Quick Reference

INTRODUCTION

AUTHOR ACKNOWLEDGMENTS

WHERE TO FIND LAWS REFERENCED IN THE MANUAL

LIST OF ACRONYMS

CHAPTERS

Chapter 1  Overview of Patient Anti-Dumping Laws
Chapter 2  When and Where Does EMTALA Begin and End?
Chapter 3  Medical Screening Examinations
Chapter 4  Financial Considerations — EMTALA and Managed Care
Chapter 5  Transferring or Discharging an Emergency Patient
Chapter 6  EMTALA and Psychiatric Emergency Patients
Chapter 7  Obligations of Receiving Hospitals
Chapter 8  Patient Refusal of Stabilizing Treatment or Transfer
Chapter 9  Maintenance of the Central Log
Chapter 10  Required Signage
Chapter 11  Physician On-Call Responsibilities
Chapter 12  Reporting Patient-Dumping Violations
Chapter 13  Regulatory Enforcement of EMTALA
Chapter 14  Private Actions to Enforce EMTALA
Chapter 15  Quality Improvement and Risk Management
Chapter 16  Application of EMTALA to Disasters and Public Health Emergencies

INDEX

APPENDIXES

Appendix A  EMTALA Statute
Appendix B  EMTALA and Emergency-Related Federal Regulations
Appendix C  EMTALA Interpretive Guidelines (Part II: Responsibilities of Medicare Participating Hospitals in Emergency Cases)
Appendix D  California Hospital Licensing Laws on Emergency Services and Care
Appendix E  CoP for Emergency Services: Hospital Interpretive Guidelines
Appendix F  Knox-Keene Act Provisions
Appendix G  Medicare Advantage Regulations
Appendix H  Special Advisory Bulletin
Appendix I  EMTALA Enforcement Chart
Appendix J  Hospital Records Subject to EMTALA Enforcement Survey
Appendix K  Investigative Procedures for EMTALA Surveyors (Part I of EMTALA Interpretive Guidelines)
Appendix L  Sample Survey Tools for Patient Transfers and Medical Screening Examinations
Appendix M  An Explanation of the Scope of RN Practice Including Standardized Procedures
Appendix N  Policies Recommended for EMTALA Compliance
Appendix O  Model Hospital Policy on Compliance with EMTALA
Appendix P  CHA Transfer Forms and Model Signage
Appendix Q  CMS Survey and Certification Memorandum 08-08: Requirements for Off-Campus Emergency Departments (Jan. 11, 2008)
Appendix R  CMS Survey and Certification Memorandum 09-52: EMTALA Options in a Disaster (Aug. 14, 2009)
Appendix S  Sample Transfer Agreement
Appendix T  Sample Transfer Checklist and Script for Accepting Emergency Patients
Appendix U  CDPH All-Facility Letter 12-17 (May 17, 2012)
Appendix V  CMS Letter Regarding Transfer of Patients to Crisis Stabilization Units
Appendix W  EMTALA Physician Review Worksheet
Appendix X  CMS Survey and Certification Memorandum 14-06: EMTALA Requirements & Conflicting Payor Requirements or Collection Practices (Dec. 13, 2013)
Appendix Y  CMS Survey and Certification Memorandum 13-38: Critical Access Hospital Emergency Services and Telemedicine (June 7, 2013)
Appendix Z  CMS Survey and Certification Memoranda 06-21 and 07-20: Detaining EMS Personnel and Equipment (July 13, 2006 and April 27, 2007)
Introduction

EMTALA — A Guide to Patient Anti-Dumping Laws, 9th edition (2017), provides guidance to hospitals and physicians on compliance with the Emergency Medical Treatment and Labor Act (EMTALA). Where applicable, the EMTALA manual also addresses California hospital licensing, involuntary commitment and managed care laws regarding the provision of emergency services and post-stabilization care.

