TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A400	**§489.20 Basic Section 1866 commitments relevant to Section 1867 responsibilities.** The provider agrees-- (l) In the case of a hospital as defined in §489.24(b), to comply with §489.24.	INTERPRETIVE GUIDELINES: §489.20(l) §489.20(l) requires the provider to comply with §489.24. However §1866(a)(1)(I)(i) of the Act requires providers to adopt and enforce a policy to ensure compliance with the requirements of §1867 (§489.24). Non-compliance is a violation of the provider's agreement with the Health Care Financing Administration (HCFA). Therefore, if the provider violates §489.24, cite a corresponding violation of §489.20(l); but if the provider does not adopt and enforce procedures and policies to ensure compliance with §489.24, cite a violation of §1866(a)(1)(I)(i). o Check the bylaws/rules and regulations of the medical staff to determine if they reflect the requirements of §489.24 and the related requirements at §489.20. o Review the emergency department policies and procedure manuals for procedures related to the requirements of §489.24 and the related requirements at §489.20. The term "hospital" is defined in §489.24(b) as including a rural primary care hospital as defined in §1861(mm)(1) of the Act.
A401	(m) In the case of a hospital as defined in §489.24(b), to report to HCFA or the State survey agency any time it has reason to believe it may have received an individual who has been transferred in an unstable emergency medical condition from another hospital in violation of the requirements of §489.24(d).	INTERPRETIVE GUIDELINES: §489.20(m) Look for evidence that the receiving (recipient) hospital knew or suspected the individual had been to a hospital prior to the receiving (recipient) hospital and had not been transferred in accordance with §489.24(d). (Evidence may be obtained in the medical record or through interviews with the patient, family members or staff.) However, termination of the receiving (recipient) hospital should be suspended pending confirmation of the suspected offense. Review the emergency department log and medical records of patients received as transfers. Look for evidence that: o The hospital had agreed in advance to accept the transfers; o The hospital had received appropriate medical records; o All transfers had been effected through qualified personnel, transportation equipment and medically appropriate life support measures; and o The hospital had available space and qualified personnel to treat the patients.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A402	(q) In the case of a hospital as defined in §489.24(b)-- (1) To post conspicuously in any emergency department or in a place or places likely to be noticed by all individuals entering the emergency department, as well as those individuals waiting for examination and treatment in areas other than traditional emergency departments (that is, entrance, admitting area, waiting room, treatment area) a sign (in a form specified by the Secretary) specifying the rights of individuals under section 1867 of the Act with respect to examination and treatment for emergency medical conditions and women in labor; and (2) To post conspicuously (in a form specified by the Secretary) information indicating whether or not the hospital or rural primary care hospital participates in the Medicaid program under a State plan approved under Title XIX;	INTERPRETIVE GUIDELINES: §489.20(q) At a minimum: o The sign(s) must specify the rights of individuals with emergency conditions and women in labor who come to the emergency department for health care services; o It must indicate whether the facility participates in the Medicaid program; o The wording of the sign(s) must be clear and in simple terms and language that are understandable by the population served by the hospital; and o The sign(s) must be posted in a place or places likely to be noticed by all individuals entering the emergency department, as well as those individuals waiting for examination and treatment (e.g., entrance, admitting area, waiting room, treatment area).
A403	(r) In the case of a hospital as defined in §489.24(b) (including both the transferring and receiving hospitals), to maintain-- (1) Medical and other records related to individuals transferred to or from the hospital for a period of 5 years from the date of the transfer;	INTERPRETIVE GUIDELINES: §489.20(r)(1) The medical records of individuals transferred to or from the hospital must be retained in their original or legally-reproduced form in hard copy, microfilm, microfiche, optical disks, computer disks, or computer memory .

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A404	(2) A list of physicians who are on call for duty after the initial examination to provide further evaluation and/or treatment necessary to stabilize an individual with an emergency medical condition; and	INTERPRETIVE GUIDELINES: §489.20(r)(2) The purpose of the on-call list is to ensure that the emergency department is prospectively aware of which physicians, including specialists and subspecialists, are available to provide treatment necessary to stabilize individuals with emergency medical conditions. If a hospital offers a service to the public, the service should be available through on-call coverage of the emergency department. The medical staff by-laws or policies and procedures must define the responsibility of on-call physicians to respond, examine and treat patients with emergency medical conditions. Physicians, including specialists and subspecialists (e.g., neurologists) are not required to be on call at all times. The hospital must have policies and procedures to be followed when a particular specialty is not available or the on-call physician cannot respond because of situations beyond his or her control. Each hospital has the discretion to maintain the on-call list in a manner to best meet the needs of its patients. Physicians are not required to be on call in their specialty or subspecialty for emergencies whenever they are visiting their own patients in a hospital. Review the hospital's policy with respect to response time of the on-call physician. Hospitals are responsible for ensuring that on-call physicians respond within a reasonable period of time. Note the time of notification and the response (or transfer) time. If a staff physician is on-call to provide emergency services or to consult with an emergency room physician is in the area of his or her expertise, that physician would be considered to be available at the hospital. Where a physician is on-call in an office it is not acceptable to refer emergency cases to their offices for examination and treatment. The physician must come to the hospital to examine the patient unless the physician is a hospital-owned facility on contiguous land or on the hospital campus.. If a physician demonstrates a pattern of not arriving at the hospital while on-call, but directs the patient to be transferred to another hospital where that physician can treat the patient, this may be a violation.

