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THE APPLICATION OF THE EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA) TO HOSPITAL INPATIENTS

JUNE 2009

ISSUE BRIEF

Introduction

This issue brief provides a brief overview of the Emergency Medical Treatment and Labor Act (EMTALA) and focuses on its application to hospital inpatients. EMTALA applies differently to patients than non-patients, and also applies differently to patients admitted through the emergency department than patients admitted as regular inpatients. In addition, courts and the Centers for Medicare and Medicaid Services (CMS) have differed in their interpretation of the statute. Depending on the specific facts of any particular case, EMTALA may or may not have implications for specialty-related transfers and discharges.

Following an overview of the statute and implementing regulations, the issue brief analyzes the law, as well as a series of relevant court decisions, for their application to hospital inpatients in emergency transfer situations.

EMTALA: An Overview

The Emergency Medical Treatment and Labor Act (EMTALA)¹ establishes a series of requirements applicable to all Medicare-participating hospitals that have a “dedicated emergency department.”² EMTALA was enacted to stop “patient dumping,” that is, the refusal to treat patients with emergencies as well as the premature discharge of unstable, uninsured patients.³ The statute establishes two basic requirements, a screening requirement as well as a stabilization and appropriate transfer requirement:

1. In the case of an individual who “comes to” a hospital’s emergency department⁴ and on whose behalf “a request is made” for examination or treatment,⁵ the hospital must provide for an “appropriate medical screening examination within the capability of the hospital’s emergency department to determine whether or not an emergency medical condition . . . exists.”⁶
2. If any individual “comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—“(i) [w]ithin the capabilities of the staff and facilities available at the hospital, for further medical examination and treatment as required to stabilize the medical condition [or] (ii) [f]or transfer of the individual to another medical facility”⁷ in accordance with the terms of the Act.

Judicial and Agency Interpretation of EMTALA’s Meaning in the Context of Hospital Inpatients

Since its enactment, EMTALA has generated a great deal of litigation about where in a hospital setting the law applies and to which patients. It is important to



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understand that a court can only define the law within its geographic jurisdictional region; until the United States Supreme Court has spoken, no single decision represents a definitive interpretation of federal law. Thus, conflicting court decisions could mean that EMTALA is applied differently across the country.

Furthermore, while federal regulations can help clarify and standardize conduct, courts actually have the power to reject an agency's interpretation of the law, that is, to choose not to defer to an agency interpretation of what a particular statute means. This judicial power to reject agency interpretation of a law – even when the agency interpreting the law is charged with its enforcement – has produced at least one significant EMTALA ruling on the law's application to inpatients.

Early Ambiguity

The challenge of applying EMTALA to hospital inpatients arose relatively early. The text of the EMTALA statute⁸ does not define certain key terms, such as “comes to the emergency department,” nor does the statute specifically address EMTALA's relationship to patients as they may be moved through the hospital in the process of being screened and stabilized. At the same time, the impetus for EMTALA was the elimination of patient dumping, both at the hospital emergency room door and prematurely out of hospitals (which was referred to as releasing patients “sicker and quicker”).

Early regulations defined the concept of coming to the hospital as being on hospital property,⁹ which in turn invited the question whether EMTALA's screening and/or stabilization requirements applied to patients who, at the time an emergency arose, were in parts of the hospital other than the emergency department. On this question, the courts reached different conclusions regarding the physical locations in which EMTALA would apply.

Some courts interpreted “come to the emergency department,” as meaning that that EMTALA would not apply to hospital inpatients, however admitted, who develop emergency conditions during the course of their hospital stay. This reading was prompted by clear evidence that EMTALA was not intended to be a “federal malpractice statute,”¹⁰ and thus, that its requirements should not supersede laws – such as state malpractice law or federal Medicare conditions of participation – which protect inpatients from professional and institutional negligence (i.e., substandard care). Under this reading, a hospital's obligations under EMTALA ended upon admission as an inpatient.¹¹

However, as noted, EMTALA's origins can be traced back to Congressional concerns over not only the failure to screen but also the premature discharge of inpatients, perhaps worsened by the enactment of the Medicare Prospective Payment System (PPS). This history, combined with the actual text of the stabilization requirement (which, as noted above, references simply coming to “a hospital” and contains no limiting references focused on emergency departments) led other courts to conclude that EMTALA did indeed reach hospital inpatients.

