals refusing or transferring uninsured patients without regard to medical stability

Three Core Obligations

1. Medical Screening Exam
2. Stabilization
3. Transfer

What is EMTALA?



Two Additional Obligations Often Overlooked

4

Acceptance of Transfer

Hospitals must accept appropriate transfers.

5

Reporting Requirements

A hospital must report to CMS anytime it has reason to believe it may have received an individual transferred in violation of EMTALA (72 hours).

The Three Pillars of EMTALA

MSE

Medical Screening Exam

Identify or rule out an emergency medical condition

EMC Treatment

Stabilization

Identify or rule out an emergency medical condition

If Needed

Transfer

Only when requirements are met

The Three Pillars of EMTALA: MSE (Slide 1 of 7)

MSE

Medical Screening Exam

Identify or rule out an emergency medical condition

If an individual comes to a hospital with a dedicated emergency department (DED), the hospital must provide an appropriate medical screening examination within the capability of the hospital's emergency department to determine whether an emergency medical condition exists.

The Three Pillars of EMTALA: MSE (Slide 2 of 7)

MSE

Medical Screening Exam

Identify or rule out an emergency medical condition

If an individual **comes to** a hospital with a **DED**, the hospital must provide an **appropriate medical screening examination** within the capability of the hospital's emergency department to determine whether an **emergency medical condition** exists.

The Three Pillars of EMTALA: MSE (Slide 3 of 7)

MSE

Medical Screening Exam

Identify or rule out an emergency medical condition

“Comes to” means:

- Presented at DED, on hospital property, or in a hospital ambulance, and
  - Requests exam/treatment for medical condition
  - Requested on their behalf (prudent layperson standard)

The Three Pillars of EMTALA: MSE (Slide 4 of 7)

APPLIES TO

✓ Medicare-participating hospitals (98%) with DEDs

✓ Labor & Delivery Units

✓ Psychiatric Hospitals/Facilities

✗ Outpatient clinics (unless they qualify as DEDs)

✗ Non-Medicare-participating facilities

✗ Patients not yet on hospital property (usually)

DED (Dedicated ED) Defined

Licensed as an ED

Under state law as an emergency department

Held out to the public

As a place to receive emergency care

Meets the 1/3 rule

1/3 or more of outpatient visits are for emergency care

The Three Pillars of EMTALA: MSE (Slide 5 of 7)

MSE

Medical Screening Exam

Identify or rule out an emergency medical condition

An appropriate MSE:

- Conducted by a credentialed, designated qualified medical provider (QMP)
- Sufficient to determine, within a reasonable clinical certainty, and within the capability of the hospital's ED, whether the cause of the patient's signs and symptoms is an EMC
- Not to be delayed in order to inquire about payment status

The Three Pillars of EMTALA: MSE (Slide 6 of 7)

MSE

Medical Screening Exam

Identify or rule out an emergency medical condition

Emergency Medical Condition (EMC):

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the health of the individual (or unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

The Three Pillars of EMTALA: MSE (Slide 7 of 7)

MSE

Medical Screening Exam

Identify or rule out an emergency medical condition

Emergency Medical Condition (EMC):

With respect to a pregnant patient who is having contractions:

- That there is inadequate time to effect a safe transfer to another hospital before delivery;

or

- That transfer may pose a threat to the health or safety of the woman or the unborn child.

The Three Pillars of EMTALA: Stabilization (Slide 1 of 3)

EMC Treatment

Stabilization

Identify or rule out an emergency medical condition

If the hospital determines that the individual has an EMC, the hospital must provide, within the capabilities of the staff and facilities available at the hospital, for further medical examination and treatment as required to stabilize the medical condition.

The Three Pillars of EMTALA: Stabilization (Slide 2 of 3)

EMC Treatment

Stabilization

Identify or rule out an emergency medical condition

If the hospital determines that the individual has an EMC, the hospital must provide, within the capabilities of the staff and facilities available at the hospital, for further medical examination and treatment as required to **STABILIZE** the medical condition.