A405	(3) A central log on each individual who "comes to the emergency department," as defined in §489.24(b), seeking assistance and whether he or she refused treatment, was refused treatment, or whether he or she was transferred, admitted and treated, stabilized and transferred, or discharged.	INTERPRETIVE GUIDELINES: §489.20(r)(3) The purpose of the central log is to track the care provided to each individual who comes to the hospital seeking care for an emergency medical condition. Each hospital has the discretion to maintain the central log in a form that best meets the needs of its patients. The central log includes, directly or by reference, patient logs from other areas of the hospital, such as pediatrics and labor and delivery where a patient might present for emergency services or receive a medical screening examination instead of in the emergency department. These additional logs must be available in a timely manner for surveyor review. Review the emergency department log covering at least a six month period that contains information on all patients coming to the emergency department and check for completeness, gaps in entries or missing information.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A405 (Cont.)		Select a sample of records from the past six months from the log for review to determine compliance with the §489.24 requirements, according to the sample size methodology in Task 2. Select an older sample if the case to be investigated occurred longer than six months ago, or if you are concerned about a possible long-term pattern of dumping.
	§489.24 Special responsibilities of Medicare hospitals in emergency cases.	**THE PROVISIONS OF THIS REGULATION APPLY TO ALL HOSPITALS THAT PARTICIPATE IN MEDICARE AND PROVIDE EMERGENCY SERVICES** Hospitals providing emergency services are required to provide for an appropriate medical screening examination; provide necessary stabilizing treatment for emergency medical conditions and labor; provide for an appropriate transfer of the patient if the hospital does not have the capability or capacity to provide the treatment necessary to stabilize the emergency medical condition; , not delay examination and/or treatment in order to inquire about the patient's insurance or payment status; accept appropriate transfers of patients with emergency medical conditions if the hospital has the specialized capabilities not available at the transferring hospital and has the capacity to treat those individuals; if the patient refuses examination, treatment, or transfer to obtain or attempt to obtain written and informed refusal of examination, treatment or appropriate transfer; and not take adverse action against a physician or qualified medical personnel who refuses to transfer a patient with an emergency medical condition, or against an employee who reports a violation of these requirements.
A406	(a) General. In the case of a hospital that has an emergency department,	INTERPRETIVE GUIDELINES: §489.24(a) A "hospital with an emergency department" is defined in paragraph (b) of this section as one which offers services for emergency medical conditions within its capability to do so. Lack of an established emergency department is not an indication that emergency services are not provided. If a hospital offers emergency services for medical, psychiatric or substance abuse emergency conditions, it is required, within its capability and capacity, to comply with all the anti-dumping statutory requirements. If a psychiatric hospital offers services for medical, psychiatric, or substance abuse emergency conditions, it is obligated to comply with all of the anti-dumping requirements of §§489.20 and 489.24. Most psychiatric hospitals are accredited by the Joint Commission and have an emergency department which provides reasonable care in determining whether an emergency exists, renders life saving first aid, and makes appropriate referrals to the nearest organizations that are capable of providing needed services. The emergency department must have a mechanism for providing physician coverage at all times.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A406 (Cont.)	If any individual (whether or not eligible for Medicare benefits and regardless of ability to pay) comes by him or herself or with another person to the emergency department and a request is made on the individual's behalf for examination or treatment of a medical condition by qualified medical personnel (as determined by the hospital in its rules and regulations), the hospital must provide for an appropriate MEDICAL SCREENING EXAMINATION within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department	Emergency services need not be provided in a location specifically identified as an emergency room or an emergency department. If an individual arrives at a hospital and is not technically in the emergency department, but is on the premises (including the parking lot, sidewalk and driveway) of the hospital and requests emergency care, he or she is entitled to a medical screening examination. For example, it may be the hospital's policy to direct all pregnant women to the labor and delivery area of the hospital. Hospitals may use areas to deliver emergency services which are also used for other inpatient or outpatient services. Medical screening examinations or stabilization may require ancillary services available only in areas or facilities of the hospital outside of the emergency department. As long as the patient is directed to a hospital-owned facility which is contiguous (i.e., any area within the hospital or a hospital-owned facility on land that touches land where a hospital's emergency department sits) or is part of the hospital "campus" and is owned by the hospital, and is operating under the hospital's provider number, the hospital is complying with §1867. Physicians' offices may be defined as such a facility, provided they are located in a hospital-owned building which is contiguous or located in a hospital-owned building which is"on campus." For example, a patient who presents to the emergency department could be sent to whatever hospital-owned contiguous or on-campus facility that the hospital deemed appropriate to conduct or complete the medical screening examination as long as (1)all persons with the same medical condition are moved to this location, regardless of their ability to pay for the treatment; (2)there is a bona fide medical reason to move the patient; and (3) qualified medical personnel accompany the patient. If the patient was initially screened in a facility outside of the emergency department, the patient could be moved to another hospital-owned contiguous or hospital-owned on-campus facility to receive additional screening or for stabilization without such movement being regarded as a transfer, as long as (1) all persons with the same medical condition are moved in such circumstances, regardless of their ability to pay for treatment; (2) there is a bona fide medical reason to move the patient; and (3) qualified medical personnel accompany the patient. If a patient comes to any contiguous or on-campus facility of a hospital that has one or more hospital-owned non-contiguous or off-campus facilities (such as an urgent care center or satellite clinic), the medical screening examination must be performed within the contiguous or on-campus facilities of the hospital. The hospital should not move the patient to a non-contiguous or off-campus facility for the medical screening examination.