Since the adoption of the initial EMTALA regulations in 1994, the U.S. Department of Health and Human Services (HHS) has committed extensive resources to enforcing EMTALA. The Centers for Medicare & Medicaid Services (CMS) is charged with the administrative interpretation and enforcement of EMTALA. As discussed in a 2001 HHS Office of Inspector General (OIG) report, the number of EMTALA investigations and their outcomes vary widely by CMS region; however, administrative enforcement by CMS Region IX (California, Arizona, Hawaii and Nevada) has been among the more active in the nation. In addition, the OIG has the authority to enforce EMTALA against hospitals and physicians by imposing civil money penalties or exclusion from the Medicare and Medicaid programs. In 2017, the civil penalties for an EMTALA violation were updated for inflation which increased sanctions to over $100,000 for an EMTALA violation (more than $50,000 for a hospital under 100 beds).

Despite three decades of experience with EMTALA, there is still considerable confusion by hospitals, physicians, state survey agencies, and even some CMS officials, on the scope and application of the law. In 1994 and 2000, CMS expanded the scope of EMTALA; in 2003, CMS both limited and expanded the scope of EMTALA in an overhaul of the 1994 and 2000 regulations. Between 2004 and 2013, CMS periodically amended the EMTALA regulations in piecemeal fashion. The EMTALA Interpretive Guidelines issued by CMS were last updated in 2010, and have been supplemented by several Survey and Certification memoranda on various topics related to EMTALA compliance.

Despite the efforts to clarify EMTALA, there are still several long-standing areas of confusion. These include the application of EMTALA to hospitals that do not operate a licensed or organized emergency department, and to hospital urgent care centers and other services that are held out for both scheduled and drop-in patients. As to emergency department operations, there are still questions about the scope of an appropriate medical screening examination, the meaning of “stabilized” and the relevance of “clinical stability” to a transfer, the obligations of receiving hospitals, and the standards for on-call coverage. There is the increasing struggle, if not crisis, in the overlay of EMTALA obligations to state involuntary commitment laws and regional treatment networks for psychiatric patients that include a mix of hospitals and ambulatory settings.
Hospitals are also subject to court decisions establishing interpretations of EMTALA, some of which vary from the EMTALA regulations or the CMS Interpretive Guidelines. As discussed in chapter 14, “Private Actions to Enforce EMTALA,” courts have issued decisions on the standard of proof for an EMTALA violation, the application of EMTALA to inpatients and to individuals in nonhospital-owned ambulances en route to a hospital, the scope of an appropriate medical screening examination, the determination of a dedicated emergency department and the obligations of a receiving hospital to accept emergency patient transfers.

The EMTALA manual is designed to summarize the EMTALA obligations for hospitals and physicians, and answer the most frequently asked questions. Readers familiar with EMTALA know that the interpretation of EMTALA is fast-changing (and at times, mind-numbing and frustrating). The 9th edition includes updates to the EMTALA regulations, the Interpretive Guidelines and CMS program memoranda through October 2017.

The EMTALA manual is written for hospital staff and physicians; therefore, the text does not include footnotes identifying the sources for the content. To assist readers, the appendices to the manual include the EMTALA statute and regulations, the Interpretive Guidelines and California hospital and managed care laws on emergency and post-stabilization services. Additional appendices include a model hospital compliance policy, a receiving hospital transfer checklist and other materials. References to these materials are marked with a ▶ throughout the manual.

The EMTALA manual is generally limited to EMTALA and California laws governing the provision of emergency services. It does not address numerous other laws and legal obligations applying to hospitals, physicians and other health care personnel in providing emergency care. These include hospital licensing laws for emergency departments; professional practice acts; accreditation standards; consent and privacy laws; reimbursement issues; requirements of regional emergency medical service networks; the rights of persons subject to involuntary detention; trauma standards; and other laws that apply to emergency services and personnel.