The Three Pillars of EMTALA: Stabilization (Slide 3 of 3)

EMC Treatment

Stabilization

Identify or rule out an emergency medical condition

Stabilize:

To provide such medical treatment of the EMC necessary to assure, within reasonable medical probability, that:

- No material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

or

- The woman has delivered the child and the placenta.

The Three Pillars of EMTALA: Transfer (Slide 1 of 4)

If Needed

Transfer

Only when requirements are met

If an individual at a hospital has an EMC **that has not been stabilized**, the hospital may not transfer the individual unless:

- The transfer is an appropriate transfer
- **A) Patient Request**

  B) Physician Certification

The Three Pillars of EMTALA: Transfer (Slide 2 of 4)

If Needed

Transfer

Only when requirements are met

Appropriate Transfer:

1. Provide medical treatment within capability to minimize risk of transfer
2. Receiving facility has the capability/capacity/acceptance
3. All medical records sent
4. Qualified personnel and transportation equipment, as required

The Three Pillars of EMTALA: Transfer (Slide 3 of 4)

If Needed

Transfer

Only when requirements are met

Patient Request:

- Patient/guardian requests the transfer
  - Informed of the hospital's EMTALA obligations and of the risk of transfer.
- 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.

The Three Pillars of EMTALA: Transfer (Slide 4 of 4)

If Needed

Transfer

Only when requirements are met

Physician Certification:

- Physician signed certification that the benefits of transfer outweigh risks.
- Must contain a summary of risks/benefits upon which it is based.
- If the physician is not present, must be in consultation with a physician who then countersigns.

When does EMTALA obligation end?

Three EMTALA Exits

1. No EMC - QMP determines no EMC exists after appropriate MSE, or EMC resolves.
2. Good-faith Admission - Patient admitted to treat EMC.
3. Transfer - Patient appropriately transferred to another hospital.

EMTALA Pitfall: Observation Status is not an Admission

Observation Status is Still Subject to EMTALA

- On-call specialists obligated to respond
- Transfers must meet EMTALA criteria
- MSE and stabilization obligations continue

The Stakes: What EMTALA Violations Actually Cost

$136,886

Max civil monetary penalty per violation

Exclusion

From Medicare/ Medicaid participation

$68,445

Per-violation for hospitals with <100 beds

Civil Suits

Private right of action under 42 U.S.C. §1395dd

SECTION 2

Medical Screening Exam Pitfalls

Where the MSE obligation breaks down in practice

MSE Pitfall #1: MSE Must Be Performed by a QMP

Avoid the Pitfall

25-year-old male presenting with ankle pain

- ✓ Quickly registered and triaged
- ✓ Appropriate history and exam by NP
- ✓ XR performed and negative
- ✓ Documented clinical assessment
- ✓ Discharged with crutches and ACE bandage
- X EMTALA VIOLATION

MSE Pitfall #1: MSE Must Be Performed by a QMP (Continued)

EMTALA allows hospitals to designate who can perform the MSE — but once you set that policy, you must follow it. Exactly.

PA/NP Performing MSE Without Written Policy

A hospital allows mid-levels to perform MSEs but never formally designates them as QMPs in its bylaws. That MSE is non-compliant regardless of clinical quality.

MSE by Unqualified Staff in a Specific Context

An MSE policy designates RNs for low acuity presentations — but an RN attempts to perform an MSE on a chest pain patient without physician involvement.

MSE Pitfall #2: MSE Is An Ongoing Process (Slide 1 of 3)

SCENARIO

A patient presented to the ED for an ankle sprain. After being medically cleared and discharged, the patient, who was homeless, became severely agitated and threatening, refusing to leave due to the cold. Security was called. Police arrived and ultimately trespassed the patient.

EMTALA VIOLATION

Avoid the Pitfall

- Significant change in condition? New MSE
- New complaint? New MSE

MSE Pitfall #2: MSE Is An Ongoing Process (Slide 2 of 3)

SCENARIO

A psychiatric patient elopes from your ED and is brought back by security 15 minutes later. Do you pick up where you left off?

