Transferring and Accepting Patients Under EMTALA

What is a transfer?

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

All patient discharges from an emergency department are transfers. All patient discharges from a hospital after an inpatient stay, no matter how long, also are transfers. All traditional transfers from an emergency department or inpatient setting to another acute care facility, whether for further care or for testing (such as a CT scan or MRI), are transfers.

All patients presenting to off-campus urgent care centers or other facilities that qualify as a department of the hospital are covered by EMTALA, so all discharges and transfers from these facilities to a different hospital meet the statutory definition of a transfer. However, movement of patients between a hospital and its own off-campus facilities qualifying as a department of the hospital, in either direction, are not considered transfers for purposes of EMTALA. This movement is analogous to moving patients between traditional departments of the hospital, such as from the emergency department to the ICU, and is not a transfer under EMTALA.

Certain actions by nonclinical personnel can result in illegal transfers. For example, if a security guard suggests that an individual come back later because "the ER is running 3 hours behind," this suggestion constitutes "movement of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated ..., with) the hospital." If a registration clerk informs an individual that his MCO will not cover the visit and directs him to a primary care physician's office, that also constitutes a transfer under the law.

However, patients who of their own volition leave against medical advice or leave before being examined are not considered to have been transferred under the law. Neither is movement of patients within the hospital or anywhere on the hospital's campus considered a transfer. (See Chapter 4 for the definition of a hospital's "campus").

Thus, the EMTALA definition of transfer emphasizes the hospital-wide and system-wide application of the law. Because EMTALA applies to transfers from inpatient areas and other locations, not just transfers from emergency departments, hospitals must educate all hospital employees, nurses, clerical personnel, volunteers, technical staff, and security staff and all members of the medical staff, not just emergency physicians.

Which transfers are governed by EMTALA?

Movement away from a hospital may be deemed a transfer under EMTALA, but it does not necessarily mean that EMTALA governs the transfer. Only those transfers of patients who have EMCs that have not been stabilized are controlled by EMTALA. The transfer of patients who do not have EMCs or who have EMCs that have been stabilized are not controlled by this law. This fact underscores the importance of understanding the legal definition of the terms "emergency medical condition" and "stabilized." It also emphasizes the importance of routinely documenting in the patient's medical record the presence or absence of...
Providing Emergency Care Under Federal Law: EMTALA

an EMC and whether the patient was stable when he or she left the hospital, regardless of whether the discharge or transfer was from the emergency department or inpatient setting.

Whether EMTALA applies to a transfer is particularly important when a hospital is under investigation for an alleged violation. State survey agencies and HCFA regional offices frequently fail to appreciate this distinction and demand that hospitals comply with EMTALA requirements for all transfers, not just transfers of patients with EMCs that have not been stabilized. They continue to assert this misinterpretation despite plain language to the contrary in the statute, direct rulings by appellate courts, and explicit statements from HCFA itself, such as: "The act does not impose any requirements on hospitals with respect to the treatment or transfer of individuals whose emergency conditions have been stabilized" and "The statute allows hospitals to transfer an individual, without meeting the requirements of an appropriate transfer after his or her emergency medical condition is stabilized." The interpretive guidelines echo the HCFA comments, stating: "If the medical screening examination is appropriate and does not reveal an emergency medical condition, the hospital has no further obligations under [EMTALA]." and "Certification of the transfer is not required for transfers of individuals who no longer have an emergency medical condition." Knowledge of when these requirements actually apply to a transfer is equally important if a hospital is sued under EMTALA for failure to arrange an appropriate transfer.

Some states have enacted EMTALA-like transfer laws, and so of them may apply to stable transfers. Most parallel EMTALA, but some are more burdensome; physicians responsible for patient transfers must be aware of controlling state laws and regulations as well as federal law. JCAHO also requires hospitals to maintain written policies and procedures governing the transfer of all patients.

Ordinary malpractice standards for arranging transfers are so similar to EMTALA standards that, regardless of whether a transfer is legally covered by EMTALA, all transfers should be arranged as EMTALA-appropriate transfers to protect patients, transferring physicians, and hospitals. Once a physician determines that a patient has an EMC, the determination of whether that patient was stabilized becomes an objective standard governed by ordinary malpractice standard-of-care considerations. In almost every case, whether the patient was stable at the time of transfer will be an open question subject to retrospective analysis and expert testimony. The documentation section of this chapter describes how documentation and transfer forms can be tailored to prevent this second-guessing by HCFA and to protect the hospital from civil liability.

Before transferring anyone away from a hospital, a physician must first determine if the individual has an EMC. If the physician determines that no EMC is present, the individual is considered stable, and EMTALA does not apply. If an EMC is identified, the physician must determine if the individual is stable, as defined by law. The determination of whether an individual is stable must be made at the time of transfer to be valid under the law. Only transfers of unstable patients are governed by EMTALA.

The next two sections of this chapter are "Transfer of Unstable Patients" and "Transfer of Stable Patients." The section on unstable patient transfers is further divided into "Medical Indicated Transfers" and "Patient-Requested Transfers." The duties and responsibilities of both the transferring hospital and the receiving hospital for each type of transfer are then delineated. The distinction between the different types of transfers is absolutely critical because the physician's and hospital's legal requirements and corresponding liability exposure are completely different for each category of transfer.

TRANSFER OF UNSTABLE PATIENTS

An individual whose condition is unstable may be legally transferred for only one of two reasons: either the transfer is medically indicated or the individual requests to be transferred. The distinction is important because the legal elements of the two types of unstable transfers are entirely different under EMTALA.

What is a medically indicated transfer?

A medically indicated transfer is a transfer to a facility that can provide the higher level of medical care that is necessary to treat a patient's condition, medical care that is not available at the transferring facility. For example, the transfer of a head injury patient from a hospital that does not have a neurosurgeon on staff to one that does, a newborn who requires specialized neonatal intensive care, or a multiple trauma patient treated initially in a rural emergency department who requires treatment at a Level I trauma center.

Such a transfer is indicated when a transferring facility lacks the capability or the resources, including physician expertise, necessary to stabilize or treat a patient's EMC. It is not illegal to transfer unstable patients. In fact, the statute specifically requires hospitals to transfer unstable patients when they are not able to stabilize their conditions and the benefits of transfer outweigh the risks of transfer. A patient with a ruptured abdominal aortic aneurysm may be hemodynamically unstable and die en route from one hospital to another, but unless the patient can reach a hospital and surgeon capable of repairing the aneurysm, the patient is doomed anyway. The transfer of
such a patient to a higher level facility is clearly medically indicated if the transferring hospital lacks the capability to repair the aneurysm, and the possible benefit of life outweighs any risks of the transfer.

**What is a patient-requested transfer?**

All transfers of unstable patients that are not medically indicated must be patient requested to be in compliance with the law. This includes transfers at the request of patients' personal physicians or managed care plans and transfers to allow patients to be closer to home. The distinguishing feature is that the patient chooses to leave for a reason other than to obtain necessary medical services that are unavailable at the transferring hospital. In essence, an unstable patient who requests a transfer that is not medically indicated is leaving the hospital against medical advice.

Legally, there is no such thing as a “managed care transfer” of an unstable patient or, for that matter, even a stable patient. Transfers for economic reasons must only occur at the request and consent of the patient, regardless of the pressures exerted by managed care entities.

**Medically Indicated Transfers (Unstable Patients)**

EMTALA governs each individual aspect of medically indicated transfers, from requiring hospitals to adopt and enforce policies to ensure compliance with the law to mandating specific actions by both the transferring hospital and the receiving hospital.\(^\text{14}\)

**What are the duties of the transferring hospital?**

To effect a medically indicated transfer of an unstable patient, the hospital must do all of the following:

- Legally “certify” that the benefits to the patient from the transfer outweigh the risks of the transfer.
- Obtain the patient’s informed consent, and
- Arrange an “appropriate” transfer, as defined by law.\(^\text{15}\)

**Complete a Physician’s Certification of Transfer**

The transferring physician must certify, in writing, 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 and, in the case of labor, to the unborn child from effecting the transfer, . . . .”\(^\text{16}\) Only medically indicated transfers of unstable patients require physician certification; no other type of transfer requires physician certification.\(^\text{17}\)

The physician should certify the transfer as being medically indicated only if transferring a patient to a hospital that has equipment or physician resources not available at the transferring facility. The benefits of transferring an unstable patient to a facility with lesser capabilities or capabilities equivalent to the transferring facility cannot possibly outweigh the risks of the transfer. In such a case, the hospital must stabilize the EMC using its own staff and available resources and not transfer the individual for stabilization elsewhere.\(^\text{16}\)

If the hospital does not have a physician on duty at the time of the transfer, a “qualified medical person,” such as a nurse, may complete and sign the certification. This person, however, must consult with a physician who accepts full responsibility for deciding that the benefits of the transfer outweigh the risks. That physician must later countersign the certificate.\(^\text{19}\) This paragraph in the statute was intended to help smaller hospitals that don’t always have emergency physicians on duty or other physicians available in house when transfers need to occur without delay. Present or not, these physicians are legally responsible for the transfers they certify.

Even if there are preexisting transfer agreements between transferring and receiving hospitals, physician certification is required for all medically indicated transfers of unstable patients.\(^\text{20}\)

**What must be included in the certification?**

The transferring physician must certify that the hospital’s statutory obligations under EMTALA and the risks and benefits of the transfer were explained to the patient and that the transfer is in the patient’s best interest.

The physician must write a summary of the risks and benefits on which the certification is based.\(^\text{21}\) The risks and benefits should be expensively documented to demonstrate that the physician actually weighed them before deciding the transfer was medically indicated. One court, in upholding a $20,000 fine against a transferring physician, commented: “This certification lacked legal effect since he [the physician] merely went through the motions rather than weighing the risks and the benefits as the Act required.”\(^\text{22}\)

Community protocols or customs, such as the automatic transfer of a multiply injured patient to a Level I trauma center, do not obviate the requirement that the physician actually weigh the risks and benefits before the transfer. Each transfer decision must be judged individually, justified under EMTALA, and documented accordingly.