The EMTALA manual is limited to the obligations to comply with EMTALA and other emergency service laws. Hospitals, physicians and other caregivers are encouraged to consider ethical, philosophical (e.g., mission and values) and industry standards in making decisions related to emergency services and care, whether or not implicated by EMTALA or other laws.
# Overview of Patient Anti-Dumping Laws

I. EMTALA Overview and History ................................................................. 1.1  
   A. The EMTALA Statute ................................................................. 1.1  
   B. The EMTALA Regulations .......................................................... 1.1  
   C. The EMTALA Interpretive Guidelines ......................................... 1.1  
   D. Special Advisory Bulletins and Other Guidance ......................... 1.2  
   E. Enforcement and Penalties ......................................................... 1.2  
   F. EMTALA Committees and Reports ............................................. 1.3  
      Office of Inspector General ....................................................... 1.3  
      General Accountability Office .................................................. 1.4  
      Secretary’s Advisory Committee on Regulatory Reform .............. 1.4  
      EMTALA Technical Advisory Group ......................................... 1.5  

II. EMTALA Compliance ........................................................................... 1.5  

III. State Laws .......................................................................................... 1.6  

IV. Definitions .......................................................................................... 1.6  
   A. Campus of a Hospital ................................................................. 1.6  
   B. Capacity ..................................................................................... 1.6  
   C. Comes to the Emergency Department ......................................... 1.7  
   D. Consultation .............................................................................. 1.7  
   E. Dedicated Emergency Department ............................................. 1.8  
   F. Emergency Medical Condition ................................................... 1.8  
   G. Emergency Services and Care ..................................................... 1.8  
   H. Hospital Property (also referred to as the “Campus of a Hospital”) 1.9  
   I. Labor ............................................................................................ 1.9  
   J. Psychiatric Emergency Medical Condition ................................... 1.9  
   K. To Stabilize .................................................................................. 1.10  
   L. Stabilized .................................................................................... 1.10  
   M. Transfer ..................................................................................... 1.10  
   N. Within the Capability of the Facility ............................................ 1.11
Overview of Patient Anti-Dumping Laws

I. EMTALA OVERVIEW AND HISTORY

A. The EMTALA Statute
The Emergency Medical Treatment and Labor Act (EMTALA) was enacted by Congress as a part of the Consolidated Omnibus Budget Reconciliation Act of 1986 to ensure access to emergency services. The statute was amended in 1988, 1989, 2003 and 2011. EMTALA applies to anyone who presents for emergency services to a hospital that participates in the Medicare program (including psychiatric hospitals). The EMTALA statute is included as Appendix A.

EMTALA was enacted in response to studies that found that indigent emergency patients had been turned away from hospitals for necessary services or transferred (i.e., “dumped”) to public and charity hospitals in an unstabilized condition. Although EMTALA was passed to mandate access to emergency services by the indigent, Congress applied the EMTALA requirements to all patients regardless of financial or insurance status. In general, both the federal regulatory agencies and the courts have defined the primary objectives of EMTALA as twofold: to enhance access by all persons to emergency services and to prohibit discrimination in the provision of emergency services to persons presenting with the same or similar types of conditions.

B. The EMTALA Regulations
The initial EMTALA regulations were published in draft form in 1988, and issued as interim final regulations on June 22, 1994. On April 7, 2000, the regulations were amended to apply the EMTALA obligations to off-campus hospital services. In September 2003, the Centers for Medicare & Medicaid Services (CMS) published further changes to the EMTALA regulations, repealing part of the 2000 regulations and clarifying the application of EMTALA to emergency patients, outpatients and inpatients. Since 2004, CMS has amended the EMTALA regulations in piecemeal fashion in 2006, 2007, 2008 and 2009. The current regulations are included as Appendix B.

C. The EMTALA Interpretive Guidelines
CMS has adopted Interpretive Guidelines as part of the Medicare State Operations Manual to provide guidance for federal and state surveyors in their enforcement of EMTALA. Although the Interpretive Guidelines are not regulations, they are considered the official interpretation of EMTALA by CMS and are used by California Department of Public Health (CDPH) surveyors and CMS regional offices in enforcement of the EMTALA obligations. The most recent update to the Interpretive Guidelines was July 16, 2010; the Interpretive Guidelines are included as Appendix C.