For example, in *Lopez-Soto v. Hawayek*,¹² the First Circuit Court of Appeals, ruling in a case brought in Puerto Rico, held that EMTALA applied to the case of an infant born in the hospital's maternity ward, who suffered a medical emergency shortly after birth. The court reasoned that EMTALA's stabilization and appropriate transfer requirements apply to patients who present with emergency conditions in parts of the hospital other than the emergency room. The court noted the law's emphasis on preventing patient dumping, which could occur anywhere in the hospital, and its specific inclusion of women in labor, who were likely to present to maternity wards rather than emergency rooms. The *Lopez-Soto* court's decision did not turn on whether the patient was admitted as an inpatient, but rather the fact that the patient was in the hospital when the emergency condition arose.¹³

Recognition of EMTALA's reach to inpatients has been evident in decisions of the United States Supreme Court as well. In the case of *Roberts v. Galen of Virginia*,¹⁴ which involved the discharge of an unstable hospital inpatient, the United States Supreme Court and lower federal courts undertook an EMTALA analysis even though the patient had been admitted to the hospital for six weeks prior to her transfer. The very fact of the analysis suggests that the Court viewed EMTALA as pertinent to the stabilization of hospital inpatients, indeed, long after the acute episode that may initially have led to the initial admission. Courts also extended EMTALA to cases in which the patient first presented to the emergency room, was subsequently admitted to the hospital for treatment, and was either inappropriately transferred or not stabilized after admission.¹⁵

The leading case for the opposing perspective – namely that inpatient admission extinguishes hospitals' stabilization requirement – is *Harry v. Marchant*.¹⁶ In *Marchant*, the United States Court of Appeals for the Eleventh Circuit, relied not on the stabilization duty itself, but instead on the definition of “to stabilize” which under EMTALA means “with respect to an emergency condition. . . to provide such medical treatment . . . as may be necessary to assure, within reasonable medical probability, that no material deterioration . . . is likely to result from or occur during the transfer of the individual from a facility. . . .”¹⁷ In the court's view, because stabilization was a process that occurred only in relation to a transfer from the emergency department, persons admitted as inpatients were not covered. The court reached this conclusion even though nothing in the definition of “to stabilize” limits transfers to those that may originate in an emergency department.

The 2003 Federal Regulations

In the wake of these conflicting court decisions, the Centers for Medicare and Medicaid Services (CMS), the agency within the United States Department of Health and Human Services (HHS) that administers Medicare and Medicaid, promulgated regulations in 2003 that came down squarely on the side of Marchant, adopting the view that as a general rule, hospital stabilization duties end upon inpatient admission.¹⁸ In addition to this change, the regulations made numerous other revisions designed to clarify EMTALA's reach. The regulations provide that EMTALA can apply to a person presenting on the hospital property seeking emergency care, even if the location is not part of a “dedicated emergency department.”¹⁹ Second, the regulations define a “dedicated emergency department” to include not only the emergency room but also other departments in the hospital “that provide emergency or labor and delivery services, or both, to individuals who present as unscheduled ambulatory patients but are routinely admitted to be evaluated and treated.”²⁰ Thus, the regulations clarify that EMTALA does indeed extend beyond a hospital's emergency department under certain circumstances.

At the same time, the regulations limit the scope of the EMTALA stabilization requirement by creating a specific exception to the stabilization obligation in the case of persons admitted as inpatients. Thus, following its explanation of the general EMTALA stabilization requirement, the regulation states:²¹

- (2) Exception: Application to inpatients. (i) If a hospital has screened an individual under paragraph (a) of this section and found the individual to have an emergency medical condition, and admits that individual as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its special responsibilities under this section with respect to that individual.
- (ii) This section is not applicable to an inpatient who was admitted for elective (nonemergency) diagnosis or treatment.
- (iii) A hospital is required by the conditions of participation for hospitals under Part 482 of this chapter to provide care to its inpatients in accordance with those conditions of participation.