The written summary must be of the medical risks and benefits. Listing risks such as “nowhere near as great as staying in this place”\(^\text{23}\) or automobile accident or road hazards alone is insufficient. The benefits and risks must be specific to the individual circumstances of each case. Examples of benefits and risks include the following:

- Physician expertise not available at the transferring facility

105
Providing Emergency Care Under Federal Law: EMTALA

- Hospital resources such as CT, MRI, or angioplasty not available at the transferring facility
- Intensive care, burn units, high-risk obstetric services, trauma care, or neonatal services not available at the transferring facility
- Worsening of the patient’s EMC or possible death en route
- Delayed access to definitive treatment because of the transfer
- Loss of IV access or airway control en route
- Additional pain, trauma, or possible disability to existing injuries as a result of physical movement and road travel

The summary should be specific enough that a peer reviewer reading the summary retrospectively would agree that the transfer was medically indicated and in the patient’s best interest.

Failure to include foreseeable medical risks in the summary could invalidate the patient’s consent. HCFA does not require that the summary of risks and benefits contain risk of travel hazards, although it seems appropriate to include those risks in the patient consent process. Financial benefits or risks are not appropriate justifications for medically indicated transfers of unstable patients and should not be included in the certificate.

At what point in the transfer process should the certification be completed?

The certification must be based on information available at the time of transfer, not solely at the time of the physician’s earlier examination of the patient. Thus, the hospital should recheck the patient’s vital signs, and the transferring physician (or qualified medical person) should reevaluate the patient just before the transfer to ensure the transfer is still medically indicated and appropriate.

If the certification and transfer papers are completed some time before the actual transfer occurs, a progress note documenting the patient’s current condition and the physician’s decision that the transfer is still medically indicated and appropriate will suffice. The paperwork does not need to be redone.

How should the hospital document the certification?

The certificate must be in writing and must be signed by the transferring physician, either at the time of transfer or later as a countersignature to the signature of the qualified medical person arranging the transfer on the physician’s behalf.

The transfer certificate is a formal, legal document that must be completed carefully. The certification language should track the statutory language, as follows: “Based on the information available to me at the time of this transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweighed the increased risk to the individual . . . from effecting the transfer.” However, HCFA will not accept this statement standing alone, or a box checked indicating that the benefits outweighed the risks. It must be accompanied by a written summary of the risks and benefits particular to the patient and the patient’s medical condition on which the certification is based.

Check boxes can be used, but they must adequately reflect the medical issues related to each individual transfer. Generally, the certification form should include a number of typical and generic check boxes, plus space to hand write risks and benefits unique to the patient being transferred. Appendix 3D includes a sample transfer certificate.

The statute and regulations require an express written certification attesting to these elements. Certification will not be inferred from the findings in the medical record and the fact that an individual was transferred, although HCFA will accept the certification if it is explicitly written into the medical record. The certification must be kept in the patient’s permanent medical record, and a copy must be sent with the patient in transfer.

HCFA commonly cites hospitals for lack of documentation of risks and benefits, even when a transfer was clearly in a patient’s best interest. Smaller hospitals, which frequently transfer unstable patients to larger, tertiary facilities, must be particularly vigilant. Even when a transfer is “the right thing to do,” HCFA still expects it to be done by the book and documented as required by law.

The courts, however, may be more lenient. In Vargas v DBL Del Puerto Hospital, a physician completed the EMTALA transfer form by checking a box that indicated the benefits of the transfer outweighed its risks but did not provide the written summary. The court determined that the physician did properly weigh the risks and benefits despite his failure to completely fill in the form. The court held that the mere absence of a written summary of the risk-benefit analysis did not by itself exclude the possibility that such an evaluation took place. The court was willing to look at other areas of the chart and records to show that the physician “deliberately and weighed” the risks and benefits prior to the transfer. The court declined to hold the hospital liable under EMTALA for what was essentially a clerical deficiency in record keeping.

How does a hospital or physician violate the transfer certification provision?

The certification requirement may be violated in one of the following ways:

106
• The physician responsible for the transfer fails to sign the certification
• The responsible physician fails to actually deliberate and weigh the medical risks and benefits of transfer before executing the certificate
• The responsible physician makes an improper (discriminatory) consideration a significant factor in the certification decision
• The responsible physician concludes that the medical risks outweigh the medical benefits of transfer but certifies that the opposite is true
• The responsible physician misrepresents the patient’s medical condition

The standard for determining if a hospital and physician negligently violated the certification provision is whether, under the circumstances, “the physician knew or should have known that the benefits of transfer did not outweigh the risks of transfer.”30 Again, notice that this is an objective standard of reasonableness subject to a battle of the experts under ordinary malpractice standards.

Obtain the Patient’s Informed Consent to the Transfer

The hospital should obtain the patient’s informed consent and signature prior to transfer. If the patient is incapacitated or incompetent to give consent, the hospital should seek consent from the patient’s family. If neither the patient nor a family member is able to consent to the transfer, the hospital should proceed with the transfer, assuming that a reasonable person in the patient’s circumstances would consent to the transfer—what the law refers to as implied consent under the emergency doctrine.31

Arrange an “Appropriate” Transfer

The transferring hospital must perform the five actions established in the EMTALA definition of an “appropriate” transfer for all medically indicated transfers,32 as described in the following sections.

1. Provide Treatment Within the Capacity of the Hospital. Prior to transfer, the hospital must do everything within its capability to minimize the risks to the patient’s health and, in the case of a woman in labor, the health of the unborn child.33 Such treatment may include securing an airway, administering IV fluids or antibiotics, splinting a displaced fracture, inserting a chest tube, or performing a procedure to stop intra-abdominal bleeding.

The timing of the transfer depends on the condition of the patient and the judgment of the examining physician. If it is in the patient’s best interest to place a cervical collar and start two large-bore IV lines and transfer the patient immediately to a major trauma center, then waiting for diagnostic test results and final paperwork would be a mistake. EMTALA should not be viewed as an obstacle to transfer when a transferring physician determines that a patient should leave immediately. Whether the hospital conducts limited evaluation and treatment or extensive evaluation and treatment before transfer is not the issue under EMTALA: each case is unique, and the decision comes down to medical principles, available resources, and physician judgment.

Remember, the hospital does not have to stabilize the EMC before transfer if the physician determines that the patient’s best interest is served by going immediately to a facility that can more effectively stabilize that condition.34

2. Arrange for Another Hospital to Accept the Patient in Transfer. Before a hospital can transfer a patient, another hospital must agree to accept that patient in transfer and provide appropriate medical treatment.35 Contrary to common belief, EMTALA does not require that a physician accept the patient in transfer. Legally, the obligation to accept transfers rests with the accepting hospital.36 The hospital may designate emergency physicians, on-call physicians, nurses, a transfer team, or even a member of the administration or admitting office to accept transfers on its behalf. (Medically, however, it is generally prudent to speak with an accepting physician prior to the transfer.) Keep in mind that some state laws require physician acceptances. Under Texas law, a physician must accept the patient in transfer; it is not sufficient that the receiving hospital alone agrees to accept the patient.37

The transferring facility also must determine that the receiving hospital has available space and qualified personnel to treat the individual.38 Transferring a head injury patient to a hospital that doesn’t have a neurosurgeon or one with its CT scanner down for repairs is a violation of the law. A transferring hospital will not be held liable if a receiving hospital in the meantime becomes unable to handle the patient’s problem or treats the patient negligently as long as at the time of transfer it reasonably ascertained that the accepting facility could care for the patient.

3. Send Appropriate Data to the Accepting Facility. The law and regulations dictate what information the transferring hospital must send to the receiving facility,39 including appropriate medical records related to the EMC, recordings of observation of signs and symptoms, preliminary diagnosis, treatment provided, results of tests performed, written informed consent for transfer, and a copy of the written certification that the transfer is medically indicated. If a hospital must transfer a patient because its on-call physician didn’t respond within a reasonable time or refused to come in to stabilize the patient, the transferring hospital must send the name and address of that on-call physician to the receiving hospital with the patient.40 Failure to do so is a violation of EMTALA and subjects the transferring physician and the hospital to penalties. When the accepting hospital receives the patient, it is required to report the transferring hospital’s violation to HCFA.
State law may require the exchange of additional transfer information. For example, Texas and New York require that a memorandum of transfer be sent with each transferred patient that includes the name of the physician authorizing the transfer. This document must be signed by both the transferring and receiving physicians. The American College of Surgeons also expects more detailed information to be contained in the trauma transfer report, such as the patient’s Glasgow Coma Scale score and the type and volume of fluids administered prior to transfer.

Never delay an emergent transfer to gather test results or medical records to send with a patient. When necessary, solve paperwork deficiencies by fax; send x-rays by cab.

The use of itemized transfer checklists ensures that the appropriate data and transfer forms accompany all patients in transfer. The hospital’s nursing staff should use the checklist to ensure that all the requirements have been met prior to transfer. The documentation requirements for transfers are discussed below; a sample checklist and sample transfer forms are included in Appendix 3.

4. Effect the Transfer Through Qualified Personnel and Transportation Equipment. The law requires that all medically indicated transfers be “effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer.”

The transferring hospital is legally responsible for the patient until the patient’s care is assumed by the receiving hospital, and it will be held responsible for the adequacy and competency of the personnel and equipment used in transport. The mode of transport and the equipment and personnel selected to transfer the patient must be sufficient to effectively manage any foreseeable complication of the patient’s condition that could arise en route.

However, EMTALA does not specify what constitutes “qualified personnel and transportation equipment.” In Burditt v US Dept of HHS, the judge ruled that the physician violated EMTALA by transporting an obstetric patient without a fetal monitor or an accompanying physician trained in emergency delivery. The judge also interpreted “transportation equipment” to include all physical objects reasonably medically necessary for safe patient transfer.