NOTE: The Interpretive Guidelines are organized by “tag numbers,” each of which corresponds to a CMS regulation that establishes the rules for EMTALA. The tag numbers
beginning with the letter “A” are applicable to hospitals and the tag numbers beginning with the letter “C” are applicable to critical access hospitals. Each tag number has four digits, with the number “2” at the beginning of each tag number.

D. Special Advisory Bulletins and Other Guidance

In November 1999, CMS and the Office of Inspector General (OIG) released a final Special Advisory Bulletin on EMTALA and managed care. The Bulletin discusses the rules on seeking health plan authorization prior to the medical screening examination (which were added to the EMTALA regulations in 2003), dual staffing of emergency departments and recommended patient registration practices to minimize violations of EMTALA. The Bulletin is discussed in chapter 4, “Financial Considerations — EMTALA and Managed Care,” and is included as Appendix H.

From time to time, CMS issues Program Memoranda on various subjects relating to EMTALA obligations. Most of these memoranda have been incorporated into the Interpretive Guidelines (see Appendix C). This manual includes the latest CMS guidance on Critical Access Hospital on-call compliance with EMTALA (Appendix Y), conflicting payor requirements (Appendix X), and Ebola implications for EMTALA (Appendix AA). These memoranda are also described in detail in applicable chapters of this manual.

E. Enforcement and Penalties

The EMTALA obligations are a condition of the Medicare provider agreement (rather than a Condition of Participation), thereby permitting CMS to terminate a provider upon a confirmed violation of EMTALA. As described in chapter 13, “Regulatory Enforcement of EMTALA,” the federal agencies charged with ensuring EMTALA compliance are CMS and the OIG.

CMS has the authority to conduct complaint and enforcement surveys for EMTALA compliance, and to terminate a hospital’s Medicare provider agreement upon confirming one or more violations of EMTALA.

Under the EMTALA statute (Appendix A), the OIG has the authority to impose civil money penalties up to $50,000 against hospitals and physicians ($25,000 for hospitals with less than 100 beds), and/or to exclude a hospital or physician from the Medicare and Medicaid programs for violations of EMTALA that are “gross and flagrant or repeated.” In December 2016, the OIG issued final regulations updating the amount of civil money penalties, including EMTALA fines. Effective in 2017, the OIG may now impose civil penalties up to $104,826 against hospitals and physicians ($52,414 for hospitals with less than 100 beds) for an EMTALA violation. The maximum amount of the fines is subject to annual adjustment for inflation.

The regional quality improvement organization (QIO) is responsible for assisting CMS and OIG review patient stabilization and other medical matters pertaining to the delivery of emergency care and services.

For hospitals that have community service obligations under the Hill-Burton Act, the Office for Civil Rights (OCR) will follow up on violations of EMTALA confirmed by CMS with a request for copies of EMTALA compliance, transfer, admission and other hospital policies.
F. EMTALA Committees and Reports

Since 2001, there have been a number of committees and governmental agencies that have issued reports on EMTALA, including reports regarding compliance by hospitals and physicians with EMTALA standards, the enforcement process and the overall effect of the law.

Office of Inspector General

In January 2001, the OIG released two reports on EMTALA: “Survey of Hospital Emergency Departments” and “The Enforcement Process.”

The OIG’s “Survey of Hospital Emergency Departments” made the following findings:

1. Emergency department personnel are familiar with the EMTALA requirements, but many are unaware of recent policy changes.
2. Training increases EMTALA familiarity for all staff; unfortunately, on-call specialists and staff in high-volume emergency departments are less likely to receive training.
3. Hospital staff report that hospitals generally comply with EMTALA, but some express concerns about compliance.
4. Hospital staff believe that some aspects of EMTALA are unclear or questionable.
5. Hospital staff believe that while EMTALA may help protect patients, it also may contribute to a hospital’s administrative and financial problems.
6. Investigations, many of which do not confirm violations, often prompt changes in forms and procedures.
7. Managed care creates special problems for hospitals in complying with EMTALA.
8. Hospitals have difficulty staffing on-call panels for some specialists.