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A406 (Cont.)		If a patient comes to a hospital-owned facility which is non-contiguous or off-campus and operates under the hospital's Medicare provider number, §1867 applies to that facility. The facility must therefore screen and stabilize the patient to the best of its ability or execute an appropriate transfer according to §1867 guidelines if necessary. If an individual is not on hospital property, this regulation is not applicable. Hospital property includes ambulances owned and operated by the hospital, even if the ambulance is not on hospital grounds. An individual in a nonhospital-owned ambulance which is on hospital property is considered to have come to the hospital's emergency department. An individual in a nonhospital-owned ambulance not on "Hospital A's" property is not considered to have come to "Hospital A's" emergency department when the ambulance personnel contact "Hospital A" by telephone or telemetry communications. A hospital may deny access to patients when it is in "diversionary" status because it does not have the staff or facilities to accept any additional emergency patients at that time. However, if the ambulance disregards the hospital's instructions and brings the individual on to hospital grounds, the individual has come to the hospital and the hospital cannot deny the individual access to hospital services. Should a hospital which is not in diversionary status fail to accept a telephone or radio request for transfer or admission, the refusal could represent a violation of other Federal or State requirements (e.g., Hill-Burton). If you suspect a violation of related laws, refer the case to the responsible agency for investigation.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A406 (Cont)		Hospitals are obligated to screen patients to determine if an emergency medical condition exists. It is not appropriate to merely "log in" a patient and not provide a medical screening examination. Medicare participating hospitals that provide emergency services must provide a medical screening examination to any individual regardless of diagnosis (e.g., labor, AIDS), financial status (e.g., uninsured Medicaid), race, color, national origin (e.g., Hispanic or Native American surnames), handicap, etc. Individuals coming to the emergency department must be provided a medical screening examination beyond initial triaging. Triage is not equivalent to a medical screening examination. Triage merely determines the "order" in which patients will be seen, not the presence or absence of an emergency medical condition. A hospital, regardless of size or patient mix, must provide screening and stabilizing treatment within the scope of its abilities, as needed, to the individuals with emergency medical conditions who come to the hospital for examination and treatment. The medical screening examination must be the same medical screening examination that the hospital would perform on any individual coming to the hospital's emergency department with those signs and symptoms, regardless of the individual's ability to pay for medical care. If the medical screening examination is appropriate and does not reveal an emergency medical condition, the hospital has no further obligations under 42 CFR 489.24. Regardless of a positive or negative patient outcome, a hospital would be in violation of the anti-dumping statute if it fails to meet any of the medical screening requirements under 42 CFR 489.24. A medical screening examination is the process required to reach with reasonable clinical confidence, the point at which it can be determined whether a medical emergency does or does not exist. If a hospital applies in a nondiscriminatory manner (i.e., a different level of care must not exist based on payment status, race, national origin) a screening process that is reasonably calculated to determine whether an emergency medical condition exists, it has met its obligations under the Emergency Medical Treatment and Labor Act (EMTALA). Depending on the patient's presenting symptoms, the medical screening examination represents a spectrum ranging from a simple process involving only a brief history and physical examination to a complex process that also involves performing ancillary studies and procedures such as (but not limited to) lumbar punctures, clinical laboratory tests, CT scans, and/or diagnostic tests and procedures. A medical screening examination is not an isolated event. It is an ongoing process. The record must reflect continued monitoring according to the patient's needs and must continue until he/she is stabilized or appropriately transferred. There should be evidence of this evaluation prior to discharge or transfer.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A406 (Cont.)		The clinical outcome of an individual's condition is not a proper basis for determing whether an appropriate screening was provided or whether a person transferred was stabilized. However, it may be a "red flag" indicating a more thorough investigation is needed. Do not make decisions base on clinical information that was not available at the time of stabilization or transfer. If a misdiagnosis occurred, but the hospital utilized all of its resources, a violation of the screening requirement did not occur. A hospital may not refuse to screen an enrollee of a managed care plan because the plan refuses to authorize treatment or to pay for such screening and treatment. Likewise, the managed care plan cannot refuse to screen and treat or appropriately transfer individuals not enrolled in the plan who come to a plan hospital that participates in the Medicare program. It is not appropriate for a hospital to request or a health plan to require prior authorization before the patient has received a medical screening exam to determine the presence or absence of an emergency medical condition or until an existing emergency medical condition has been stabilized. Once an emergency medical condition has been determined not to exist or the emergency medical condition has been stabilized, §1867 of the Act no longer applies and prior authorization for further services can be sought. (NOTE: Background issue on Payment: Once a patient has presented to the hospital seeking emergency care, the determination of whether an emergency medical condition exists is made by the examining physician(s) or other qualified medical person actually caring for the patient at the treating facility, not the managed care plan. Beneficiaries have a right to emergency services if they have symptoms of sufficient severity (which may include severe pain) and sudden onset, and they are acting reasonably, given their knowledge, experiences, and state of mind.)