EMTALA VIOLATION

Avoid the Pitfall

- Eloped or left ER? New MSE

MSE Pitfall #2: MSE Is An Ongoing Process (Slide 3 of 3)

SCENARIO

A patient with a history of gastric bypass is diagnosed with an SBO and is pending transfer to a facility with a bariatric surgeon. He continues to complain of pain, and a series of physicians order narcotics to manage his pain during a protracted wait for EMS to transfer.

EMTALA VIOLATION

Avoid the Pitfall

- ✓ MSE/Stabilization obligations apply until patients leave your ED.
- ✓ Ongoing monitoring must occur, and any changes in condition must be evaluated.
- ✓ A reassessment note should be in the record at the time of transfer.

MSE Pitfall #3: You Must Do the MSE

SCENARIO

EMS mistakenly bring a trauma patient from a motor vehicle crash to a hospital on diversion, after being informed of the diversion status. Upon arrival, hospital staff again inform EMS of their diversion status and redirect the crew to another facility. The patient never enters the ED.

EMTALA VIOLATION

Avoid the Pitfall

- Diversion status does not negate EMTALA obligations.
- Do not send EMS away without an MSE.
- Ensure staff understand the threshold for “coming to the hospital.”
- Parental consent not required for MSE.

MSE Pitfall #4: MSE Cannot be Inappropriately Delayed

SCENARIO

A physician is managing multiple critical patients. A new walk-in arrives, appearing uncomfortable. To "keep the process moving," a registration tech enters the exam area and begins gathering insurance data before the patient has received an MSE.

EMTALA VIOLATION

Avoid the Pitfall

- EMTALA requires that clinical evaluation always takes precedence.
- Non-clinical staff are not trained to assess medical urgency.

MSE Pitfall #5: Leave Without Being Seen (LWBS)

SCENARIO

A patient presents to the ED for cough and SOB. He is registered and triaged with normal vital signs. He sits in the waiting room for three hours and then yells “This is ridiculous, I’m out of here” and heads for the door…

EMTALA VIOLATION

Avoid the Pitfall

- Advise patients that they have a right to be seen and should wait for evaluation.
- Make reasonable efforts to convince the patient to stay. Discuss risks/benefits. Assess capacity.
- Document, document, document (You’ll be hearing a lot of this.)

MSE Pitfall #5: Leave Without Being Seen (LWBS): ED Log

Every individual who "comes to the emergency department" must be logged, regardless of whether they are registered, screened, or treated.

Avoid the Pitfall

- A central log must be maintained on **all** individuals who "come to the ED."
- Common failure points: Patient asks about insurance, requests a specific test or treatment, asks about wait times, then leaves — none of this gets logged.
- CMS investigators will review security footage. If the camera shows the patient at the desk, the log must show them too.
- You do not need the patient's name, DOB, or insurance — "John/Jane Doe" with time, circumstances, and disposition is compliant.

SAMPLE CENTRAL LOG ENTRY

PATIENT NAME:	DOE, JOHN (UNKNOWN)	**LOG ENTRY #:**	2025-11-14-0047
DATE OF BIRTH:	*UNKNOWN*	**MRN:**	*N/A — UNIDENTIFIED PT*
ARRIVAL DATE/TIME:	11/14/2025 · 14:22	**ARRIVAL MODE:**	WALK-IN (UNASSISTED)
INSURANCE:	*UNKNOWN — NOT PROVIDED*	**CHIEF COMPLAINT:**	*NOT OBTAINED*
DISPOSITION:	**REFUSED TREATMENT**	**MSE COMPLETED:**	**NO**
		AMA SIGNED:	**NO**

REGISTRATION / NURSING NOTE:

At approximately 14:22, an adult male of unknown identity approached the registration desk. Registration staff greeted the individual and began the intake process. The individual asked whether the visit would be covered by insurance. Staff explained that they were unable to guarantee coverage and that billing would depend on his individual plan. The individual stated he did not wish to proceed and began to leave. Charge RN [initials: AB] was immediately notified and approached the individual prior to his departure. The individual was informed of his right to a medical screening examination at no cost obligation prior to billing, and of the hospital's EMTALA obligations. The individual verbally declined the MSE. An AMA refusal form was offered; the individual refused to sign. The individual was not threatened, coerced, or otherwise discouraged from remaining for examination. No information was withheld or misrepresented. Individual departed the ED of his own volition at approximately 14:25.