The OIG report made three conclusions:

1. CMS should use a variety of methods to communicate important policy changes, including e-mail and the Internet.
2. CMS should support legislation that compels managed care plans to reimburse hospitals for EMTALA-related services, including screening exams that do not reveal the presence of an emergency medical condition.
3. Uncompensated care and on-call panels are very complex problems that may require action at the federal, state and local levels as well as by private entities.

The OIG reported that CMS concurred with its recommendations.

In “The Enforcement Process” report, the OIG issued the following findings on the EMTALA enforcement process:

1. The EMTALA enforcement process is compromised by long delays and inadequate feedback.
2. The number of EMTALA investigations and their ultimate disposition vary widely by CMS region and year.
3. Poor tracking of EMTALA cases impede oversight.
4. Peer review is not always obtained before CMS considers terminating a hospital for medical reasons.

The OIG report recommended that CMS increase its oversight of the regional offices, improve collection and access to EMTALA data, ensure that peer review occurs for cases involving medical judgment, and establish an EMTALA technical advisory group. The OIG reported that CMS concurred with its recommendations.

**General Accountability Office**

In June 2001, the U.S. General Accountability Office (GAO) released its own report entitled “EMTALA Implementation and Enforcement Issues.” Among other findings, the GAO reported that providers generally support the goals of EMTALA, but are uncertain about the extent of their obligations and have concerns about its effects on emergency care. In Table 1 of the report, the GAO listed seven issues identified as provider uncertainties:

1. Scope of the medical screening exam
2. Definition of patient stability for transfer
3. Obligations for post-hospital care
4. Application of the 250-yard rule
5. Obligations related to patients in other hospital departments
6. Requirement for on-call coverage
7. Compliance with local emergency medical systems for routing of ambulances

The comments by CMS on those issues are addressed in various sections of this manual.

Regarding the enforcement of EMTALA, the GAO reported that most EMTALA violations involve failure to screen, stabilize or transfer appropriately. They noted that although hospitals have concerns about CMS enforcement, CMS usually accepts corrective action plans and rarely terminates hospitals from the Medicare program. Finally, the GAO found that the OIG focuses on future compliance in assessing fines for EMTALA violations, and generally does not pursue a physician in the absence of clearly culpable behavior. The GAO endorsed many of the OIG recommendations in the two earlier reports discussed above.

In April 2009, the GAO issued a report entitled “Hospital Emergency Departments — Crowding Continues to Occur, and Some Patients Wait Longer than Recommended Time Frames.” The report looked at indicators of emergency department crowding, including ambulance diversion, wait times and patient boarding. The report determined that the primary factor for emergency department crowding is the lack of inpatient beds, with the following secondary factors: lack of access to primary care, a shortage of available on-call specialists and difficulties with transferring or discharging psychiatric patients. The report, “GAO 09-347,” can be accessed on the GAO website at www.gao.gov/new.items/d09347.pdf.

**Secretary’s Advisory Committee on Regulatory Reform**

In June 2001, the Secretary of the U.S. Department of Health and Human Services (HHS) established an Advisory Committee on Regulatory Reform to provide findings and recommendations regarding potential regulatory burdens and costs associated with HHS
Chapter 1 — Overview of Patient Anti-Dumping Laws

regulations. The Committee reviewed the status of EMTALA regulations and issued a final report in November 2002. The recommendations may be found at www.regreform.hhs.gov/materials/recommendations_masterlist.htm. Some of the recommendations were adopted in the 2003 EMTALA regulations or addressed in CMS Program Memoranda.