In its explanation of this provision, CMS reiterated that EMTALA is not a federal malpractice statute, noting that “once a hospital admits an individual as [an inpatient, a] hospital has a variety of other legal, licensing, and professional obligations with respect to the continued proper care and treatment of such patients.”²² Therefore, under the revised regulations, a failure to stabilize an emergency condition after inpatient admission would not give rise to an EMTALA claim, but rather, a claim for medical negligence or a complaint filed against the hospital for failure to adhere to applicable Medicare Conditions of Participation (COPs) (and by definition, Medicaid participation rights, given the link between the two laws with respect to conditions of participation).²³

The CMS rule stresses that the admission must be in good faith and for the purpose of stabilization; the Preamble to the rule emphasizes that a hospital can still be liable under EMTALA if it does “not admit an individual in good faith with the intention of providing treatment (that is, the hospital [uses] the inpatient admission as a means to avoid EMTALA requirements).” Once the patient has been admitted in good faith, EMTALA no longer applies even if the patient subsequently becomes unstable or develops a new emergency medical condition.²⁴ Presumably, the burden of proving bad faith would fall on the complainant.

Post-2003 Court Decisions Construing the Meaning of EMTALA’s Stabilization Obligations

Since the 2003 regulations, most courts considering EMTALA stabilization violation claims brought by inpatients have rejected those claims because the individuals were inpatients.²⁵ Two important exceptions to this trend are *Lima-Rivera v. UHS of Puerto Rico*,²⁶ and *Moses v Providence Hospitals and Medical Center*.²⁷

In *Lima Rivera*, a pregnant woman with an emergency condition and in labor presented to a hospital’s emergency room and delivered a baby in the hospital’s operating room. The infant was admitted to the hospital’s regular nursery as an inpatient but shortly developed an unstable emergency medical condition. The infant was transferred in an unstable condition to a different hospital, where he died within a day of the transfer.

The court held that the plaintiffs had a case under EMTALA even though the infant had been admitted as an inpatient. Relying on *Lopez-Soto*, the court held that the infant “presented” to the hospital when he was born in the operating room after a cesarean section²⁸ and that the hospital staff identified his emergency medical condition,²⁹ which triggered EMTALA’s stabilization and appropriate transfer requirement. The court did not say when the infant was admitted to the hospital’s nursery, but it appears that the emergency condition was detected after he was transferred to the nursery. Thus, the court in *Lima-Rivera* applied the law’s stabilization and appropriate transfer requirement to an apparent inpatient. Although this application is in conflict with the 2003 regulations, the facts of the *Lima-Rivera* case happened before the regulations took effect, so the court specifically declined to follow them. No court has followed *Lima-Rivera* and applied EMTALA to facts that happened after the regulations took effect.

In *Moses*, potentially the most important post-2003 regulation case to date, the United States Court of Appeals for the Sixth Circuit, rejected the HHS stabilization rule out of hand as clearly contrary to Congressional intent and the statutory language of EMTALA, in addition to finding the regulations inapplicable because they were enacted after the facts of the case. Construing the stabilization obligation, the court reasoned that the statute “requires more than the admission and further testing of a patient; it requires that actual care, or treatment, be provided as well. Accordingly, Defendants could not satisfy their EMTALA obligations merely by screening [the patient] and admitting him to conduct further testing.”³⁰ The court also reasoned that EMTALA’s requirement that the hospital determine that the patient has actually stabilized before release “would be unnecessary if a hospital only needed to admit the patient

in order to satisfy EMTALA.”³¹ Therefore, the court declined to follow the HHS rule that admission satisfies EMTALA’s stabilization requirement and concluded that under the statute, a hospital is required to actually stabilize the patient, not merely admit the patient for stabilization, so the hospital could be liable under EMTALA for failing to stabilize a patient who had been admitted as an inpatient.