The mode of transport selected (helicopter, BLS/ALS ambulance, private car) should be dictated by the patient’s medical condition. Some experts believe that all patients should be transferred by ambulance rather than by private vehicle. However, each case depends on the patient’s individual circumstances and the transferring physician’s judgment. For example, an individual with an eye injury can certainly go by car if someone else is driving; so can a person with a hand injury. At least one court has held that transfer by personal car was allowable because the plaintiff provided no expert testimony that the transfer was medically inappropriate.

The courts have determined that this section of the statute requires “personnel and transportation that a reasonable physician would consider appropriate to safely transport the patient in question.” Thus, the transport mode/personnel decision is an objective, reasonable physician standard and will be judged on an ordinary malpractice, standard-of-care basis. Once a hospital determines that an individual has an EMC, the decisions of whether a transfer is medically indicated, when the individual should be transferred, and how and by whom the transfer should be completed can be litigated under EMTALA for “failure to arrange an appropriate transfer.” For example, in Smith v James, the court allowed the decision to transport an unstable patient by ground ambulance instead of by helicopter to be litigated under EMTALA. The courts will accept expert testimony to establish that the transportation equipment chosen was not appropriate in view of the patient’s condition. The transport decision is another physician action that will be judged retrospectively if something goes wrong during a transfer.

The hospital is ultimately responsible for ensuring that the transfer is effected appropriately even though it delegates its duty under the statute to the transferring physician. Hospitals must ensure that transfers are as safe as possible for the conditions for which patients are being transferred and that physicians carefully document their transfer decision-making processes. EMTALA forces hospitals to select ambulance carriers based on competency rather than on low contract bid.

If hospitals are responsible for effecting safe transfers, must each hospital operate its own ambulance transport service?

No. The HCPA Interpretive guidelines specifically state: “While the hospital is ultimately responsible for ensuring that the transfer is effected 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.” At least one court has also determined that EMTALA does not obligate hospitals to operate ambulance transportation services.

5. Meet Other Requirements. According to the law, the transfer must meet “such other requirements as the Secretary [of HHS] may find necessary in the interest of the health and safety of the individual transferred.” To date, no other requirements have been set by HHS. This section gives the government wide discretion to further regulate unstable patient transfers in the future. However, it does not provide the government the authority to regulate the transfer of stable patients.
Where should hospitals send patients who require medically indicated transfers?

Hospitals must send patients to facilities that have the resources and capabilities to manage their EMCS. Thus, a receiving facility must have some resources or physician expertise that the transferring hospital does not. Transfers of unstable patients to facilities with lesser or reasonably the same capabilities as the transferring facilities ("lateral transfers") are illegal under EMTALA. However, lateral transfers of stable patients are not prohibited by EMTALA.

It is not a hospital's overall capability that matters; it is the hospital's capability to treat a specific EMC that counts. For example, it is appropriate to transfer a sick newborn to a hospital that specializes in neonatal care regardless of that hospital's capability to handle trauma, cardiac surgery, or obstetrics. It is not appropriate to send a burn victim who needs specialized emergency burn treatment to a tertiary academic facility if that facility does not have burn care capabilities.

If an affiliated hospital or a hospital's off-campus facility, such as an urgent care center, must comply with EMTALA, that facility must decide where to send medically indicated transfers based on the immediate individual needs of the patients and not automatically transfer patients back to the main hospital. If a closer, more appropriate facility is available and in the patient's best interest, the patient must be transferred to that facility and not to the main hospital. Informed consent includes where a patient is to be transferred, not just that the patient is to be transferred. (See Chapters 3 and 4 for a discussion of off-campus facilities.) If EMTALA does not apply to the off-campus facility or a physician's private office, the patient with an unstable EMC can be sent to any facility of his or her choice. In this case, transfers from an office to a hospital will be judged only under ordinary malpractice standards, not under EMTALA.

Similarly, even if a hospital has prearranged transfer agreements with other designated facilities, a patient can't automatically be sent to a designated facility. Each medically indicated transfer must be judged based on its individual circumstances, and each patient must be sent to the most appropriate facility. If two or more facilities are equally competent and appropriate to stabilize a patient's EMC, the hospital can send the patient to any one of those facilities (preferably, the patient's choice).

Managed Care Considerations

MCOs may try to dictate where hospitals transfer patients. Although hospitals should attempt to accommodate patients' insurance needs when possible, the transfer of unstable patients is strictly and entirely controlled by EMTALA without regard for the business objectives of managed care. If a transfer is not completed appropriately, only the transferring hospital and responsible physician will be held liable, not the MCO.

A hospital should never transfer an unstable patient at the request of an MCO if the transferring hospital is capable of stabilizing the patient's EMC. Otherwise, the hospital violates the EMTALA stabilization requirement.

A hospital should never transfer a patient to a hospital mandated by an MCO unless the transferring physician determines that the MCO facility has the necessary resources and physician expertise available to manage the patient's EMC and any reasonably foreseeable complications. Otherwise, the transferring hospital violates EMTALA by failing to arrange an appropriate transfer.

A hospital should never transfer a patient to a hospital mandated by an MCO if the transferring physician judges it more appropriate to send the patient to a different facility that is better equipped to stabilize the patient's EMC. If the physician can send the patient to any equally appropriate hospital, including one contracted with the patient's MCO, the physician should ask the patient which hospital he or she prefers. For example, if there are two equidistant Level I trauma centers in town, one affiliated with the patient's MCO and the other with a competing insurance plan, it is perfectly reasonable to ask which one the patient prefers based on his or her insurance. Remember, there is no such thing as a managed care transfer. Even for a medically indicated transfer of an unstable patient, if there are multiple choices of where to send the patient, the patient gets to choose after being informed of the different options.

However, if another hospital is more suitable, either because of available resources, physician expertise, closer in distance, or the time required to reach definitive stabilizing care, then the transferring physician must recommend that the patient be transferred to the more appropriate hospital. If the two trauma centers were not equidistant and the transferring physician believed that the patient's injuries should be treated at the closer facility, the physician must choose the closer trauma center; its proximity makes it the most appropriate facility.

Whether the MCO grants authorization for the transfer to the closer hospital is irrelevant. The transferring hospital is required to send the patient to the most appropriate hospital, and the receiving hospital is required to accept the patient in transfer regardless of whether the MCO authorizes the transfer. Authorization concerns payment only; transfer decisions must be made according to the mandates of EMTALA.

Furthermore, the EMTALA no-delay provision applies to transfer situations just as it does to screening and stabilization. Assume, again, that the two trauma centers are equidistant and the MCO facility can't accept the patient for 2 hours. If the other facility can accept the patient...
Providing Emergency Care Under Federal Law: EMTALA

immediately, holding the unstable patient for later transfer to the MCO hospital would delay the patient's access to stabilizing treatment because of insurance status, a direct violation of the no-delay clause.

Prearranged Transfer Agreements

Ideally, hospitals should establish standing transfer agreements with appropriate designated higher level facilities to accept transfers of patients with EMCs they are incapable of managing. Transfer agreements help expedite transfers, prevent typical transfer hassles, and lead to more timely stabilizing treatment.

Transfer Records

Hospitals must maintain all records related to all transfers (in and out) for 5 years.2 This includes patients transferred from inpatient settings, not just from emergency departments. Hospitals also must have systems to retrieve these transfer records for HCFA to review on request.

Whistleblower Protection

The statute prohibits hospitals from taking adverse action against any qualified medical persons or physicians because they refused to authorize transfers of individuals with EMCs that had not been stabilized when the hospital could have stabilized them.35

Patient Refusals

If a patient refuses to consent to a medically indicated transfer, the hospital will not be liable under EMTALA if it informed the patient of the risks and benefits of refusing the transfer. The hospital must ascertain that the patient is competent to refuse the transfer and, according to the statute, "take all reasonable steps to secure the individual's written informed consent to refuse such transfer."34 The medical record must contain a description of the benefits of the recommended transfer offered and a description of the examination, treatment, or transfer refused.34

Use the Informed Consent to Refuse Examination, Treatment, or Transfer form in Appendix 3G. The hospital should follow essentially the same process described in Chapter 4 for patients who refuse MSEs.

The statutory language seems to indicate that if a patient refuses to consent to a medically indicated transfer, the hospital no longer has an obligation under EMTALA to provide further stabilizing treatment.36 Certainly the standard of care requires the hospital to still treat the patient within the scope allowed by the patient until the patient is stabilized (or dead). Because Congress clearly intended for patients to receive stabilizing treatment within the full capabilities of the hospital, the courts may not allow hospitals to stop caring for an unstable patient simply because the patient refused transfer.

What are the duties of the hospital receiving a medically indicated transfer?

EMTALA requires hospitals capable of specialized care to accept transfers of patients with EMCs who require their services. This EMTALA nondiscrimination clause reads as follows:

"A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, ...) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual."

This section of the law was added in 1989 to prevent the widespread practice of tertiary hospitals refusing to accept patients in transfer who did not have insurance, euphemistically called "reverse dumping."38

Previously EMTALA required transferring hospitals to obtain the acceptance of receiving hospitals prior to sending patients, but neither EMTALA nor most state law required hospitals to accept patients in transfer.39 Potential receiving hospitals used this dual hammer to refuse indigent patients, even in life-threatening situations, and simultaneously threaten to report hospitals to HCFA if patients were transferred without their permission.38

Policies and Procedures

The duty to accept patients in transfer requires all hospitals to establish written transfer acceptance policies, implement procedures for accepting or rejecting transfers, and educate their medical staffs and others involved in accepting or rejecting transfer requests on the hospitals' behalf.40 Hospitals must monitor and enforce performance compliance with their transfer acceptance policies.41

The OIG successfully fined an Oklahoma hospital $25,000 because the administrative law judge determined that the hospital had "neither articulated a clear transfer acceptance policy which assured compliance with the Act nor did it educate its staff and on-call physicians as to their responsibilities."42 The administrative law judge measured the hospital's culpability based on its "actions to attain or not to attain compliance with the requirements of the nondiscrimination section" and the hospital's "slipshod enforcement of its own transfer acceptance policy."

Who can accept or reject transfers on behalf of a hospital?