**EMTALA Technical Advisory Group**

In the 2003 Medicare reform legislation, Congress directed the Secretary of HHS to establish a Technical Advisory Group (TAG) to solicit advice concerning the EMTALA regulations and enforcement. The Secretary signed the charter establishing the TAG on May 11, 2004; the tag had a term of 30 months. The TAG was composed of 19 members, including four hospital representatives and seven physicians. The final meeting of the TAG was Sept. 17-18, 2007.

The TAG had the following responsibilities:

1. Review the EMTALA regulations;
2. Provide advice and recommendations to the Secretary concerning the regulations and their application to hospitals and physicians;
3. Solicit comments and recommendations from providers and the public regarding the implementation of the regulations; and
4. Disseminate information on the EMTALA regulations to providers and the public.

During its tenure, the TAG issued seven reports and made several recommendations to CMS, some of which resulted in changes to the regulations and others in updated guidance issued in Program Memoranda. At its final meeting, the TAG adopted a series of recommendations related to accepting hospital obligations, clarification of conditions that constitute an "emergency medical condition," clarification of the term "stabilization" (including a proposed concept of "temporary stabilization"), and procedures and criteria for transferring patients with stabilized conditions to physician offices for follow-up evaluation and care. It is uncertain whether these recommendations will be accepted by CMS, and if so, whether there will be any changes.

Further information on the TAG, including meeting agendas and reports, is available on the CMS website at www.cms.hhs.gov/EMTALA/03_emtalatag.asp. The final report of the EMTALA TAG, dated April 2008, is available at www.magpub.com/emtala/EMTALA%20Final%Report_FINAL.pdf.

**II. EMTALA COMPLIANCE**

Hospitals should adopt a hospital-wide policy that commits the facility to comply with EMTALA as well as quality improvement, risk management and corporate compliance programs to monitor adherence with EMTALA standards. A model policy is included as Appendix O. Other recommended EMTALA policies are discussed throughout this manual and are listed in Appendix N.
III. STATE LAWS

The EMTALA statute expressly provides that the federal obligations do not preempt state and local emergency laws unless they conflict with the EMTALA obligations.

Some states have adopted emergency services statutes or regulations. Readers of this manual should consult with their legal counsel as to the effect of these laws. (Relevant California laws are discussed in this manual.)

In 1987, the California Legislature amended the hospital licensing laws to enact state patient anti-dumping laws. The California emergency medical service requirements are similar to EMTALA requirements, with some exceptions that are discussed in this manual. The following are some examples:

1. California law applies to hospitals that are licensed to provide emergency services; EMTALA applies to all hospitals that provide emergency services, even if they do not have licensed emergency departments.

2. California law expressly prohibits discrimination in the provision of emergency services by hospitals and physicians.

3. EMTALA focuses on whether a patient with an emergency condition is “stabilized” for transfer or discharge; California law primarily focuses on transfers that are made for nonmedical reasons (such as insurance or financial reasons), which apply to patients with emergency conditions that are considered to be stabilized. California law does not apply to a transfer that is made for medical reasons (although other state requirements pertaining to the transfer of patients may apply).

The California licensing laws on “emergency services and care” are included as Appendix D.

The EMTALA regulations contain a series of defined terms that are essential to the regulatory scheme. The key terms defined below are based on definitions in the EMTALA statute or regulations, except for a number of terms defined by California law that are so indicated. Readers of this manual in other states should consult with their legal counsel as to state laws and regulations that define other terms that are applicable to emergency services rendered in their state.

IV. DEFINITIONS

A. Campus of a Hospital

(See “Hospital Property (also referred to as the “Campus of a Hospital”),” page 1.9.)