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A406 (Cont.)		Prearranged community or State plans which identify certain hospitals that will care for selected individuals (e.g., Medicaid patients, psychiatric patients, pregnant women; (see tag A407)) do not relieve other hospitals of the obligation to comply with the screening and treatment requirements of §489.24 before appropriately transferring the individual. If a screening examination reveals an emergency medical condition and the individual is told to wait for treatment, but the individual leaves the hospital, the hospital did not "dump" the patient unless: o The individual left the emergency department based on a "suggestion" by the hospital, and/or o The individual's condition was emergent, but the hospital was operating beyond its capacity and did not attempt to transfer the individual to another facility. Hospital resources and staff available to inpatients at the hospital for emergency services must likewise be available to individuals coming to the hospital for examination and treatment of emergency medical conditions because these resources are within the capability of the hospital. For example, a woman in labor who presents at a hospital providing obstetrical services must be treated with the resources available, whether or not the hospital normally provides unassigned emergency obstetrical services. If a hospital chooses to meet its responsibility to provide adequate medical personnel to meet its anticipated emergency needs by using on-call physicians either to staff or to augment its emergency department, then the capability of its emergency department includes the services of its on-call physicians.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A406 (Cont.)	to determine whether or not an emergency medical condition exists.	"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in: o Placing the health of the individual (or, with respect to a pregnant woman, the health of a woman or her unborn child) in serious jeopardy; o Serious impairment to any bodily functions; o Serious dysfunction of any bodily organ or part; or o With respect to a pregnant woman who is having contractions: -- That there is inadequate time to effect a safe transfer to another hospital before delivery, or -- That the transfer may pose a threat to the health or safety of the woman or the unborn child. Psychiatric hospitals that provide emergency services are obligated under these regulations to respond within the limits of their capabilities. Some intoxicated individuals may meet the definition of "emergency medical condition" because the absence of medical treatment may place their health in serious jeopardy, result in serious impairment of bodily functions, or serious dysfunction of a bodily organ. Further, it is not unusual for intoxicated individuals to have unrecognized trauma. Likewise, an individual expressing suicidal or homicidal thoughts or gestures, if determined dangerous to self or others, would be considered to have an emergency medical condition.
A406 (Cont.)	The examinations must be conducted by individuals determined qualified by hospital bylaws or rules and regulations and who meet the requirements of §482.55 concerning emergency services personnel and direction.	This delegation should be set forth in a document approved by the governing body of the hospital. If the rules and regulations of the hospital are approved by the board of trustees or other governing body, those personnel qualified to perform these examinations may be set forth in the rules and regulations, instead of placing this information in the hospital by-laws. It is not acceptable for the hospital to allow informal personnel appointments that could frequently change.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
	(c) Necessary stabilizing treatment for emergency medical conditions and labor --	"Labor", as defined in paragraph (b) of this section, means the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman is in true labor unless a physician or qualified individual certifies that, after a reasonable time of observation, the woman is in false labor.