Other cases have adhered to the HHS rule. In *Morgan v. North Mississippi Medical Center*,³² the EMTALA stabilization protections were invoked by an individual who suffered various injuries due to a fall, was rushed to the hospital in an ambulance, received emergency trauma care, and was admitted as an inpatient. The hospital informed the patient’s wife that she would have to make financial arrangements to pay for his care and attempted to discharge him several times. Nine days after his admission, he was discharged and an ambulance controlled by the hospital took him home, where he died 12 hours later from untreated injuries related to his original fall. The court concluded that the facts showed evidence that the admission was not in “good faith” as required under the rule, but ultimately found that the evidence failed to document bad faith conduct by the hospital.³³ Other cases also followed the HHS stabilization rule, including: *Anderson v. Kindred Hosp.*,³⁴ *Benitez-Rodriguez v. Hosp. Pavia Hato Rey, Inc.*,³⁵ *Estate of Haight v. Robertson*,³⁶ *Preston v. Meriter Hospital, Inc.*,³⁷ and *Prickett v. Hot Spring County Med. Ctr.*³⁸

The Special Case of Newborns under EMTALA

The preceding discussion underscores the variable outcomes that can arise in the case of infants born in Medicare-participating hospitals to mothers who are in locations other than the emergency department (e.g., a hospital birthing center, an inpatient operating room). A baby delivered in an emergency department with an emergency condition clearly would be covered by EMTALA. But the situation is less clear in the case of infants born in hospital birthing centers (for example, would a birthing center be considered to hold itself out as a dedicated emergency department with regard to its ability to manage a birth, including a birth that rapidly developed into an emergency?). The regulations would seem to deny EMTALA protections to infants born to mothers who are inpatients, but the courts seem to be unsettled about how to deal with the rules.

The Impact of the Born-Alive Infants Protection Act of 2002 on EMTALA

The Born-Alive Infants Protection Act of 2002³⁹ (BAIPA) is a federal law that defines the terms “individual”⁴⁰ and “born alive”⁴¹ for the purpose of interpreting and applying all federal laws, including EMTALA. BAIPA’s purpose is to ensure that infants that are expelled or extracted from their mothers at any stage of development are treated as living beings if they have “a beating heart, pulsation of the umbilical cord, or definite movement of the voluntary muscles.”⁴²

In 2005, CMS issued guidance regarding the effect of BAIPA on EMTALA. The guidance seeks to clarify those situations in which EMTALA protects an infant who is born alive as the term is used in the BAIPA. The guidance notes that if a hospital’s labor and delivery department meets the definition of a “dedicated emergency department,” then EMTALA would protect the infant born or delivered in such a setting either if a request were made for an emergency screening and stabilization or if a prudent layperson were to conclude that based on its appearance the infant required emergency care. CMS also notes that EMTALA screening and stabilization duties might be triggered “elsewhere on the hospital campus (i.e., not in the hospital’s dedicated emergency department)” if a “prudent layperson observer concluded, based on the born-alive infant’s appearance or behavior, that the born-alive infant were suffering from an emergency medical condition.” This passage suggests that in contrast to the 2003 regulations, CMS considers the health of the infant to be paramount in labor and delivery cases, not the setting of the care. If a prudent layperson were to recognize the need for screening and stabilization, the duty would attach

regardless of where on the campus the birth occurred. While the guidance also notes that once the infant is transferred to inpatient care, EMTALA protections cease, the initial screening and stabilization duties may be applicable anywhere on a hospital campus.

Conflicting Opinions Regarding Newborn Inpatient Status

The court in *Lopez-Soto* appeared to consider the newborn to be a new patient presenting to the hospital with an emergency condition.⁴³ The court in *Lima-Rivera* also found that the baby presented to the hospital independently from his mother when he was born in the hospital's operating room.⁴⁴ In contrast, the Wisconsin court in *Preston v. Meriter Hospital, Inc.*⁴⁵ held that EMTALA did not apply to an infant born with an emergency condition because the infant was deemed an inpatient by virtue of its mother's admission as an inpatient. The court in *Preston* concluded that since the mother was admitted as an inpatient while in labor at the birthing center, the baby was automatically an inpatient as well.⁴⁶ Therefore, under the inpatient exception from the 2003 regulations, EMTALA did not apply. (The *Preston* court did not reference the 2005 CMS guidance regarding BAIPA or the conflicting analysis in *Lopez-Soto* and *Lima-Rivera* on the issue of the infant's inpatient status.)

2008 Federal Regulations

Further complicating the picture, in April 2008, CMS proposed new regulations concerning EMTALA's application to inpatients.⁴⁷ Although CMS reiterated that EMTALA obligations end when a hospital that detected an emergency medical condition admits the patient in order to provide necessary treatment for that condition, it also stated a belief that "the obligation of EMTALA does not end for all hospitals once an individual has been admitted as an inpatient to the hospital where the individual first presented."⁴⁸ Rather, CMS proposed that if a hospital attempts to transfer an admitted patient to another hospital with specialized capabilities, the receiving hospital has an obligation under EMTALA to accept the transfer if it has the capacity to treat the person, regardless of the person's inpatient status.