B. Capacity

“Capacity” refers to the ability of a hospital to accommodate a transfer patient. Capacity encompasses such things as the number and availability of qualified staff, beds and equipment, and the hospital’s past practices of accommodating additional patients in excess of its occupancy limits.
Index

SYMBOLS

9-1-1, 2.10, 3.16, 3.17
24-hour hold, 6.29 to 6.32
250-yard rule, 1.9, 2.9
5150, 6.1 to 6.32 — See also Lanterman-Petris-Short (LPS) Act

A

Active labor — See Labor and delivery
Advance Beneficiary Notice of Noncoverage (ABN), 4.6
Aerosol transmissible disease, 5.9 to 5.10
Ambulance, 1.7, 2.2, 2.16 to 2.18, 14.9
Ancillary services, 3.1, 3.8
Arrington v. Wong, 2.16
Authorization, 4.7 to 4.10

B

Bioterrorism — See Disasters
Blood pressure check, 2.15

C

California Department of Public Health (CDPH), 6.9, 6.14, 12.1
Campus, 1.6
Capability, 1.11, 5.13 to 5.15
Capacity, 1.6, 5.13 to 5.15
CDPH — See California Department of Public Health (CDPH)
Centers for Medicare & Medicaid Services (CMS), 1.2, 6.9, 6.11, 6.13, 6.15, 6.16, 12.1, 13.1 to 13.7
Central log, 9.1 to 9.4
Clinics, 2.4
CMS — See Centers for Medicare & Medicaid Services (CMS)
Comes to the hospital, 2.2, 2.11 to 2.16
Community call plan, 11.9 to 11.11
Complaint, 13.1, 13.3
Complaint survey, 13.4 to 13.6
Consultation, 1.7
Contraction — See Labor and delivery
Crisis stabilization unit, 6.5 to 6.6, 6.20 to 6.21
Critical access hospitals, 1.2, 3.7

D

Dedicated emergency department, 1.8, 2.1, 2.3, 2.5 to 2.7, 2.11 to 2.12, 2.19, 3.8, 3.12, 3.14, 6.9 to 6.10
Definitions, 1.6
Department of Health Care Services (DHCS), 6.1, 6.5, 6.8, 6.9
Designated hospitals/facilities, 6.5 to 6.6
DHCS — See Department of Health Care Services (DHCS)
Disasters, 16.1 to 16.7
Discrimination, 1.1, 1.6, 3.3, 3.10, 4.1
Diversion — See Diversionary status
Diversionary status, 2.16
Documentation, 3.4, 3.10, 3.18, 5.1, 6.13, 7.10, 8.1, 8.4, 11.14

E

Emergency medical condition, 1.8 — See also Psychiatric emergency medical condition
EMTALA waiver — See Waiver
EMTs — See Paramedics
Financial considerations, 4.1 to 4.14, 5.11, 7.12 — See also Discrimination

G

General Accountability Office (GAO), 1.4

H

Helipad, 2.17
Hill-Burton Act, 1.2
Holding out test, 1.8, 2.5, 6.9
Homeless patient, 5.18 to 5.22
Hospital property, 1.9, 2.8 to 2.9
Infant — See Labor and delivery, See Newborn
Inpatient, 2.4, 2.18 to 2.20, 14.4 to 14.13
Interpreter Guidelines, 1.1 to 1.2
Involuntary detention, 6.1 to 6.32

Joint Commission — See The Joint Commission

Labor and delivery, 1.8, 1.9, 1.10, 2.6, 3.13 to 3.14, 3.17 to 3.20
Lanterman-Petris-Short (LPS) Act, 6.1 to 6.32
Lawsuits, 14.1 to 14.13
License test, 2.5
LPS — See Lanterman-Petris-Short (LPS) Act

Managed care patients, 3.10, 3.12, 4.1, 4.6 to 4.14
Post-stabilization services, 4.7 to 4.13
Prior authorization, 4.7 — See also Prior authorization
Medi-Cal, 6.9, 6.14, 6.22
Medical clearance, 2.15
Medical screening examination, 3.1 to 3.22
Labor patient, 3.17
Psychiatric patient, 3.21, 6.12
Triage — See Triage
Medicare Advantage, 4.13
Mental health patient — See Psychiatric patient
Mid-level practitioner, 3.6 to 3.8, 3.17, 11.12
Midwife — See Mid-level practitioner
Minors, 3.11, 6.8