A407	(1) General. If any individual (whether or not eligible for Medicare benefits) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either-- (I) Within the capabilities of the staff and facilities available at the hospital,	INTERPRETIVE GUIDELINES : §489.24(c)(I) A managed health care plan (e.g., HMO, PPO) cannot deny a hospital permission to treat its enrollees. It may only state what it will or will not pay for. Regardless of whether a hospital will be paid, it is obligated to provide the services specified in the statute and this regulation. Capabilities of a medical facility means that there is physical space, equipment, supplies, and services that the hospital provides (e.g., surgery, psychiatry, obstetrics, intensive care, pediatrics, trauma care). Capabilities of the staff of a facility means the level of care that the personnel of the hospital can provide within the training and scope of their professional licenses. The capacity to render care is not reflected simply by the number of persons occupying a specialized unit, the number of staff on duty, or the amount of equipment on the hospital's premises. Capacity includes whatever a hospital customarily does to accommodate patients in excess of its occupancy limits §489.24(b). If a hospital has customarily accommodated patients in excess of its occupancy limits by whatever means (e.g., moving patients to other units, calling in additional staff, borrowing equipment from other facilities) it has, in fact, demonstrated the ability to provide services to patients in excess of its occupancy limits. The by-laws, protocols and medical staff appointments approved by the governing body should require that all individuals are screened and stabilized within the capability of the hospital and should specify which staff members (by position) are authorized to perform the treatment. A hospital may appropriately transfer an individual before the sending hospital has used and exhausted all of its resources available if the individual requests the transfer to another hospital for his or her treatment, and refuses treatment at the sending hospital. (See Tag A409.) If a community-wide plan exists for certain hospitals to treat certain emergency medical conditions, then the individual should be screened, stabilized, or appropriately transferred to the community-plan hospital.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A407 (Cont.)	for Further Medical Examination and Treatment as required to stabilize the medical condition; or	Compliance with the medical screening examination and stabilization requirements under §1867 mandate that all patients with similar medical conditions be treated consistently. In some cases, local, State, or regionally-approved emergency medical systems (EMS), point-of-entry, and/or system protocols are in place. Compliance with EMS protocols with respect to the transport of emergent patients is usally deemed to indicate compliance with §1867; however a copy of the protocol should be obtained and reviewed at the time of the survey. If a hospital complies with other regional authority or State or locally approved point-of-entry protocols for emergency care (e.g., for psychiatric emergencies or physicial or sexual abuse) then the hospital is usually in compliance with §1867of the Act, as long as the hospital ensures that the patient is stable for transfer. If the individual seeking care is a member an HMO or CMP, the hospital's obligation to comply with the requirements of §489.24 is not affected. "To stabilize," as defined in paragraph (b) of this section means, with respect to an emergency medical condition, to either provide such medical treatment of the condition necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility, or that the woman has delivered the child and the placenta. A patient will be deemed stabilized if the treating physician attending to the patient in the emergency department/hospital has determined, within reasonable clinical confidence, that the emergency medical condition has been resolved. For patients whose emergency medical condition has not been resolved, the determination of whether they are stable "medically" may occur in one of the following two circumstances: o For purposes of transferring a patient from one facility to a second facility "stable for transfer"; and o For purposes of discharging a patient other than for the purpose of transfer from one facility to another facility "stable for discharge". For transfer between facilities: a patient is stable for transfer if the patient is transferred from one facility to a second facility and the treating physician attending to the patient has determined, within reasonable clinical confidence, that the patient is expected to leave the hospital and be received at the second facility, with no material deterioration in his/her medical condition; and the treating physician reasonably believes the receiving facility has the capability to manage the patient's medical condition and any reasonably foreseeable complication of that condition. If there is a disagreement between the treating physician and an off-site physician (e.g., a physician at the receiving facility or the patient's primary care physician if not physically present at the first facility)about whether a patient is stable for transfer, the medical judgment of the treating physician usually takes precedence over that of the off-site physician.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A407 (Cont.)		If a physician is not physically present at the time of transfer, then qualified personnel (as determined by hospital bylaws or other board-approved documents) in consultation with a physician can determine if a patient is stable for transfer. The failure of a receiving facility to provide the care it maintained it could provide to the patient when the transfer was arranged, should not be construed to mean the patient's condition worsened as a result of the transfer.
	for **FURTHER MEDICAL EXAMINATION AND TREATMENT** as required to stabilize the medical condition; or	A patient is considered stable for discharge (vs. for transfer from one facility to a second facility) when, within reasonable clinical confidence, it is determined that the patient has reached the point where his/her continued care, including diagnostic work-up and/or treatment, could be reasonable performed as an outpatient or later as an inpatient, provided the patient is given a plan for appropriate follow-up care with the discharge instructions. For purposes of transferring a patient from one facility to a second facility, for psychiatric conditions, the patient is considered to be stable when he/she is protected and prevented from injuring himself/herself or others. For purposes of discharging a patient (other than for the purpose of transfer from one facility to a second facility), for psychiatric conditions, the patient is considered to be stable when he/she is no longer considered to be a threat to him/herself or to others. "Stable for transfer" or "Stable for discharge" does not require the final resolution of the emergency medical condition. Hospitals may not circurnvent the requirements in §489.24 by admitting individuals with emergency medical conditions to other departments of the hospital and then discharging them prior to stabilization. These requirements apply to all areas of the hospital.