The hospital has the legal duty to accept appropriate transfers; EMTALA does not impose a duty on physicians to accept patients in transfer.43 The hospital can delegate that duty to whomever it chooses, but it remains legally responsible and liable for the actions of its delegates. The hospital can designate emergency physicians, on-call
Transferring and Accepting Patients Under EMTALA

physicians, physician referral lines, nurse supervisors, a transfer team, an administrator, or an admitting office to accept transfers on its behalf. Some state laws require that a physician accept patients prior to transfer.64

From a medical perspective, it's best for a hospital to delegate this duty to members of its medical staff. Physicians will provide the care requested by transferring hospitals and are in the best position to determine which patients should be accepted. However, the availability of physician expertise is only half of the accepting decision. Prior to accepting a transfer, a hospital also must ascertain whether it has the resources and staff available that are necessary to manage the transferred patient’s EMC appropriately, such as ICU bed space, operating room and anesthesia services, CT scanning, angiography, MRI capability, and adequate nursing coverage. Thus, the decision to accept a transfer should be a joint decision between a physician and the hospital itself.

When choosing which physicians to designate to accept patients on its behalf, the hospital should consider a number of factors. It may seem logical to route transfer requests directly to the physicians on call, but using on-call physicians alone to accept or reject transfers uniformly fails. It’s virtually impossible to educate the entire medical staff sufficiently in the nuances of the hospital’s duty to accept transfers. Many physicians don’t understand or refuse to acknowledge that, when on call, they are agents of the hospital and represent the hospital, not their private practices, and that acceptance is mandatory, not optional, under federal law. Their interests and perspectives are different from the hospital’s, and they tend to consider how accepting a transfer will affect them personally rather than as the hospital’s obligation. Also, it is difficult for the hospital to document and monitor the transfer requests and physician performance if transfer calls go directly to the on-call physicians. And it only takes one tired or uninformed on-call specialist’s rejection of an appropriate transfer to initiate HCFA termination proceedings or a civil action against the hospital.

Also, on-call physicians usually don’t have up-to-the-minute knowledge of the hospital’s resource capability. If called at home at midnight, a neurosurgeon could accept a patient not knowing that the hospital’s CT scanner broke down an hour earlier. A cardiologist may accept a patient only to find that there is no bed in the CCU and the emergency department is already holding several patients waiting on CCU beds and the emergency department is closed to local EMS.

Hospitals should consider designating their emergency physicians on duty responsible for accepting transfer requests from other emergency departments. Emergency physicians tend to be more knowledgeable of EMTALA; they are a smaller group to educate and monitor, and they are present in the hospital 24 hours a day. Emergency department staff members generally know what resources and personnel are available and have experience arranging such transfers. Patients “advertised” to need a certain type of specialist may actually need a different specialist, or the emergency physicians may be able to handle the patients’ problems themselves. To facilitate the process, after an emergency physician speaks to the transferring physician or evaluates the patient on arrival, the emergency physician can assemble the appropriate on-call specialists and other hospital personnel and resources needed to manage the patient’s EMC on a timely basis. Such an approach often prevents unnecessary calls to (and involvement of) on-call physicians and reduces waiting time.

Interns and residents should never be allowed to reject transfers. They may be allowed to accept transfers, but only when acting under the direct authority of a supervising attending physician.

The refusal of patients in transfer by tertiary hospitals is one of the fastest growing areas of EMTALA citations against hospitals. The citations usually result from on-call physicians’ improper rejections of appropriate transfers. A hospital is directly liable for a physician’s inappropriate transfer rejection, regardless of whether the physician violated hospital policy and even when the hospital was totally unaware of the rejection.62 When on call, physicians act as agents of the hospital, not their private practices, and must accept appropriate transfers under EMTALA for the hospital.63 According to the courts, “any EMTALA violation by a physician is also a violation by the hospital.”62

In Inspector General v St Anthony Hospital, the hospital’s on-call thoracic surgeon refused to accept an appropriate transfer of a trauma victim from a nearby hospital. The judge agreed with the OIG and fined the hospital $35,000, holding that the physician was the hospital’s agent for the purpose of deciding whether the hospital would accept the transfer according to EMTALA.63

A Georgia hospital paid a $45,000 fine because an on-call surgeon refused to accept an appropriate transfer of an individual who required the hospital’s specialized facilities when the hospital had both the capability and the capacity to treat the individual. A California hospital paid $40,000 because it refused to accept an appropriate transfer, allegedly because the emergency physician refused to call the hospital’s on-call specialist.64

With increased government scrutiny of transfer acceptance decisions and the potential severe regulatory and civil ramifications for failure to accept appropriate transfers, hospitals should carefully consider which physicians they choose as their agents for accepting or rejecting transfers. I strongly recommend that hospitals not use on-call physicians alone to accept or reject transfers on their behalf. At least one author recommends that hospitals specifically
state that on-call physicians are not authorized to accept or reject transfers on their behalf. Hospitals should, instead, coordinate on-call physicians' involvement with another representative of the hospital, either the emergency physician or a hospital administrative designee, as explained below.

How should the hospital accept or reject transfers?

Identify Who Can—and Who Cannot—Accept Transfers on the Hospital's Behalf. After determining who will act on its behalf, the hospital should formally designate, in writing, who has the authority to accept or refuse transfers on its behalf. Equally important, the hospital should specifically delineate which members of the hospital staff are not authorized to accept or reject transfers.

Set Up a Single Transfer Acceptance Telephone Line. Ideally, all transfer calls would come into the emergency department. If the transfer was from another emergency department, the emergency physician would decide whether the hospital will accept the patient after checking with a designated administrative person to confirm bed space and that the necessary hospital resources are available to handle the patient's EMC. Generally, this administrative person would be the triage or nursing supervisor. When necessary, the emergency physician would consult with an on-call specialist before accepting the patient.

If the hospital or medical staff was unwilling to allow the emergency physician to accept patients on behalf of the hospital and the medical staff, the emergency physician could contact the appropriate on-call physician for every transfer. Medical staffs often are unwilling to relinquish control over accepting transfers, but in reality, this control is illusory. The hospital must accept the patient, and most of the time the emergency physician knows whether the hospital has the capability and capacity to treat the patient. In either scenario, patients generally should be sent from the transferring emergency department to the accepting hospital's emergency department rather than be admitted directly. Certainly, some patients can be directly admitted, but it is usually better to reexamine patients in the emergency department on arrival. Patients may need different bed resources or different specialists than requested or their conditions may be different than advertised. A reevaluation in the emergency department would simply expedite proper patient care and provide a service to the on-call specialist.

If the requested transfer was for an inpatient, the on-call physician who would manage the patient on arrival must discuss the case directly with the transferring physician and decide whether to accept or reject the transfer on behalf of the hospital. These cases are generally more complex, and it is more appropriate for the hospital to vest the authority to accept or reject the transfer with the on-call physician. Inpatient transfers should be arranged as direct admits in most instances.

Using a single transfer intake line and persons designated to accept transfers reduces the likelihood of mistakes in the transfer process. It is also fair for public relations and greatly appreciated by transferring facilities. "One call does all" should be the goal of accepting facilities.

Another advantage of using a single intake line is the ability to taperecord all transfer requests. This practice reduces the number of inappropriate transfers and helps modify the behavior of accepting physicians. The recordings also can be used to monitor quality.

Document EMTALA Compliance Using Standardized Forms. All transfer requests should be documented. A sample form ("EMTALA Transfer Acceptance or Denial") is included in Appendix 3E. Record the caller's name and hospital, the patient's name, the date and time, the reason for the transfer, and whether the transfer was accepted or rejected. If the transfer was rejected, document the reason. The hospital's designee who took the call and decided whether to accept or reject the transfer on behalf of the hospital should sign the form.

These completed forms prove the hospital's compliance with EMTALA in the event that HCFA questions a rejected transfer or a plaintiff claims harm as a result of the hospital's rejection of a transfer. Unfortunately, the hospital will be required to prove a negative—that it didn't inappropriately refuse a patient a transfer—which may be impossible without adequate documentation. HCFA has suggested the use of such a form in its investigations and citations of hospitals. Also, if a hospital receives a patient transferred inappropriately in violation of EMTALA, this same form can be completed and submitted to hospital legal counsel or risk management to facilitate reporting the transferring facility to HCFA. The hospital should keep these forms for 5 years.

Educate the Entire Hospital Staff. The hospital has a duty to ensure that its staff members and physicians understand their responsibilities under EMTALA and act accordingly. Nurses, clerical personnel, telephone operators, medical staff members, and any other staff member likely to receive calls requesting the hospital accept a transfer must be educated on the hospital's policies and procedures. Specifically, they must know who can and cannot accept patients in transfer.

Educate Area Hospitals. Inform transferring hospitals in the referral area about the system created to accept patients in transfer, including who can and who cannot accept patients, the transfer intake telephone number, and
the resources available and not available at the facility. All hospitals should follow the lead of trauma centers, burn centers, and neonatal centers, which have systems for disseminating information on their capabilities, single contact telephone numbers, and established intake avenues.

When must a hospital accept an unstable patient in transfer?

A hospital that has specialized capabilities or facilities and the capacity to treat an individual's EMC must accept the appropriate transfer of such an individual.72

"Specialized Capabilities or Facilities." The law does not define this term, but it almost certainly applies to any hospital that has the resources or physician expertise needed to manage an individual's EMC when those resources are not available at the transferring hospital. HCFA and the OIG clearly take this position, citing Congress's intent to expressly forbid hospitals to refuse patients on any basis, including lack of insurance, other than their physical inability to provide proper treatment.73

HCFA limits the acceptance mandate in this language, stating: "If the transferring hospital wants to transfer a patient because it has no beds or is overcrowded, but the patient does not require any 'specialized' capabilities, the receiving (recipient) hospital is not obligated to accept the patient."74

In the only case to address this issue specifically, Inspector General v St Anthony Hospital, the judge took an expansive view of a hospital's duty to accept transfers. The judge said that "specialized care may include any care which requires the services of specialists and facilities that are not within the reach of smaller hospitals that offer a lower level of care." The judge did not limit the duty to accept transfers to specialized units, such as the examples given in the statute of burn units, shock-trauma units, neonatal ICUs, or regional referral centers. The issue is not whether a hospital has a particular specialty unit; the issue is whether the receiving hospital has the capability to manage an individual's EMC.