MSE Pitfall #6: Do Not Discourage MSE

Avoid the Pitfall

- If your response gives the impression that waiting will be too long or is unsafe, the patient may choose to leave.
- When asked about wait times, your answer must be honest, but NEVER suggest leaving.
- "Let's get you triaged and see what's going on first. Wait times vary, but once you're triaged, we'll make sure you're seen as soon as possible."

"How long is the wait?"

MSE Pitfall #7: Your Policies Can Define Your Obligations

CMS stresses that hospitals must not only have EMTALA-related policies but enforce and apply them "uniformly to all patients with similar complaints". Failing to follow policies related to screening, stabilizing treatment, or appropriate transfer risks citations and civil monetary penalties.

Avoid the Pitfall

- St. Joseph's Medical Center v. OIG: Policy required experienced nurses to perform triage.
- Diamond v. Adventist: Policy stated all patients would be triaged within 3 minutes.
- Bode v. Parkview: Policy required BP in patients 6 and older, and vital signs be repeated Q2H before discharge.

You will be held to the standard you set.

⚠ CRITICAL

MSE Pitfall #8: Psychiatric Patients

SCENARIO

The patient is brought in by the police for a medical clearance. In triage, he becomes agitated and attempts to strike the nurse. The physician quickly medically clears him, and upon being told the jail has psychiatric capabilities, discharges the patient to jail in police custody.

EMTALA VIOLATION

Avoid the Pitfall

- All patients, including agitated psychiatric patients, must receive an MSE. Protocols for the management of agitated patients must be in place and followed.
- MSE must assess for organic causes, related medical EMCs, psychiatric EMCs (risk to self/others?).
- ED QMP is ultimately responsible for MSE.

MSE Pitfall #9: Pregnant Patients

SCENARIO

Patient arrives by POV with contractions at 37 weeks gestation. First pregnancy, water just broke. An EMS crew happens to be available to immediately take her to a facility with L&D just down the street.

EMTALA VIOLATION

Avoid the Pitfall

- Must perform MSE to ensure transfer is safe.
- Document regularity and duration of contractions, fetal heart tones, cervical dilation, status of membranes.
- Explicitly document thought process.
- Do NOT direct patient elsewhere.

SECTION 3

Stabilization Pitfalls

What “stabilized” really means — and where we get it wrong

Defining EMC and Stabilization (Slide 1 of 3)

Emergency Medical Condition (EMC) Identified: (*Mark appropriate box(s), then go to Section II)*

I. MEDICAL CONDITION: Diagnosis_____

☐ **No Emergency Medical Condition Identified:** This patient has been examined and an EMC has not been identified
☐ **Patient Stable -** The patient has been examined and any medical condition stabilized such that, within reasonable clinical confidence, no material deterioration of this patient's condition is likely to result from or occur during transfer.
☐ **Patient Unstable -** The patient has been examined, an EMC has been identified and patient is not stable, but the transfer is medically indicated and in the best interest of the patient. *I have examined this patient and based upon the reasonable risks and benefits described below and upon the information available to me, I certify that the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risk to this patient's medical condition that may result from effecting this transfer.*

⚠ **CRITICAL**

"Stable" in the clinical sense does NOT automatically mean "stabilized" under EMTALA.

Defining EMC and Stabilization (Slide 2 of 3)

1

42 CFR 489.24(b) — The Legal Floor

No material deterioration likely during transfer

The statutory standard. The operative question: Have all necessary interventions to stabilize the EMC been provided, such that transfer will not cause material deterioration of that condition?

By definition, an EMC is a condition such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy.

2

Appendix V — Clinical Operationalization

The EMC must be resolved

The underlying disease may persist, but the emergency phase has ended. Patient no longer requires emergency-level intervention.

e.g., Asthma attack resolved; asthma persists. EMTALA done.

3

Appendix V — Discharge Standard

Continued care can safely proceed as outpatient

Work-up may be incomplete; treatment may be ongoing. Patient is stable if the hospital is no longer the necessary venue, with a follow-up plan.