CMS received many comments opposed to this proposal because of the potential burden that would inure to specialty hospitals that would find themselves in a position of having to accept inpatient transfers. Ultimately in its final rule,⁴⁹ CMS did not adopt its own proposal and instead remained firm in the position that EMTALA obligations end once a patient is admitted in good faith to treat an emergency condition, and thus, that a hospital with specialized capabilities has no EMTALA obligation to accept the transfer of an inpatient of another hospital. Hospitals with specialized capabilities continue to have an obligation to accept the transfer of patients held in emergency departments and in need of emergency specialized care.⁵⁰ The final rule was published in the Federal Register on August 19, 2008 and went into effect on October 1, 2008.

This final position was reaffirmed by recent Interpretive Guidelines released by CMS on March 6, 2009. The guidelines state (emphasis in original):⁵¹

[O]nce an individual is admitted in good faith to the admitting hospital, the admitting hospital has satisfied its EMTALA obligation with respect to that individual, even if the individual remains unstabilized, **and** a hospital with specialized capabilities does **NOT** have an EMTALA obligation to accept an appropriate transfer of that individual. However, it is important to note that this rule does not apply to individuals who are protected under EMTALA and placed in observation status rather than admitted as inpatients. These individuals are outpatients.

Thus, in the absence of bad faith, the federal government considers EMTALA to end at the point of inpatient admission.

However, it is important to note that despite CMS's interpretation of EMTALA, courts may disagree with that interpretation and impose liability under EMTALA based on their own interpretation of the law. The *Moses* case, discussed above, is the most recent example of this.⁵² In that case, the U.S. Court of Appeals for the Sixth Circuit specifically rejected the defendants' reliance on the 2003 CMS regulation, stating that the regulation was promulgated after the facts occurred and, more significantly, that the CMS regulation was contrary to the statutory language of EMTALA and Congressional intent.⁵³ This ruling further confuses the EMTALA liability landscape for hospitals.

Where Does All of This Leave Hospitals?

Under the most recent CMS regulations, as well as most courts, EMTALA does not apply to hospital inpatients, whether admitted because of an emergency or for a non-emergency (i.e., scheduled) procedure, as long as the admission occurs in good faith. Therefore, hospitals seeking to transfer inpatients could not invoke their stabilization and appropriate transfer rights under EMTALA. In addition, while a receiving hospital has an obligation to accept an appropriate transfer of an emergency department or ambulance patient, such a hospital does not have an obligation to accept an appropriate transfer of an inpatient.⁵⁴ Thus, if a patient is admitted as an inpatient, that admission determines not only the obligations of the admitting hospital under EMTALA but also the obligations of other hospitals where the patient might be transferred. Of course, state law may obligate specialty facilities to accept certain inpatient transfers, even if EMTALA does not.

These CMS rules may create a new type of health care quality challenge. Hospitals may attempt to hold patients in emergency departments instead of admitting them as inpatients in order to preserve the facility's ability to transfer an unstable patient. In doing so, the originating hospital could face liability under both EMTALA and malpractice law for failure to properly stabilize a patient (in the case of EMTALA, the duty is absolute; in the case of malpractice liability, the issue would focus on the professional standard of institutional care when dealing with a unstable patient with the type of emergency medical condition in question). This practice would also exacerbate ED crowding.

If, on the other hand, the originating hospital admits the patient in order to diagnose and/or stabilize him or her but cannot do so, the obligations of the transfer facility are extinguished, yet the originating hospital may face medical negligence or COP charges for substandard care in its efforts to admit and stabilize. Children more likely adversely affected under this scenario as many hospitals lack sub-specialty services needed to deal with complex injury and illness in the very young.

It is also worth noting that courts show unease with the stabilization rule. If additional courts follow the lead of the Court of Appeals for the Sixth Circuit in *Moses*, discussed above, then an inpatient admission will not extinguish the EMTALA obligations of either the originating or the transfer hospital, regardless of what the rules say.