	(ii)For transfer of the individual to another medical facility in accordance with paragraph (d) of this section.	"Transfer" as defined in paragraph (b) of this section, means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who has been declared dead or leaves the facility without the permission of any such person. If discharge would result in the reasonable medical probability of material deterioration of the patient, the emergency medical condition should not be considered to have been stabilized. When a hospital has exhausted all of its capabilities in attempting to remove the emergency medical condition, it must effect an appropriate transfer of the individual. (See Tag A409)

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A407 (Cont.)	(2) Refusal to consent to treatment. A hospital meets the requirements of paragraph (c)(1)(i) of this section with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of the examination and treatment, but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and treatment. The medical record must contain a description of the examination, treatment, or both if applicable, that was refused by or on behalf of the individual. The hospital must take all reasonable steps to secure the individual's written informed refusal (or that of a person acting in his or her behalf). The written document should indicate that the person has been informed of the risks and benefits of the examination or treatment, or both.	Emergency medical conditions must be stabilized. If a woman is in labor, the hospital must deliver the baby or transfer appropriately. She may not be transferred unless she, or a legally responsible person acting on her behalf, requests a transfer or if a physician or other qualified medical personnel, in consultation with a physician, certifies that the benefits to the condition of the woman and/or the unborn child outweigh the risks associated with the transfer. If the individual's condition requires immediate medical stablizing treatment and the hospital is not able to attend to that individual because the emergency department is operating beyond its capacity, then the hospital should transfer the individual to a facility that has the capability and capacity to treat the individual's emergency medical condition, it possible. INTERPRETIVE GUIDELINES: §489.24(c)(2) The medical record should reflect that screening, further examination, and/or treatment was offered by the hospital prior to the individual's refusal. In the event an individual refuses to consent to further examination or treatment, the hospital must indicate in writing the risks/benefits of the examination and/or treatment; the reasons for refusal; a description of the examination or treatment that was refused; and the steps taken to try to secure the written, informed refusal if it was not secured. Hospitals may not attempt to coerce individuals into making judgments against their best interest 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 to another hospital. A hospital cannot be left without recourse if an individual refuses treatment, refuses to sign a statement to that effect, and leaves against medical advice. Hospitals may document such refusals as they see fit. An individual may only refuse examination, treatment, or transfer on behalf of the patient if the patient is incapable of making an informed choice for him/herself.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A408	(3) Delay in examination or treatment. A participating hospital may not delay providing an appropriate medical screening examination required under paragraph (a) of this section or further medical examination and treatment required under paragraph (c) in order to inquire about the individual's method of payment or insurance status.	INTERPRETIVE GUIDELINES: §489.24(c)(3) Hospitals should not delay in providing a medical screening examination or necessary stabilizing treatment by inquiring about an individual's ability to pay for care. All individuals who have an emergency medical condition must be served, regardless of the answers the individual may give to the insurance questions asked during the registration process. In addition, a hospital may not delay screening or treatment to any individual while it verifies the information provided. However, hospitals may continue to follow reasonable registration processes for individuals presenting with an emergency medical condition. Reasonable registration processes may include requesting information about insurance as long as these procedures do not delay screening or treatment. If a delay in screening was due to an unusual internal crisis whereby it was simply not within the capability of the hospital to provide an appropriate screening examination at the time the individual came to the hospital (e.g., mass casualty occupying all the hospital's resources for a time period), interviews with staff members should elicit this information. This requirement applies equally to both the referring and the receiving (recipient) hospital.
A409	(d) Restricting transfer until the individual is stabilized.-- (1) General. If an individual at a hospital has an emergency medical condition that has not been stabilized (as defined in paragraph (b) of this section), the hospital may not transfer the individual unless-- (i) The transfer is an appropriate transfer (within the meaning of paragraph (d)(2) of this section); and	INTERPRETIVE GUIDELINES: §489.24(d)(1) (See the definition of “Stable for transfer” at Tag A407) INTERPRETIVE GUIDELINES: §489.24(d)(1)(i) There are 4 requirements of an "appropriate" transfer. These requirements are found in §§489.24(d)(2)(i), 489.24(d)(2)(ii), 489.24(d)(2)(iii), and 489.24(d)(2)(iv).

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A409 (Cont.)	(ii)(A) The individual (or a legally responsible person acting on the individual's behalf) requests the transfer after being informed of the hospital's obligations under this section and of the risk of transfer. The request must be in writing and indicate the reasons for the request as well as indicate that he or she is aware of the risks and benefits of the transfer;	INTERPRETIVE GUIDELINES: §489.24(d)(1)(ii)(A) The request must contain a brief statement of the hospital's obligations under the statute and the benefits and risks that were outlined to the person signing the request. Any transfer of an individual with an emergency medical condition must be initiated by either a written request for transfer or a physician's certification. If both are provided (as is often the case), the individual must still be informed of the risks vs. benefits of the transfer. The request must be made a part of the individual's medical record, and a copy of the request should be sent to the receiving (recipient) facility along with the individual transferred. If an individual's request for transfer is obtained by coercion or by misrepresenting the hospital's obligations to provide a medical screening examination and treatment for an emergency medical condition or labor, the request does not meet the hospital's obligations under these regulations.
A409 (Cont.)	(ii)(B) A physician (within the meaning of §1861(r)(1) of the Act) has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the unborn child, from being transferred. The certification must contain a summary of the risks and benefits upon which it is based; or	INTERPRETIVE GUIDELINES: §489.24(d)(1)(ii)(B) Section 1861(r) of the Act defines physicians as: (i) A doctor of medicine or osteopathy. (This provision is not to be construed to limit the authority of a doctor of medicine or osteopathy to delegate tasks to other qualified health care personnel to the extent recognized under State law or a State's regulatory mechanism); (ii) A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State and who is acting within the scope of his or her license; (iii) A doctor of podiatric medicine, but only with respect to functions which he or she is legally authorized by the State to perform; (iv) A doctor of optometry who is legally authorized to practice optometry by the State, but only with respect to services related to the condition of aphakia; or (v) A chiropractor who is licensed by the State or legally authorized to perform the services of a chiropractor, but only with respect to treatment by means of manual manipulation of the spine to correct a subluxation demonstrated by X-ray to exist.