Key: A follow-up plan is required as part of stabilization.

Defining EMC and Stabilization (Slide 3 of 3)

Appendix V:

⚠ CRITICAL

"If a hospital is alleged to have violated EMTALA by transferring an unstable individual without implementing an appropriate transfer according to §489.24(e), and the hospital believes that the individual was **stable (EMC resolved)** *the burden of proof is the responsibility of the transferring hospital."*

Stabilization Pitfall #1: Inpatient Admission Ends EMTALA, but It’s a Double-Edged Sword

A 14-year-old is admitted before CT results return. Imaging then shows a brain mass requiring neurosurgery. The tertiary center had capability and capacity but refused the transfer.

Best practice: Delay inpatient admission until critical diagnostics needed to determine the right level of care are back.

Stabilization Pitfall #2: Capability and Capacity – Critical Terms

CAPABILITY

DEFINITION

What your hospital can do — your services, specialties, technology, and staffing as a whole.

EXAMPLE

Your hospital has an ICU. That is your capability, regardless of whether it is scheduled to shut down tomorrow.

You cannot decline to stabilize based on capability you have at this moment.

CAPACITY

DEFINITION

Whether you have the physical space and staff available at this moment to care for this patient.

EXAMPLE

Your ICU has one bed available. You have capacity, even if your hospital practice is to keep a bed open, or if you know that a patient has an elective surgery the next day who will need a bed.

True capacity limitations must be very well documented and defended.

Stabilization Pitfall #2: Capability and Capacity – Critical Terms (Continued)

CAPACITY

If all your beds are full, you may still be deemed to have capacity.

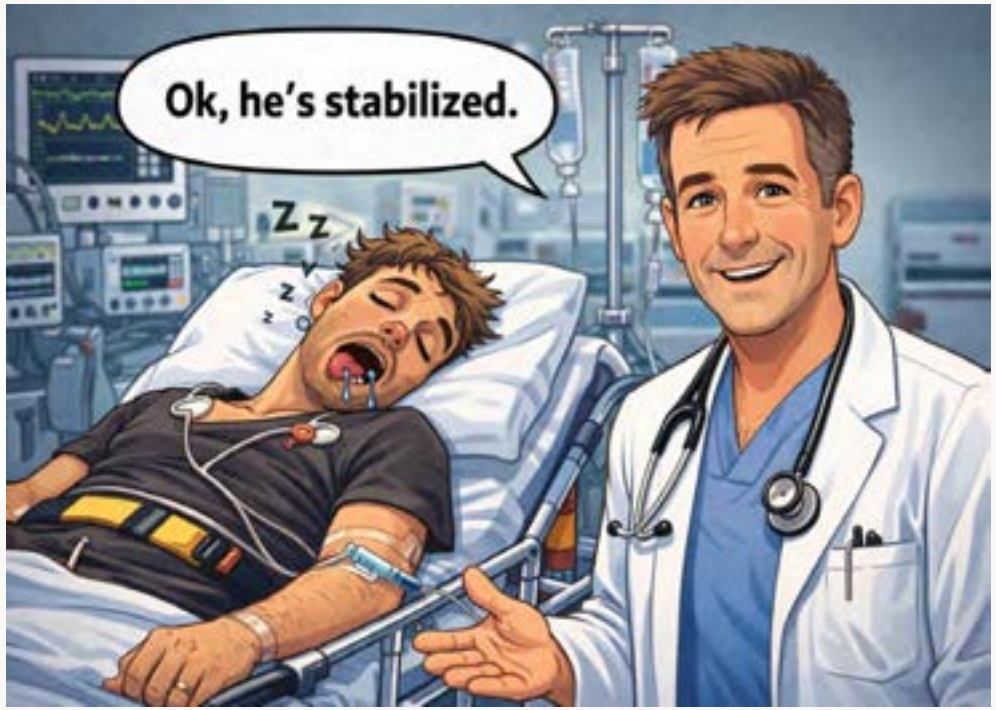
"Capacity includes whatever a hospital customarily does to accommodate patients in excess of its occupancy limits. If a hospital has customarily accommodated patients in excess of its occupancy limits by whatever means (e.g., moving patients to other units, calling in additional staff, borrowing equipment from other facilities), it has, in fact, demonstrated the ability to provide services to patients in excess of its occupancy limits."