"Capacity." A hospital may, and should, refuse a transfer if it does not have the capacity to treat the patient's condition. However, HCFA defines capacity very generously to include "such things as numbers and availability of qualified staff, beds, and equipment and the hospital's past practices of accommodating additional patients in excess of its occupancy limits."75 According to HCFA, if a hospital can accommodate additional patients by moving patients to other units, calling in additional staff, borrowing equipment from other facilities, or some other means, it has demonstrated the ability to provide services to patients in excess of its occupancy limits.76 So even if accepting a transfer would force the hospital to exceed its licensed capacity, if it had done so in the past, HCFA would expect it to do so again.

In one case, an on-call neurosurgeon refused a requested transfer of a patient with a neurosurgical emergency, stating that the ICU was full. However, the hospital was holding one ICU bed open in case of an in-house emergency; this was its standard practice. HCFA deemed the refusal a violation of EMTALA, stating that if the hospital had an open ICU bed for possible in-house needs, that bed was available to accept an emergency transfer.77

If a hospital's beds truly are full, it does not have to accept a patient in transfer. This emphasizes the importance of involving the hospital in the acceptance process and not delegating the decision unilaterally to a physician. Even if a physician is willing to accept a patient in transfer, the hospital can and should refuse the transfer if it does not have the capacity to treat the patient. To accept the transfer would not be in the best interest of that patient or the patients already at the hospital.

However, if a hospital is not closed to its local EMS system, it may not be considered to be at capacity under EMTALA. A hospital that is open to its community is open to any community that has a patient who needs its services. The EMS situation is one of the factors HCFA will consider in determining whether a hospital really was "at capacity" when it refused a transfer. Sometimes trauma centers may be an exception, keeping beds or operating suites available for acute trauma while declining to accept transfers of trauma patients who are inpatients at other hospitals or who could be managed at other facilities. Their goal is to remain available to meet the immediate trauma needs of the community.

In summary, if a hospital can take care of a patient's needs, it must accept that patient in transfer. Hospitals need to define their resources and capacity carefully and specify the times when those resources are available.

What is an "appropriate transfer" that hospitals must accept?

Hospitals with specialized capabilities or facilities are only required to accept appropriate transfers. Neither the statute nor the regulations explain the meaning of the term or relate it to requirements of the transferring hospital to arrange an "appropriate transfer." Thus, the word has its ordinary dictionary meaning for this section of the law applicable to accepting hospitals.

For example, if a transferring hospital clearly has the staff and resources to handle an individual's EMC, it is not appropriate to transfer that individual and no other hospital is required to accept the transfer.78 If a patient needs further stabilizing treatment before transfer, such as endotracheal intubation, blood transfusion, and chest tube
insertion, a trauma center can refuse the transfer until these procedures are completed because it would not be within the EMTALA definition of "appropriate" to transfer the patient without these interventions. Regardless of whether a hospital has the capacity to manage a patient's condition, if transfer to that hospital is clearly not in the patient's best medical interest, the hospital does not have to accept the transfer.

However, a hospital that refuses a transfer in this scenario had better be right. If the sending hospital truly does not have the capability to treat the patient, the hospital will be in violation of EMTALA. A safer approach is to accept the transfer then recommend to the transferring hospital how to manage the patient's condition prior to transfer.

**Must the individual's condition be unstable at the time of transfer for the transfer to be considered appropriate?**

No. A hospital asked to accept a patient in transfer may not refuse the transfer on the grounds that the transferring hospital has already stabilized the patient. The issue for a potential receiving hospital is whether the patient has an EMC that requires further emergency care—care that the receiving hospital is able to provide but the transferring hospital is not. The law does not limit a hospitals duty to accept transfers to only those patients whose EMCs are unstable. As the court stated in *Inspector General v St Anthony Hospital*: "It is not relevant whether [the patient's] medical condition was stabilized prior to his transfer."

For example, a major trauma patient at a small community hospital is "stabilized" by securing the airway, inserting a chest tube, splinting fractures, and administering IV fluids and blood. The patient may be temporarily hemodynamically stable, and legally stable such that "no material deterioration is likely to result from or occur during the transfer," but that does not allow a potential receiving hospital to refuse the transfer. The patient may still have an EMC, such as a ruptured spleen or complex pelvis fracture, that requires treatment that the transferring hospital cannot provide and the receiving hospital can. A patient with AIDS who has a disseminated opportunistic infection can be stabilized at the time of transfer and still require transfer to a hospital that has infectious disease experts to treat his underlying EMC. A hospital may be able to stabilize a child who has acute hemolytic-uremic syndrome from an *E. coli* O157:H7 infection but still needs the expertise of a hospital with pediatric specialists. A suicidal individual who has been chemically or physically restrained to prevent him from harming himself is stabilized but still requires transfer to a psychiatric facility for definitive treatment of his EMC, suicidal intent.

The linchpin is whether the individual still has an EMC that the transferring hospital can't handle but the receiving hospital can. Such a transfer is clearly appropriate and must be accepted. However, if the individual does not have an EMC, a hospital does not have to accept the requested transfer. HCFA provides the following example in its comments on the regulations: "A hospital with an orthopedic department and orthopedic physicians on-call would not be required to accept a transfer of an individual with a simple, closed fractured arm just because the transferring hospital does not have an orthopedic service." A simple, closed fracture is not an EMC, so another hospital does not have to accept the patient in transfer. But if the fracture is significantly displaced or coupled with neurovascular compromise, an EMC does exist and a hospital with orthopedic surgeons would be required to accept the patient in transfer. This would be an appropriate transfer, and regardless of whether the patient is medically or legally stable at the time of transfer, a hospital capable of treating the fracture would be required to accept the transfer. The duties of a hospital that is asked to accept a patient in transfer are separate and distinct from the duties of the hospital that is transferring the patient. The duty to accept appropriate transfers is not in any way related to another hospitals duty to stabilize patients before transfer. The EMTALA duties of the transferring hospital end when the patient is stabilized, but that does not end the duty of the receiving hospital to accept the patient in transfer.

**What reasons are not acceptable for refusing an appropriate transfer?**

Unacceptable reasons for refusing transfers of patients with EMCS include a patient's lack of insurance, a hospital's nonparticipation in a patient's managed care plan, a patient's physician not being on staff at a hospital, a patient's receiving services at a different hospital previously, and physician convenience. Hospitals may not refuse patients because they are from another county or state (including out-of-state Medicaid patients) or from outside a hospital's defined referral service area. The law does not provide for such territorial safe harbors. Hospitals do not have to accept transfers from facilities outside the boundaries of the United States.

Refusal of a medically indicated transfer for any reason other than physical inability to care for the patient is expressly prohibited by EMTALA.

**Can a hospital refuse to accept a patient in transfer if the transferring facility wants to skip over other hospitals to send the patient there?**

No. A hospital cannot refuse to accept a patient on the grounds that the transfer should have been made to a clos-
Managed Care Considerations

Hospitals must accept appropriate patient transfers even if the patients' insurance or managed care plans will not authorize payment for their care. Hospitals also cannot refuse to accept specific managed care plans' patients because they do not have contracts with those MCOs. Refusals of medically indicated transfers on the basis of patients' insurance status are illegal.

Furthermore, a receiving hospital cannot ask a transferring hospital to delay a transfer until it obtains payment authorization from an MCO. This, too, is illegal.

Transfer Records

Hospitals must maintain all records related to transfers both into and out of their facilities for 5 years. This includes transfers from inpatient settings, not just transfers from emergency departments. Hospital also must keep copies of x-rays, lab reports, ECGs, and other materials sent by transferring facilities. Hospitals must have systems to retrieve these transfer records for HCFA to review on request.

Mandatory Reporting of EMTALA Transfer Violations

Any time a hospital "has reason to believe" it may have received a patient transferred in an unstable condition from another hospital, in violation of EMTALA, it must report the transferring hospital to HCFA or the state agency.

Only inappropriate transfers of unstable patients, true "dumps," should be reported. Medically indicated transfers of unstable patients, those in which the benefits of transfer outweighed the risks of transfer, should not be reported. However, no improper motive is required before a receiving hospital must report an inappropriate transfer. According to HCFA, receiving hospitals have to report transferring hospitals whenever they have "a reason to believe that a violation has occurred, regardless of whether the receiving hospital believes the sending hospital violated the law intentionally or with any ill motive."

The duty to report rests with the hospital, not the physicians, but HCFA expects the hospital "to have and enforce policies and procedures to require its employees and staff physicians to report to the administration instances where an individual has been inappropriately transferred under this statute." Physicians who receive inappropriate unstable transfers should inform the hospital's legal counsel, who can then determine the appropriate action after consulting with the hospital's administrative leadership.

Only the receipt of inappropriate unstable transfers must be reported under EMTALA. The hospital has no legal duty to report other known violations by other hospitals, such as failure to screen a patient or "reverse dumping" — the failure to accept a patient in transfer who...
requires specialized services. Hospitals are not required to self-report, such as when an on-call physician refuses to come to the emergency department to provide stabilizing care to a patient or the hospital triages an MCO patient away without an MSE. However, state laws may require more extensive reporting of violations. For example, Florida law requires any health care professional, including physicians and nurses, who has knowledge of a violation to report it to the state within 30 days. This state law, unlike EMTALA, also requires hospitals to report themselves for violating the law.\(^9\)

Reporting under EMTALA is mandatory, not discretionary. Failure to report is itself a violation, and HCFA can terminate a hospital's Medicare provider agreement for this violation.\(^9\) According to HCFA, "the formal reporting procedures are an integral part of the department's enforcement scheme to ensure that hospitals are complying with the statute. We are looking to those institutions in the best position to discern when an inappropriate transfer has taken place in violation of the statute, because Congress regards them also as victims of 'dumping.'\(^9\) Since the mandatory reporting requirement took effect in September 1995, receiving hospitals have become the single largest source of complaints to HCFA.