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A409 (Cont.)		The regulation requires an express written certification. Physician certification cannot simply be implied from the findings in the medical record and the fact that the patient was transferred. The certification must state the reason(s) for transfer. The narrative rationale need not be a lengthy discussion of the individual's medical condition reiterating facts already contained in the medical record, but it should give a complete picture of the benefits to be expected from appropriate care at the receiving (recipient) facility and the risks associated with the transfer, including the time away from an acute care setting necessary to effect the transfer. This rationale may be on the certification form or in the medical record. In cases where the individual's medical record does not include a certification, give the hospital the opportunity to retrieve the certification. Certifications may not be backdated. Document the hospital's response. Regardless of practices within a State, a woman in labor may be transferred only if she or her representative requests the transfer or if a physician or other qualified medical personnel signs a certification that the benefits outweigh the risks. If the hospital does not provide obstetrical services, the benefits of a transfer may outweigh the risks. A hospital cannot cite State law or practice as the basis for the transfer. Hospitals that are not capable of handling high-risk deliveries or high-risk infants often have written transfer agreements with facilities capable of handling high-risk cases. The hospital must still meet the screening, treatment, and transfer requirements. The certification that the benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the risk of the transfer is not required for transfers of individuals who no longer have an emergency medical condition. The date and time of the physician certification should closely match the date and time of the transfer.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A409 (Cont.)	(c) If a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as determined by the hospital in its by-laws or rules and regulations) has signed a certification described in paragraph (d)(1)(ii)(B) of this section after a physician (as defined in section 1861(r)(1) of the Act), in consultation with the qualified medical person, agrees with the certification and subsequently countersigns the certification. The certification must contain a summary of the risks and benefits upon which it is based.	INTERPRETIVE GUIDELINES: §489.24(d)(1)(C) Individuals other than physicians may sign the certification of benefits versus risks of a transfer. These individuals must be identified in hospital bylaws, rules and regulations, or another board-approved document . If a certification of benefits versus risks was signed by a qualified medical person, a physician's countersignature must be present. Hospital by-laws or policies and procedures will describe the maximum amount of time allowed to obtain physician countersignatures on hospital documents.
	(d)(2) A **TRANSFER** to another medical facility will be **APPROPRIATE** only in those cases in which-- (i) The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;	INTERPRETIVE GUIDELINES: §489.24(d)(2)(i) This is the first requirement of an appropriate transfer. The provision of treatment to minimize the risks of transfer is merely one of the 4 requirements of an appropriate transfer. If the patient requires treatment, it must be sufficient so that no material deterioration is likely to occur or result from the transfer. NOTE: The 4 requirements of an "appropriate" transfer are applied only if the transfer is to another medical facility. In other words, the hospital has the alternative of either (1) providing treatment to stabilize the emergency medical condition and subsequently discharging or transferring the individual, or (2) appropriately transferring an unstabilized individual to another medical facility if the emergency medical condition still exists. There is no "third" option of simply "referring" the individual away after performing step one (treatment to minimize the risk of transfer) of the 4 transfer requirements of an appropriate transfer.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A409 (Cont.)		If a patient is moved to another part of the hospital, the transfer requirements are not applicable because technically the patient has not been transferred. If an individual is moved to a diagnostic facility owned by another hospital with the intention of returning to the first hospital, an appropriate transfer (within the meaning of paragraph (d)(2) of this subsection) must still be effectuated. For example, when Hospital A shares a CT Scanner with Hospital B (Hospital B houses the CT Scanner), if Hospital A sends the individual to Hospital B for a CT scan as part of the appropriate medical screening examination to determine whether the individual has an emergency medical condition, the appropriate transfer requirements must be met. After the investigation of the transferring hospital, call or go to the receiving (recipient) facility and determine whether the receiving (recipient) facility verifies the transferring hospital's information. In cases of discrepancy, obtain the medical record from the transferring and receiving hospitals and the ambulance service for review. Review each hospital's information. If you determine that it is necessary to conduct a complaint investigation at the receiving (recipient) hospital, notify the RO to request an extension of the investigation timeframe. Review the transfer logs for the entire hospital, not merely the emergency department. Examine the following for appropriate transfers: o Transfers to off-site testing facilities and return; o Death or significant adverse outcomes; o Refusals of examination, treatment, or transfer; o Patients leaving against medical advise (AMA); o Returns to the emergency department within 48 hours; and o Emergency department visits where the patient is logged in for an unreasonable amount of time before the time indicated for commencement of the medical screening examination.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A409 (Cont.)	(ii) The receiving facility -- (A) Has available space and qualified personnel for the treatment of the individual; and (B) Has agreed to accept transfer of the individual and to provide appropriate medical treatment;	INTERPRETIVE GUIDELINES: §489.24(d)(2)(ii) This is the second requirement of an appropriate transfer. The transferring hospital must obtain permission from the receiving (recipient) hospital to transfer an individual. The transferring hospital should document its communication with the receiving (recipient) hospital, including the date and time of the transfer request and the name of the person accepting the transfer.