Stabilization Pitfall #3: Psychiatric Stabilization

When is a patient with a psychiatric EMC considered stable?

Avoid the Pitfall

- ✓ When they are protected and prevented from injuring or harming themselves or others.
- ✓ Chemical or physical restraints may *temporarily* stabilize.
- ✓ Ongoing MSE/stabilization until transfer.
- ✓ Do *not* discharge into police custody.
- ✓ EMTALA > State law/local policies.



Stabilization Pitfall #4: Against Medical Advice

SCENARIO

A patient *voluntarily* presents for suicidal ideation, and you determine that he poses threat of imminent harm to himself. While awaiting transfer to a facility with psychiatric capabilities, you're informed that he wishes to leave AMA.

EMTALA VIOLATION

Avoid the Pitfall

- Assess capacity.
- Patients with psych EMC presumed to lack capacity.
- Protocols to prevent elopement.
- Document, document, document.

Stabilization Pitfall #5: SANE Exam Patients

SCENARIO

A patient presents for genital pain following sexual assault, requesting forensic SANE exam. You don't have SANE nurses at your facility, so you transfer the patient to a facility that does.

EMTALA VIOLATION

Avoid the Pitfall

- **SANE exam ≠ MSE and ≠ Stabilization**
- These patients, *if they have a complaint*, MUST undergo a thorough MSE.
- If EMC present: stabilize fully before discharge/transfer.
- If no EMC, discharge is appropriate.