Several hospitals have been cited for failure to report other hospitals that transferred patients inappropriately.\(^9\) When HCFA investigates a hospital for an alleged dumping violation, it also reviews the records at the receiving hospital to substantiate the claim and to determine if the receiving hospital should have reported the incident to HCFA. Thus, if an unstable patient was transferred inappropriately, both the sending and the receiving hospital could be cited.

HCFA officials have indicated that they want hospitals to report violations within 72 hours of their occurrence. However, neither the regulations nor the interpretive guidelines include such a rule, so HCFA may have trouble enforcing its desired time requirement. No hospital has been cited for violating the 72-hour guideline. HCFA recognizes that it may take hospitals a significant amount of time to adequately investigate incidents to determine if they "reasonably believe" that they received unstable patients in transfer in violation of the law. As long as hospitals act with due diligence and report within a reasonable period of time, they should have nothing to fear from HCFA if they don't report violations within 72 hours.\(^9\)

Hospitals should review the transfer records, discuss the issues with the receiving physicians and staff, and meet with hospital legal counsel and administrators to decide if the facts warrant reporting the incident to HCFA. During its review of the case, the hospital also should contact the transferring facility. Often, information from the transferring hospital establishes that no violation occurred.

**Whistleblower Protection**

The law prohibits hospitals from penalizing or taking any adverse action against hospital employees because they reported violations of EMTALA.\(^9\)

**Patient-Requested Transfers**

If an unstable patient asks to be transferred from an emergency department or inpatient setting to a different hospital for further stabilizing treatment, EMTALA still governs the actions of the transferring hospital, but not of the receiving hospital.

**Duties of the Transferring Hospital**

Because the hospital has the capability and capacity to stabilize the patient's EMC, a patient who chooses to leave is effectively refusing stabilizing treatment and leaving the hospital against medical advice. (See the sections in Chapters 4 and 5 on refusal of the MSE and stabilizing treatment.) In this situation, EMTALA requires the hospital to take the following steps:\(^9\):

- Inform the patient of hospital's obligations to provide stabilizing treatment.
- Inform the patient of the risks and benefits of transfer compared to staying. The risks and benefits should be documented expansively; failure to include foreseeable risks could invalidate the patient's consent.
- Obtain the patient's written informed consent to refuse the offered stabilizing treatment. The patient's signature should indicate that the patient is aware of the hospital's obligations and the risks and benefits of the transfer.
- Ascertain the patient's competence to make an informed decision, to refuse the offered stabilizing treatment, and to understand the risks and the benefits of transfer at this time.
- Obtain the patient's request for transfer and reason for transfer in writing. The statute and regulations require this specifically. The request must be made part of the patient's medical record, and a copy of it should be sent to the receiving facility with the patient. The government is concerned that patients may be economically induced to request transfer. "Hospitals should not attempt to coerce individuals into making judgments against their best interests by informing them that they will have to pay for their care if they remain, but that their care will be free or at low cost if they transfer." HCFA also maintains that patient requests for transfer should be unsolicited.\(^9\)
- Arrange an "appropriate" transfer. All transfers of unstable patients, whether medically indicated or patient requested, must meet the criteria for an
appropriate transfer under EMTALA, as discussed earlier for medically indicated transfers.\textsuperscript{97} Even though the patient is refusing stabilizing treatment at the hospital, the hospital must arrange the transfer and remains responsible and liable for the transfer until the patient reaches the accepting facility.

These elements should be documented using a standardized form such as the one in Appendix 3E.

Certification is not required for patient-requested transfers, even if the patient is unstable. How can a physician possibly certify that the benefits of transfer outweigh the risks of transfer if the patient is leaving against medical advice? A physician or hospital should never certify a transfer that is not medically indicated. To do so would suggest that the physician and hospital believed the transfer was indicated and appropriate and expose them to potential regulatory and civil sanctions.

Hospitals must maintain records related to all transfers, including patient-requested transfers, both into and out of the hospital, for 5 years. This includes transfers from inpatient settings, not just from emergency departments.\textsuperscript{98}

Where can an unstable patient who requests transfer be sent?

Transfers of unstable patients who request transfer must be arranged as "appropriate" transfers, exactly the same as medically indicated transfers. Thus, these patients should be sent to hospitals that have the necessary resources and physician expertise to manage the patients' EMCs. However, patients can transfer to any facility they want to that will accept them in transfer. The transfer of an unstable patient to a facility with lesser capabilities or capabilities reasonably the same as the transferring facility is not a violation of EMTALA when the patient insists on being transferred there. As long as the hospital explains the risks and benefits of transfer to a requested facility, the physician and hospital are not liable for any adverse consequences related to the patient's choice of hospital.

Duties of the Hospital Receiving an Unstable Patient-Requested Transfer

If a patient wants to go to another hospital but does not require any treatment beyond the capabilities and facilities available at the transferring hospital, the requested receiving hospital may refuse to accept the patient in transfer.\textsuperscript{99} Because the transfer is not medically indicated, no hospital has a legal duty to accept it. It has the option to accept, but not the duty. Thus, it can refuse the transfer until authorization is received from the patient's MCO or refuse the transfer outright for any reason. The receiving hospital is not required to report to HCFA that it received a patient in an unstable condition from another hospital because the patient requested the transfer as long as the transferring hospital did not violate EMTALA by sending the patient there.\textsuperscript{100} However, the receiving hospital still must maintain records related to all transfers, including patient-requested transfers, for 5 years. This includes patients transferred from inpatient settings.\textsuperscript{101}

**TRANSFER OF STABLE PATIENTS**

Stable patients can be transferred at any time, to any hospital, for any reason, including economic reasons, and EMTALA does not apply.\textsuperscript{102} Stabilized patients include those who do not have EMCs as determined by an appropriate MSE. Furthermore, HCFA now agrees that being "stable for discharge" or "stable for transfer" does not require final resolution of the EMC, only that "no material deterioration of the emergency medical condition is likely, within reasonable medical probability, to result from or occur during the transfer."\textsuperscript{103} When transferring stable patients, hospitals are not required to arrange appropriate transfers as defined and required by EMTALA for unstable patients.\textsuperscript{104} In *Cherukuri v Shalala*, the court stated: "The act does not impose any requirements on hospitals with respect to the treatment or transfer of individuals whose emergency condition has been stabilized."\textsuperscript{105}

Some HCFA regional offices and state surveyors believe that EMTALA prohibits the transfer of any patient for economic reasons, including stable patients. Their belief is unexplained. When explaining the law to his fellow senators, Sen. Durenberger (D-Minn) stated: "This amendment does not prevent hospitals from making appropriate and safe transfers of patients for economic reasons."\textsuperscript{106} The courts agree, stating: "While it would be laudable for private hospitals to never transfer patients to a public hospital based on their inability to pay, EMTALA does not impose such a duty on participating hospitals."\textsuperscript{107} Similarly, the courts hold that plaintiffs cannot sue hospitals for inappropriate transfer or failure to certify under the law unless they prove that the patient was unstable at the time of transfer.\textsuperscript{108} EMTALA simply does not regulate any aspect of the transfer of stabilized patients, even when the reason is purely financial.

For example, if an emergency physician or on-call surgeon determines that an individual with abdominal pain does not have acute appendicitis but needs to be reexamined in 6 to 8 hours, that individual does not have an EMC at that time and is considered stable for transfer. He could be transferred to another facility for economic reasons, such as to a hospital that contracts with his MCO. He could be transferred to a facility with lesser capabilities, or laterally transferred to one with reasonably the same capabilities as the sending facility. EMTALA does not prohibit lateral transfers of *stable* patients, only lateral transfers of *unstable* patients.\textsuperscript{109}
If the surgeon determined that the individual had an acute abdomen, the necessary stabilizing treatment for which is surgery, the hospital cannot transfer him to the MCO facility to have the operation performed there. Doing so would constitute a failure to stabilize an EMC prior to transfer and a delay in stabilizing treatment based on the patient's insurance status, both of which are illegal under EMTALA.

Hospitals and physicians should recognize, however, that economic transfers will always be subjected to greater scrutiny. Compliance with EMTALA, or ordinary malpractice, will be reviewed retrospectively with the knowledge that the decision to transfer was based on the patient's lack of financial resources. Hospitals should select carefully which patients are transferred for economic reasons, ensuring that such transfers occur smoothly and without any significant risk of harm to the patient.

**Duties of the Transferring Hospital**

When transferring a stable patient, the hospital should clearly differentiate whether the patient was determined not to have an EMC or did have an EMC that has been stabilized. If the hospital fails to find an EMC after performing an appropriate MSE, it cannot be held liable for failure to stabilize the EMC. The hospital's transfer forms should include check boxes that reinforce this distinction. (See the documentation section below and the transfer packet in Appendix 3.)

**Should the hospital certify the transfer of stable patients?**

According to the law, certification is not required for the transfer of stable patients. The 6th Circuit specifically addressed this issue, stating: “Under the language of the law a physician may transfer any emergency room patient to another hospital without any certifications and without the express consent of the receiving hospital if he reasonably believes that the transfer is not likely to cause a ‘material deterioration of the patient’s condition.’”

However, patient transfer is an area of emergency medicine that is fraught with medical-legal risk; the hospital's transfer policy should reflect an understanding of this risk and include safeguards for all involved. The hospital should still divide transfers of stable patients into those that are medically indicated and those that are patient requested. A patient may be deemed “stable for transfer” and still need further medical intervention that the hospital is unable to provide. In this case, and with all other types of medically indicated transfers, the physician should certify that the benefits of care at the receiving hospital outweigh the risks of the transfer at the time of transfer.