A409 (Cont.)	(iii) The transferring hospital sends to the receiving facility all medical records (or copies thereof) related to the emergency condition which the individual has presented that are available at the time of the transfer, including available history, records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) required under paragraph (d)(1)(ii) of this section, and the name and address of any on-call physician (described in paragraph (f) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment. Other records (e.g., test results not yet available or historical records not readily available from the hospital's files) must be sent as soon as practicable after transfer; and	INTERPRETIVE GUIDELINES: §489.24(d)(2)(iii) This is the third requirement of an appropriate transfer. Individuals being transferred to another hospital must be accompanied by necessary medical records. To the extent that services are performed before transfer, those services should be reflected in the medical records transferred. If transfer is in an individual's best interest, it should not be delayed until records are retrieved or test results come back from the laboratory. Whatever medical records are available at the time the individual is transferred should be sent to the receiving (recipient) hospital with the patient. Test results that become available after the individual is transferred should be telephoned to the receiving (recipient) hospital, and then mailed or sent via electronic transmission.
A409 (Cont.)	(iv) The transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.	INTERPRETIVE GUIDELINES: §489.24(d)(2)(iv) This is the fourth requirement of an appropriate transfer. Emergency medical technicians may not always be "qualified personnel" for purposes of transferring an individual under these regulations. Depending on the individual's condition, there may be situations in which a physician's presence or some other specialist's presence might be mandatory. The physician at the sending hospital (and not the receiving hospital) has the responsibility to determine appropriate mode, equipment, and attendants for transfer.

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A409 (Cont.)		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.
	(4) Refusal to consent to transfer. A hospital meets the requirements of paragraph (c)(1)(ii) of this section with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with paragraph (d) of this section and informs the individual (or a person acting on his or her behalf) of the risks and benefits to the individual of the transfer, but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer. The hospital must take all reasonable steps to secure the individual's written informed refusal (or that of a person acting on his or her behalf). The written document must indicate the person has been informed of the risks and benefits of the transfer and the reasons for the individual's refusal. The medical record must contain a description of the proposed transfer that was refused by or on behalf of the individual.	INTERPRETIVE GUIDELINES: §489.24(c)(4) A hospital cannot be left without recourse if an individual or the individual's representative refuses transfer and also refuses to sign a statement to that effect. Hospitals may document such refusals as they see fit.
A410	(3) A participating hospital may not penalize or take adverse action against a physician or a qualified medical person described in paragraph (d)(1)(ii)(C) of this section because the physician or qualified medical person refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized, or against any hospital employee because the employee reports a violation of a requirement of this section.	INTERPRETIVE GUIDELINES: §489.24(d)(3) A "participating hospital" means a hospital that has entered into a provider agreement under §1866 of the Act.

TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
A411	(e) Recipient hospital responsibilities. A participating hospital that has specialized capabilities or facilities (including, but not limited to such facilities as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers) may not refuse to accept from a referring hospital within the boundaries of the United States, an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual.	INTERPRETIVE GUIDELINES: §489.24(e) Recipient hospitals only have to accept the patient if the patient requires the specialized capabilities of the hospital in accordance with this section. 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. If the patient required the specialized capabilities of the intended receiving (recipient) hospital, and the hospital had the capability and capacity to accept the transfer but refused, this requirement has been violated. Lateral transfers, that is, transfers between facilities of comparable resources, are not sanctioned by §489.24 because they would not offer enhanced care benefits to the patient except where there is a mechanical failure of equipment, no ICU beds available, or similar situations. However, if the sending hospital has the capability but not the capacity, the individual would most likely benefit from the transfer. The number of patients that may be occupying a specialized unit, the number of staff on duty, or the amount of equipment on the hospital's premises do not in and of themselves reflect the capacity of the hospital to care for additional patients. If a hospital generally has accommodated additional patients by whatever means (e.g., moving patients to other units, calling in additional staff, borrowing equipment from other facilities), it has demonstrated the ability to provide services to patients in excess of its occupancy limit. For example, a hospital may be able to care for one or more severe burn patients without opening up a "burn unit." In this example, if the hospital has the capacity, the hospital would have a duty to accept an appropriate transfer of an individual requiring the hospital's capabilities, provided the transferring hospital lacked the specialized services to treat the individual. The provisions of this requirement are applicable only when the sending hospital is located within the boundaries of the United States. Medicare participating hospitals with specialized capabilities or facilities are not obligated to accept transfers from hospitals located outside of the boundaries of the United States. RURAL REGIONAL REFERRAL CENTERS The criteria for classifying hospitals as rural regional referral centers have been defined in 42 CFR 412.96 for the purpose of exemptions and adjustments of payment amounts under the Prospective Payment System. The criteria in 42 CFR 412.96 are applicable to the nondiscrimination provisions of §489.24. Check with the Division of Medicaid and State Operations in the appropriate HCFA RO for information as to whether the hospital is designated as a rural regional referral center. A designated rural regional referral center is obligated to accept appropriate transfers of individuals who require the hospital's specialized capabilities if the hospital has the capacity to treat the individual.