Newborn, 3.19
Non-designated hospitals, 6.24, 6.29 to 6.32
Notice to patient, 2.8, 4.6, 4.10
Nurse — See Mid-level practitioner
Nurse-staffing ratios, 5.14 to 5.15, 7.9

Observation status, 2.19
Occupational medicine, 2.7
OCR, 1.2, 13.1 to 13.7
Off-campus facilities, 2.1, 2.3, 2.10, 3.16 to 3.17

Office for Civil Rights — See OCR
Office of Inspector General — See OIG
OIG, 1.2, 1.3 to 1.4, 13.1 to 13.7, 13.15
On-call, 7.7, 11.1 to 11.16
One-third test, 1.8, 2.5, 6.9
Outpatient department, 2.3, 2.6

Pandemic — See Disasters
Paramedics, 3.9
Peer review records, 14.2
Penalties, 12.3, 13.1, 13.16
Physician, 13.1
Physician assistant — See Mid-level practitioner
Physician certification, 5.5 to 5.7
Plan of correction, 13.7 to 13.9
Policies and procedures, 2.7, 3.13, 3.15, 3.16, 3.20, 15.1
Post-stabilization services, 4.9
Preventive care services, 2.14
Prior authorization, 4.1, 4.3, 4.11, 5.16, 7.9
Provider number, 2.4, 3.14
Prudent layperson, 1.7, 2.2
Psychiatric emergency medical condition, 6.13 to 6.19
Psychiatric health facility, 6.5, 6.9, 6.11, 6.20 to 6.21
Psychiatric hospitals/facilities, 2.5, 3.20, 6.9
Psychiatric patient, 3.21, 6.1 to 6.32
Stabilized, 5.4, 5.18
Psychiatric service, 2.6

QAPI — See Quality improvement
QIO, 1.2, 13.1 to 13.7, 13.5, 13.10
Quality improvement, 15.1 to 15.3
Quality Improvement Organization — See QIO

Receiving hospital obligation, 7.1 to 7.14
Record retention, 3.5, 5.1
Refusal of examination, 8.1 to 8.6
Refusal of treatment, 8.1 to 8.6
Refusal to accept transfer, 8.1 to 8.6
Registered nurse — See Mid-level practitioner
Reporting violations, 12.1 to 12.3
Request for transfer — See Transfer request
Required signage, 10.1 to 10.4
Retaliation — See Whistleblower
Risk management, 15.1 to 15.3
S

Special Advisory Bulletin, 1.2
Specialized capabilities or facilities, 7.1
Stabilization, 5.4
Stabilized, 1.10, 5.4, 5.17
  Psychiatric patient, 6.15 to 6.17
St. Anthony Hospital, 13.15
State laws, 1.6
Statement of Deficiencies, 13.7 to 13.9
Stewart v. Parkview Hospital, Inc., 6.10
Surge, 16.5
Survey process, 2.5

T

Tags, 1.2
Technical advisory group, 1.5
Telemedicine, 11.13
Termination of provider agreement, 13.1, 13.6 to 13.7, 14.3
The Joint Commission, 6.15
TJC — See The Joint Commission
Transfer, 1.10
  Appropriate, 5.1, 5.5, 5.7 to 5.10
  Transportation, 5.12
  Unstabilized patient, 5.1
Transfer agreement, 5.11, 7.12
Transfer request, 5.5
Treating physician, 3.12, 4.4, 5.11, 5.12
Triage, 3.2

U

Unstabilized patient, 5.1, 5.2
Urgent care center, 2.5, 2.6 to 2.7

V

Violations, 12.1 to 12.3, 12.3, 13.6

W

Waiver, 16.1 to 16.7
Whistleblower, 12.3, 13.4