**Why? First, the determination of whether an EMC is stable is an objective one and subject to retrospective analysis. If the government or the courts later determine that the EMC was not stable at the time of transfer, the certification will protect the physician and the hospital from claims that they failed to certify or appropriately transfer the patient. Second, a medically indicated transfer generally is recommended and initiated by a physician, and that physician still must weigh the risks and benefits of the transfer, document that he or she believes the benefits outweigh the risks, and obtain the patient's informed consent. Using the same EMTALA "Medically Indicated Transfer" form and completing the certification prevents potential errors. The form in Appendix 3D also includes a section for documenting the presence or absence of an EMC and whether the patient was stable or unstable at the time of transfer. Proper completion of these sections will contemporaneously indicate that EMTALA does not apply to the transfer, in which case the certification simply becomes the ordinary explanation and documentation of the risks and benefits of the transfer.

Conversely, physicians should not certify stable patient-requested transfers. Instead, the hospital should use the "Patient-Requested Transfer" form in Appendix 3E, which explains the risks and benefits but does not state that the physician believes the benefits outweigh the risks. The hospital should not create any documents that could indicate that an EMC was present or that the physician or hospital initiated the transfer.

**Should the hospital arrange an “appropriate” transfer for a stable patient?**

EMTALA transfer requirements do not apply to transfers of stabilized patients. However, the hospital still should arrange all transfers as “appropriate” transfers. Why? To establish and reinforce uniform hospital policy and practice, to ensure that the hospital routinely complies with EMTALA transfer requirements, and to conform to the expected standard of care for any transfer.

The hospital should document that the patient is stable using language that tracks the law, such as: “This patient is stabilized such that no material deterioration of the condition is likely, within a reasonable degree of medical certainty, to result from the transfer.” Again, the assessment and documentation should be done at the time of the transfer.

The transfer of a stable patient still requires that patient's consent. The patient must understand the risks and benefits and must be competent to make the decision to be transferred. The hospital must send any necessary medical information with all patients, including stabilized patients, who are discharged or transferred to
other facilities, as required by both non-EMTALA Medicare Conditions of Participation and the standard of care.\footnote{111}

\textbf{State Laws}

Several state laws and hospital licensure requirements regulate or even prevent a hospital from transferring stable patients for economic reasons when it has the capability and capacity to treat patients’ EMCs or underlying medical conditions.

In Nevada, Kentucky, and Florida, all hospitals with full-time emergency departments must admit any emergency patient who needs admission regardless of ability to pay.\footnote{112}

\textbf{Duties of the Receiving Hospital}

If a patient does not have an EMC, no hospital has a duty to accept that patient in transfer under EMTALA. If a patient has an EMC, the receiving hospital must accept the patient if it has the capability and capacity to treat the EMC, regardless of whether the transferring hospital has stabilized the EMC. The EMTALA duties of the transferring hospital end when it stabilizes the patient, but not the duty of other hospitals to accept medically indicated, appropriate transfers of patients who have EMCs that have been stabilized. The hospitals duty to accept is the same as discussed above in the section on unstable patients.

\textbf{Records and Reporting Requirements}

Hospitals must keep records of all incoming transfers, even stable transfers. There is no reporting requirement related to transfers of stable patients.

\textbf{Managed Care Considerations}

If a patient does not have an EMC, the hospital can refuse the transfer for economic reasons, including no MCO authorization or no contract with the patient’s MCO. If the patient does have an EMC and is a medically appropriate transfer, even if the EMC has been stabilized, the receiving hospital must accept the patient regardless of authorization or insurance status whenever it has the capacity and capability to treat the patient’s EMC. This situation is exactly the same as the duty to accept unstable patients discussed earlier.

\textbf{Must public hospitals accept stable patients in transfer?}

Public hospitals have no legal duty under EMTALA to accept stable patients who are being transferred solely for economic reasons. One private hospital in Miami sued a public hospital to force it to accept indigent patients in transfer once they were stabilized.\footnote{113} The Florida Supreme Court concluded that no state law required county hospitals to accept patients hospitalized elsewhere or to pay for services provided at the private hospital. Similarly, the US Supreme Court has ruled that the US Constitution imposes no obligation on states to pay the medical expenses of indigents.\footnote{114} However, some public hospitals, particularly state-funded psychiatric institutions, may be required by state law to accept stable patients in transfer. State laws may apply where EMTALA does not.

If a patient is unstable or has an EMC that has been stabilized but is an appropriate transfer, a public hospital has the same duty to accept the patient in transfer as any other Medicare-participating hospital. If the transferring hospital doesn’t have the expertise or resources to manage the patient’s EMC but the public hospital does, the public hospital must accept the transfer. It also has the duty to accept regardless of whether the patient is out of county, out of state, outside of its referral area, or not covered by publicly funded programs.

\textbf{DOCUMENTATION}

Every hospital should have a single transfer policy, a single transfer procedure, and a single set of forms to use to transfer patients out of the facility, regardless of whether a transfer is from its emergency department, its inpatient unit, or an off-campus urgent care center. The same forms should be used for both stable and unstable patients even though transfer forms are not required by EMTALA for stable patients. Using the same forms for all transfers ensures uniformity, minimizes error, and, if drafted and completed correctly, protects the hospital from adverse government actions and civil litigation.

Hospitals should create a “transfer packet” that contains everything staff members need to transfer patients and place packets in every area that transfers patients. The staff can pull the packet off the shelf, follow the directions, complete the forms, and consistently effect appropriate transfers under the law that minimize risks to patients and liability to providers. Appendix 3 contains a sample transfer packet. Hospitals also must continually educate all staff involved in transfers on the use of the forms and the key concepts of EMTALA related to transfers.

The nursing staff should follow and complete a transfer checklist for every transfer to ensure that all EMTALA mandates are completed prior to the transfer (Figure 1, Appendix 3B). Many hospitals require a nursing supervisor to check and sign off on the documentation before any transfer leaves the hospital to guarantee compliance with EMTALA.

Every transfer should include a “Patient Transfer Order” form completed by the transferring physician (Appendix 3C). This form documents the reason for the transfer and contains the physician’s transfer orders such as the destination and accepting physician, records to accompany the
patient, the mode of transport, and medical orders to be carried out en route.

Every transfer also should include either a "Medically Indicated Transfer" form (Appendix 3D) or a "Patient-Requested Transfer" form (Appendix 3E), depending on which type of transfer is occurring. The "Medically Indicated Transfer" form contains the physician's certificate of transfer, the legal document in which the physician certifies in writing that the benefits of the transfer outweigh the risks of transfer.

Well-drafted transfer forms document the presence or absence of an EMC, whether stabilization was achieved, the risks and benefits to the patient regarding transfer, the reason for the transfer, and the patient's informed consent. They also contain all the information necessary to protect the physician and hospital from liability. Forms should be user friendly and contain adequate space for documentation, especially for risks and benefits.

The hospital should send one copy of the transfer forms with the patient to the receiving facility and keep one copy in the patient's permanent hospital medical record. HCFA requires the hospital to maintain all transfer records for 5 years. Some state laws require transfer forms or additional documentation for all transfers, not just for unstable transfers as required by EMTALA. New York and Texas require that a memorandum of transfer be sent with all transfers.

Remember too, that all patients discharged from the emergency department or the inpatient setting are considered to have been transferred. Assuming the emergency department and hospital discharge only stable patients, the law no longer applies, and the treating physicians do not need to complete transfer forms. However, physicians must document stability in the medical record using words that mirror the language of the law whenever patients are discharged from the emergency department or the hospital.

Does EMTALA apply to, and does the hospital need to complete transfer forms for, patients transferred for diagnostic or therapeutic procedures?

Patients are often transferred from one emergency department or hospital to another hospital for diagnostic testing, such as CT, MRI, angiography, cardiac catheterization, or ultrasonography. Occasionally patients are transferred from the hospital to an off-site diagnostic facility. If the purpose of the transfer is to help determine if the patient has an EMC, the hospital is still in the process of its MSE and EMTALA applies. The hospital must arrange an appropriate transfer and complete all the transfer forms.

Important to note is that the transferring hospital must obtain advance acceptance of the transfer by the receiving hospital. Acceptance can be by protocol if to an affiliated facility, or by an individual physician such as a radiologist for the CT scan, but contact should occur each time to ensure that the receiving facility has the capability and capacity to conduct the study and handle any foreseeable complications.

If the receiving hospital returns the patient to the original hospital after the testing is completed, it does not need to complete any transfer forms. The return transfer is not governed by EMTALA because the patient was not presenting to that hospital for examination or treatment, only to have a test performed. The rationale is the same as discussed in Chapter 4.

However, both hospitals should arrange in advance how they will handle patients who deteriorate during transfer or are determined to have an EMC by the diagnostic study. If the patient's test reveals a condition that requires immediate intervention, it would not be appro-
priate to return the patient to a transferring hospital that couldn’t handle the emergency. Physician communication and coordination of the patient’s care between the two facilities is essential in these cases.

**Must the hospital complete transfer forms on transfers to nursing homes or rehabilitation centers?**

Any discharge is a transfer, but in these cases, the patient is stable at the time of transfer, so EMTALA does not apply and no EMTALA forms are required. However, the patient is being sent to another health care facility, and one that has lesser capabilities than the hospital. The hospital must carefully document that the patient was stable at the time of transfer to prevent liability for “dumping” the patient to a lower level of care.

The only EMTALA case to reach the US Supreme Court, *Roberts v Galen of Virginia, Inc.*, involved a patient who was transferred to an extended care facility after an 8-week stay in the hospital. The court held that the hospital could be sued for failing to stabilize the patient’s EMC if the plaintiff could show that the patient was unstable at the time of transfer. Because stabilization is judged on an objective standard, hospitals may end up defending their decisions that patients were stable at the time of transfer. The best way to ensure that excruciating documentation finds its way into the medical record is to complete EMTALA transfer forms on all these transfers. The elements of an appropriate transfer under EMTALA are common sense and comport with the standards of care for any transfer. The design of the forms protects hospitals. It is strongly recommended that all transfers from hospitals to other health care facilities use the same transfer forms used for EMTALA-governed transfers.

However, typical discharges from the emergency department or the hospital of nursing home patients back to their nursing homes do not need EMTALA transfer papers. These patients are being discharged/transferred “home” just like any other emergency department or hospitalized patient.