The bottom line is that hospitals must be aware that the law is unsettled here. Admitting a patient may, if the CMS rules are presumed to apply, affect the rights of the patient and the obligations of the receiving hospital if a transfer is necessary. Not attempting an inpatient stabilization prior to transfer may open up the originating hospital to both EMTALA and medical liability, and yet avoiding admission becomes urgent under the EMTALA rules if the originating hospital is to maintain any federally protected transfer options to a specialty facility.

Consider a hypothetical child who comes to the emergency room of a community hospital with a parent reporting that the child has seizures. After appropriate screening, it is determined that the seizures

present an emergency condition and the child is unstable, but that the child may have an underlying medical condition causing the seizure disorder and may require specialty pediatric neurology and diagnostic services that are not available at the community hospital. If the community hospital recognizes the potential for a complex underlying condition and thus seeks to transfer the child to a hospital with the necessary specialized capabilities for stabilization and treatment, the specialty hospital will have an EMTALA obligation to accept a medically appropriate transfer and stabilize the child upon arrival.⁵⁵ If, on the other hand, the community hospital admits the child as an inpatient in order to fully diagnose the etiology of the seizures to be able to appropriately stabilize the child, then the specialty hospital will have no obligation to accept a subsequent transfer under EMTALA in federal circuits that adhere to the CMS standard, but may be obligated in those judicial circuits that, like the Sixth Circuit, have found the standard to be contrary to the statute and to Congressional intent.

Community and specialty hospitals can help ease this dilemma by developing protocols governing patient transfers both before and after inpatient admission. Clearly, the paramount issue is the well-being of the child, not whether or how the two hospitals will share liability and payment for stabilization and treatment. Advance protocols that address certain common types of emergency situations such as respiratory illnesses, traumatic injury, and other conditions requiring surgical intervention would seem highly warranted so that community hospitals can be better guided in their medical judgments as to whether to attempt an inpatient admission and stabilization prior to transfer or, alternatively, to allow the transfer to rapidly take place prior to admission. Such agreements would serve a second purpose as well, since they would be evidence of carefully developed treatment protocols representing the professional standard of care and could, in a liability situation, serve as evidence of appropriate professional conduct in addressing what might be life-and-death matters.

¹ Title IX of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. No. 99-272, § 912(b), 100 Stat. 82, 164 (1986) adding Section 1867 to the Social Security Act. (Codified as amended at 42 U.S.C.A. § 1395dd (1992 and Supp. 1997)). The acronym EMTALA comes from the original name of the legislation, the “Emergency Medical Treatment and Active Labor Act.” The word “active” was subsequently removed from the title. Sec. 6211(h)(2), Pub. L. No. 101-239, The Omnibus Budget Reconciliation Act of 1989. The text of the law can be found codified as Section 1867 of the Social Security Act in the United States Code under the heading “Examination and Treatment for Emergency Medical Conditions and Women in Labor.” 42 U.S.C. § 1395dd (2008). Implementing regulations can be found in the Code of Federal Regulations at 42 CFR § 489.24 et seq.

² 42 U.S.C. §1395dd(a) (1). Federal regulations interpreting the statute, 42 CFR § 489.24(a), define the term “dedicated emergency department” as:

[A]ny department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements:

- (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department;
- (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or
- (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

³ 68 Fed. Reg. 53223 (September 9, 2003) (citing EMTALA’s legislative history at H.R. Rept. No. 99-241, Part I, 99th Cong., 1st Sess. (1985), p.27.).

⁴ The regulations clarify that “comes to” the emergency department means that a person who is not already a patient (inpatient or outpatient):

- (1) Has presented at a hospital’s dedicated emergency department, as defined in this section, and requests examination or treatment for a medical condition, or has such a request made on his or her behalf. In the absence of such a request by or on behalf of the individual, a request on behalf of the individual will be considered to exist if a prudent layperson observer would believe, based on the individual’s appearance or behavior, that the individual needs examination or treatment for a medical condition;
- (2) Has presented on hospital property, as defined in this section, other than the dedicated emergency department, and requests examination or treatment for what may be an emergency medical condition, or has such a request made on his or her behalf. In the absence of such a request by or on behalf of the individual, a request on behalf of the individual will be considered to exist if a prudent layperson observer would believe, based on the individual’s appearance or behavior, that the individual needs emergency examination or treatment; [or]
- (3) [is in an ambulance for purposes of receiving emergency medical examination and treatment at the hospital (see regulation for additional details of this provision)]