HIV Exposure & PEP

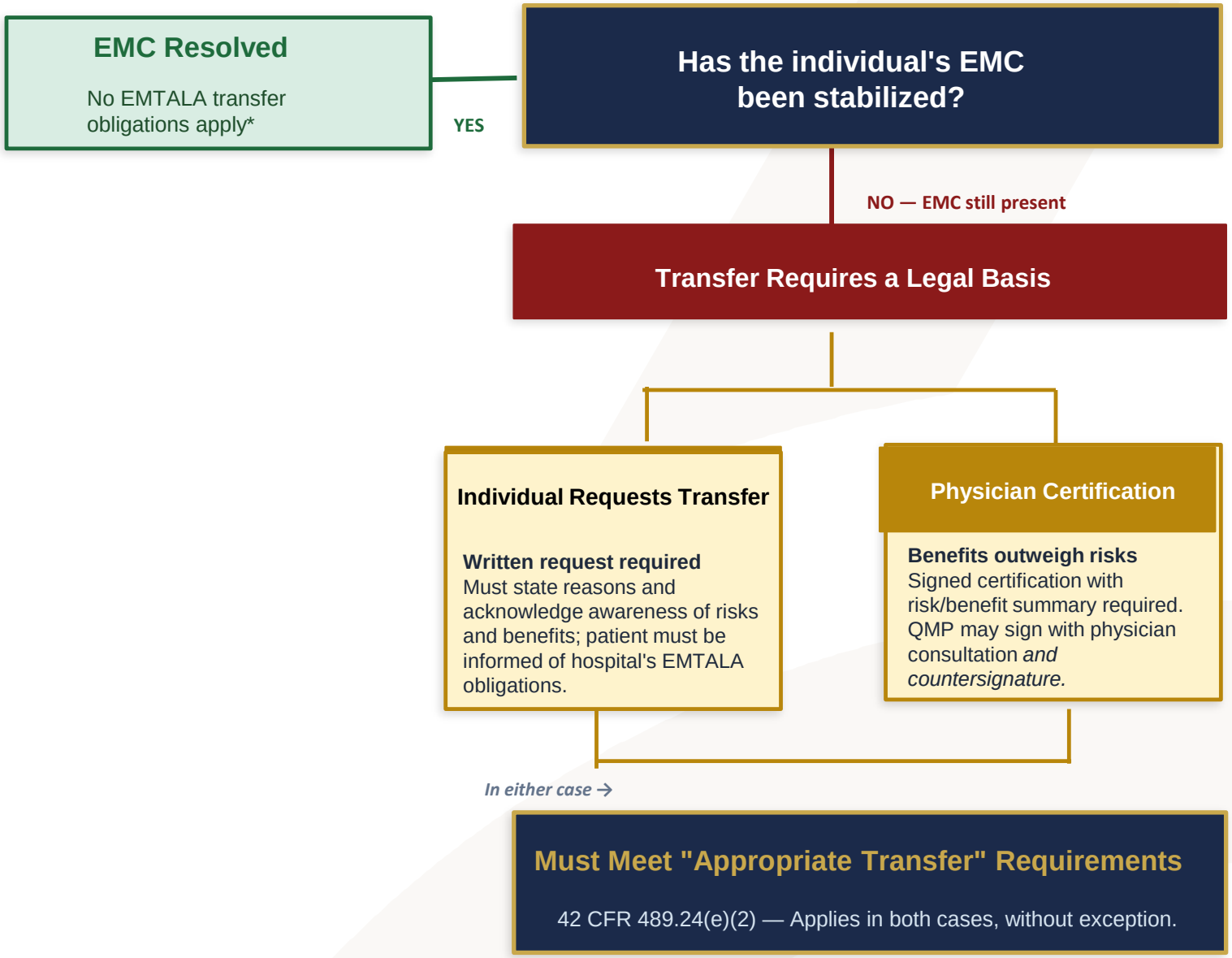
STI Prophylaxis

SECTION 4

Transfer Pitfalls

EMTALA governs both sides of the transfer — sending and receiving

Transfer Flowsheet



Components of an Appropriate Transfer

Failure to satisfy any single component renders the transfer inappropriate under EMTALA, regardless of whether a valid legal basis for transfer existed.

1 Sending Hospital Minimizes Risks

The sending hospital must stabilize to the extent it can before sending to minimize risk of transfer.

2 Receiving Facility Is Qualified & Has Agreed

The receiving facility must have the capability and capacity and have agreed to accept the transfer.

3 Medical Records Accompany the Individual

Available records must be sent with the patient. Records not yet available must be sent as soon as possible.

4 Qualified Personnel & Appropriate Equipment

The transfer must be effected through qualified personnel and transportation equipment appropriate to the individual's condition.

Transfer Pitfall #1: The Continuity of Care Conundrum

SCENARIO

You’re treating a patient with a post-op complication, a large surgical site abscess, but of course, it wasn't done at your hospital. Your surgeons are always hesitant to touch "another surgeon's site," so you transfer to a hospital where their original surgeon has privileges. That seems reasonable, right?

EMTALA VIOLATION

Avoid the Pitfall

- Can only transfer if patient requests or physician certifies that benefits outweigh risks.
- Stabilize what you can before transfer (antibiotics, fluids, etc.).
- Abide by all other standard EMTALA transfer requirements.
- Strongly consider consulting your on-call specialist and having them document a rationale for why the patient is safe to transfer and why the benefits outweigh the risks.

Transfer Pitfall #2: The Benefit/Risk Certification Is Not Boilerplate

The transferring physician's certification is a real clinical and legal document. Signing a pre-printed form without genuine analysis is a violation waiting to happen.

What the Certification Should Reflect

→ Specific medical benefits expected from transfer

→ Specific risks of transfer identified

→ Physician signature and date/time

→ Patient's condition at time of transfer decision

→ What stabilization was provided before transfer

→ Clear rational why benefits outweigh risks for THIS patient

Common Certification Red Flags

✗ Generic pre-printed form with no individualization

✗ "Transfer for higher level of care" with no specifics

✗ Benefits stated, but risks *of transfer* not acknowledged

✗ Date/time of signature significantly after transfer*

Transfer Pitfall #3: Transport Level Must Match Patient Acuity

SCENARIO

A patient is brought by parents to the ED with suicidal ideation. After medical clearance, a clinician identifies an EMC and arranges inpatient psychiatric admission. The family wishes to drive their child over to the facility and appear reliable.