**If a patient is being transferred under involuntary commitment papers to a state psychiatric institution, does the hospital still need to complete EMTALA transfer forms?**

The required documentation for involuntary commitments under state law does not in any way preempt EMTALA documentation requirements. Most of these transfers meet the EMTALA definition of a medically indicated transfer; the transfer is to obtain treatment of an EMC, such as suicidal intent, that the transferring hospital does not have the capability to manage. Therefore, the hospital should complete the forms to document contemporaneously that the patient was stable at the time of transfer. These transfers are always highly scrutinized retrospectively.

**If a hospital transfers a patient from the emergency department to a physician’s office, must it complete the transfer forms?**

In general, HCFA believes that on-call physicians must come to the hospital in all these cases and that patients should not be sent from the emergency department to a physician’s office (see Chapter 6). Occasionally, however, a transfer from an emergency department to a physician’s office is actually a transfer to a higher level of care, or a “specialized facility,” because the office may have better equipment and resources to evaluate the patient than the emergency department. This scenario is probably most common with ophthalmologists. The transfer is part of the MSE to determine if the patient has an EMC, such as a retinal detachment, herpetic keratitis, or a corneal ulcer, so the hospital remains responsible for the patient. HCFA accepts that patients can be transferred to offices in these cases, but it holds that the patients are still unstable and must be appropriately transferred and EMTALA transfer forms completed.

Recognize that the elements of EMTALA match what an emergency physician would do in every case—treat the patient as best as he or she can, contact the ophthalmologist to arrange for the patient to be seen immediately, and send the patient via appropriate transportation. If all these elements are on the chart, it meets the mandates of EMTALA. However, it is “cleaner” and good risk management practice to just use the forms.

Most physicians do not have “specialized capabilities or facilities” in their offices. If and when patients should be sent from the emergency department to an on-call physician’s office are discussed in detail in Chapter 6.

**References**

1. 42 USC 1395dd(e)(4).
2. 42 CFR 489.24(h)(3). Prior to October 10, 2000, movement between a hospital’s main campus and an off-campus facility, in either direction, even if the off-campus facility operated under the hospital’s Medicare provider number, was legally defined as a transfer.
3. *Cherubini v Shalala*, 1999 Fed App 01605 (6th Cir); *Green v Tourom Infirmary*, 992 F2d 537 (5th Cir 1993); *Delaney v Cade*, 756 F Supp 1476 at 1486 (D Kan 1991); *Baxter v Holy Cross Hospital of Silver Spring, No 98-1169 (4th Cir 1998), cert denied, 567 US 3590 (US March 22, 1999); *Clark v Baton Rouge General Medical Center*, 857 So2d 743 (La App 1995); cert denied, 661 So2d 1347 (La 1999).
4. *Eg, Cherubini v Shalala*, 1999 Fed App 01605 (6th Cir), “Stabilized patients may be transferred without limitation under the language of the statute.”
5. 59 Federal Register 32105.
6. 59 Federal Register 32104.
Providing Emergency Care Under Federal Law: EMTALA

8. HCFA Interpreting Guidelines, V-29.
12. 42 USC 1395ddd(c).
14. 42 USC 1395cc(a)(1)(B)(i); 42 USC 1395dd.
15. 42 USC 1395ddd(c)(1)(A)(ii).
16. 42 USC 1395ddd(c)(1)(ii).
17. 42 USC 1395ddd(c)(1)(ii); 42 CFR 489.24(d)(ii)(B); HCFA Interpreting Guidelines, V-29.
18. 42 USC 1395dd.
20. HCFA Interpreting Guidelines, V-21 to V-29.
25. 42 USC 1395ddd(c)(3).
28. Vargas v DBL Del Puerto Hospital, 98 F3d 1202 (9th Cir 1996); see also Repp v Anadarko Municipal Hospital, 43 F3d 519 (10th Cir 1994), holding that minimal variations from a hospital's policies and procedures do not equate to a per se violation of the law.
30. 42 USC 1395dd(c)(1)(B)(i); Cherukuri v Shalala, 1999 FED App 01606 (5th Cir).
32. 42 USC 1395ddd(c)(2).
33. 42 USC 1395ddd(c)(2)(A).
34. 42 USC 1395ddd(b)(1)(B).
35. 42 USC 1395ddd(c)(2)(D).
36. 42 USC 1395dd(c)(2)(D).
38. 42 USC 1395ddd(c)(2)(D).
39. 42 USC 1395ddd(c)(2)(D); 42 USC 1395dd(c)(2)(C); 42 CFR 489.24.
40. 42 USC 1395dd(c)(2).
41. Eg. 25 Tex Admin Code 133.101 and Texas Dept Health, Hospital Licensing Regulations, Ch 11, Section 2.10; NY Comp Codes R and Regs Title 4, Section 405.22(2)(X).
43. 42 USC 1395dd(c)(2)(D).
44. Wey v Evangelical Community Hospital, 833 F Supp 453 (MD Pa 1993).
45. Smith v James, 895 F Supp 875 (SD Miss 1995).
47. HCFA Interpreting Guidelines, V-33.
48. 42 USC 1395dd(c)(2)(D).
49. 42 USC 1395dd(c)(2)(D).
51. 42 USC 1395ddd(b).
52. 42 USC 1395cc(a)(1)(A)(i).
53. 42 USC 1395ddd(c); 42 CFR 489.24(d)(3).
54. 42 USC 1395ddd(b)(3); 42 CFR 489.24(c)(2).
55. 42 CFR 489.24(c).
56. 42 USC 1395ddd(b)(3).
57. 42 USC 1395dd(g).
60. 42 USC 1395cc(a)(1)(D)(v); 42 CFR 489.24(c); Inspector General v St Anthony Hospital, DAB No C-98-460, Department of HHS, Departmental Appeals Board, Civil Remedies Division (October 5, 1999).
61. 42 USC 1395cc(a)(1)(D)(v).
62. Inspector General v St Anthony Hospital, DAB No C-98-460, Department of HHS, Departmental Appeals Board, Civil Remedies Division (October 5, 1999), DAB DOCKET No A-2000-12/Decision No DAB1728, June 5, 2000. (Affirming administrative law judge decision and increasing the fine to $35,000 but determined the patient must be unstable at the time of transfer.)
63. 42 USC 1395dd(c)(2)(D).
64. Eg 25 Tex Admin Code 133.101(b)(8)(E).
65. 42 USC 1395cc(c)(2)(D).
68. With acknowledgment to Amy Parnitore, RN, former director of emergency department nursing at the Carolinas Medical Center, Charlotte, NC.
70. Thanks to Todd Taylor, MD, FACEP, and Arizona ACEP for their considerable help on this form.
71. 42 USC 1395cc(a)(1)(C)(v); 42 CFR 489.24(c); Inspector General v St Anthony Hospital, DAB No C-98-460, Department of HHS, Departmental Appeals Board, Civil Remedies Division (October 5, 1999).
72. 42 USC 1395ddd(g).
74. HCFA Interpreting Guidelines, V-34.
75. 42 CFR 489.24(b).
76. 59 Federal Register 32105 (1994); HCFA Interpreting Guidelines, V-23.
78. 59 Federal Register 32105 (1994). A hospital requested to accept a patient in transfer can refuse "if the individual seeking care does not require any treatment beyond the capabilities available at the transferring hospital."
79. 59 Federal Register 32105 (1994).
80. 59 Federal Register 32105 (1994); HCFA Interpreting Guidelines, V-34.
Transferring and Accepting Patients Under EMTALA

81. 42 USC 1395dd(g).
82. Inspector General v St Anthony Hospital, DAB No C-98-460, Department of HHS, Departmental Appeals Board, Civil Remedies Division (October 5, 1999). A hospital may not reject an appropriate transfer "regardless of whether some other hospital might be better suited to care for that individual."
83. Fla Stat Ann Section 395.1041(3)(e)
84. 42 USC 1395dd(b)(2)(D); HCFA Interpretive Guidelines, V-32.
85. 42 USC 1395dd(b).
86. 42 USC 1395cc(a)(1)(D)(ii); 42 CFR 489.200(c)(1).
87. 42 CFR 489.200(m).
88. 59 Federal Register 32106 (1994).
89. Fla Stat Ann Section 395.1041.
90. 42 CFR 489.24(f).
91. 59 Federal Register 32106-32107.
94. 42 USC 1395dd(i); 42 CFR 489.24(d)(3).
96. 59 Federal Register 32101 (1994).
97. 42 USC 1395dd(c)(2)(B).
98. 42 USC 1395dd(g); 59 Federal Register 32103 (1994).
99. 42 CFR 489.200(m).
100. 42 USC 1395cc(a)(1)(D)(ii).
102. Green v Touro Infirmary, 992 F.2d 537 (5th Cir. 1993); Delaney v Cade, 750 F Supp 1476 (D Kan 1991); Cheruburi v Shalala, 1999 FED App 0160P (6th Cir).
103. HCFA Interpretive Guidelines, V-25.
104. 59 Federal Register 32105 (1994).
106. 113 Congressional Record S13882 (October 23, 1985), statement of Sen. Durenberger.
108. Green v Touro Infirmary, 992 F.2d 537 (5th Cir. 1993); Delaney v Cade, 750 F Supp 1476 at 1486 (D Kan 1991).
109. 42 USC 1395dd(c)(1).
110. Eg, Summers v Baptist Medical Center Arlington, 91 F.3d 1132 (8th Cir 1996); Vickers v Nash General Hospital, Inc., 78 F.3d 139 (4th Cir 1996).
111. 42 CFR 482.21(b)(2).
113. Duke County v American Hospital of Miami, Inc., 502 So2d 1231 (Fla 1987).
114. Maher v Rat, 432 US 464 (1977); See also Harris v McRae, 448 US 297, 318 (1980).
115. 42 USC 1395cc(a)(1)(D)(ii).
116. 25 Tex Admin Code Section 133.101, and Texas Dept Health, Hospital Licensing Regulations, Ch 11, Section 2.10; NY Comp Codes R and Regs Title 4, Section 405.22(j)(2)(b).