EMTALA VIOLATION

Avoid the Pitfall

- Very high-risk scenario. Often occurs with pediatric patients.
- Appropriate transfer includes transport by qualified personnel. Family members don't count.
- A patient with SI typically does not have the decision-making capacity to refuse ambulance transport.
- If a patient *with capacity* refuses transport you believe necessary, document written refusal with risks/benefits and complete all other aspects of an appropriate transfer.

Transfer Pitfall #3: Transport Level Must Match Patient Acuity (Continued)

EMTALA requires transfer by 'qualified personnel and transportation equipment.' This is a clinical determination — not a logistical one.

Patient Condition	Appropriate Transport	Would Likely Be Insufficient
Hemodynamically stable patient, non-critical transfer	BLS ambulance	Private vehicle or taxi
Chest pain, EKG changes, potential ACS	ALS ambulance with paramedic and cardiac monitoring	BLS ambulance without paramedic capability
Intubated patient on vent, ICU-level acuity	Critical care transport (CCT) team	ALS ambulance without critical care capability
Obstetric patient, active labor	ALS with OB-trained personnel or air transport if appropriate	Any non-ALS transport

Transfer Pitfall #4: Refusing Transfer Requests

SCENARIO

You receive a transfer request for a patient with a STEMI who will be coming POV and bypassing multiple other hospitals en route with PCI capabilities. Also, you're a specialty cardiac hospital without an ED. Naturally you refuse…

EMTALA VIOLATION

Avoid the Pitfall

- Can *only* refuse based on lack of capability/capacity.
- The sending physician determines appropriate transport and destination.
- EMTALA accepting hospital obligation applies to *all* hospitals, whether or not they have a DED.
- "*any hospital…that refuses a request…risks violating…[EMTALA]…to the extent it chooses to second-guess the medical judgment of the transferring hospital.*"
  -St. Anthony Hospital v. DHHS

Transfer Pitfall #5: Transferring for Insurance Reasons

SCENARIO

A patient presents to the ED with an Emergency Medical Condition. Admission is recommended, but…"Admission here will be very expensive. Their insurance prefers Hospital B." The patient is transferred.

EMTALA VIOLATION

Avoid the Pitfall

EMTALA does not permit transfer of an unstabilized patient for financial or insurance reasons.

The transfer must be truly patient-requested.

- The patient must be informed that the hospital is willing and able to provide stabilizing treatment.
- The patient must be informed of the specific risks of transfer.
- The request must be made in writing after those risks are explained.
- The transfer must still meet all "appropriate transfer" requirements.

SECTION 5

Key Takeaways

Six Overarching Principles

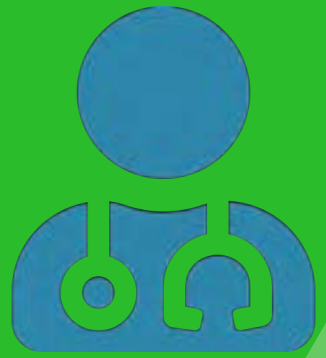
1. When in doubt, do what's best for the patient. Err on the side of caution.
2. Document, document, document. Explain what happened and your thought processes.
3. Understand the key EMTALA terms and requirements
4. Review and revise your EMTALA relevant bylaws and policies.
5. Create systems that encourage compliance: Standardized phrasing, optimized forms, etc.
6. Focus on developing and following standardized protocols for high-risk scenarios.

The Bottom Line

Most EMTALA violations are not caused by bad actors.

They are caused by systems that weren't designed with EMTALA in mind and teams who think they know the law well enough that they stopped checking.

The fix is systems. Documentation. Policy. Training. Audits.



Thank you!

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Key Regulatory References

42 U.S.C. § 1395dd
The EMTALA statute — primary authority

42 C.F.R. § 489.24
CMS regulations implementing EMTALA

42 C.F.R. § 489.20
Hospital obligations

CMS State Operations Manual, Appendix V
EMTALA survey and certification guidance

CMS EMTALA FAQ (2019, 2020)
Frequently asked questions — clarifies gray areas

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