42 CFR § 489.24(b) (2008).

⁵ According to the definition of “comes to the emergency department” (note 4, *supra*), the request may either be made by the person or on behalf of the person, or a request will be assumed if the person appears to be in need of examination or treatment for a medical condition. 42 CFR § 489.24(b). The regulations clarify that if the person is seeking care for a non-emergency medical condition, the hospital is only required “to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition.” 42 CFR § 489.24(c).

⁶ 42 CFR § 489.24(a)(1)(i).

⁷ 42 CFR § 489.24(d)(1).

⁸ 42 U.S.C. § 1395dd (2008).

⁹ 59 FR 32086, 32121 (June 22, 1994).

¹⁰ See, e.g., *Harry v. Marchant*, 291 F.3d 767 (11th Cir. 2002); *Bryan v. Rectors & Visitors of the Univ. of Va.*, 95 F.3d 349 (4th Cir. Va. 1996).

¹¹ See, e.g., *Bryant v. Adventist Health System/West*, 289 F.3d 1162 (9th Cir. 2002).

¹² *Lopez-Soto v. Hawayek*, 175 F.3d 170 (1999).

¹³ See below for a discussion of the special case of newborns under EMTALA.

¹⁴ *Roberts v. Galen of Virginia*, 525 U.S. 249 (1999).

¹⁵ See, e.g., *Thornton v. Southwest Detroit Hospital*, 895 F.2d 1131 (6th Cir. 1990); *Smith v. Richmond Mem’l Hosp.*, 416 S.E.2d 689 (Va. 1992).

¹⁶ 291 F.3d 767 (11th Cir. 2002).

¹⁷ 42 U.S.C. § 1396dd(e)(2).

¹⁸ 68 Fed. Reg. 53222-53264.

¹⁹ 68 Fed. Reg. 53232. “Hospital property” includes the entire hospital campus, including the parking lot, sidewalk, and driveway, except areas or structures of the hospital’s main building that are not part of the hospital, such as physician offices, rural health centers, skilled nursing facilities, or other entities that participate separately under Medicare, or restaurants, shops, or other nonmedical facilities. 42 CFR § 489.24(b) and 42 CFR § 413.65(b).

²⁰ 68 Fed. Reg. 53229.

²¹ 42 CFR § 489.24(d)(2).

²² 68 Fed. Reg. 53244.

²³ The regulations set forth no administrative procedure for filing such complaints.

²⁴ 68 Fed. Reg. 53245.

²⁵ See, e.g., *Anderson v. Kindred Hospital*, Case No. 1:05-cv-294 (E.D. Tenn. Mar. 24, 2008); *Quinn v. BJC Health Sys.*, 364 F. Supp. 2d 1046 (E.D. Mo. 2005).

²⁶ *Lima-Rivera v. UHS of Puerto Rico*, 476 F. Supp. 2d 92 (2007).

²⁷ *Moses v. Providence Hospital*, 561 F.3d 573 (6th Cir. 2009).

²⁸ “Lima-Rivera’s newborn arrived at HSPE seeking treatment when he was birthed in the operating room after a cesarean section.” 476 F. Supp. 2d at 98.

²⁹ “At the nursery, the baby presented tachypnea and evidence of hypotonia, which are medically considered critical conditions.” 476 F. Supp. 2d at 99.

³⁰ 561 F. 3d at 583-4.

³¹ 561 F. 3d at 583..

³² *Morgan v. North Mississippi Medical Center, Inc.*, 403 F. Supp.2d 1115 (S.D. Ala. 2005).

³³ *Morgan v. North Mississippi Medical Center, Inc.*, 458 F. Supp. 2d 1341 (S.D. Ala. 2006).

³⁴ 2008 U.S. Dist. LEXIS 23162 (D. Tenn., Mar. 24, 2008).

³⁵ 588 F. Supp. 2d 210 (D.P.R. 2008).

³⁶ 2008 U.S. Dist. LEXIS 30262 (D. Ind., Mar. 31, 2008).

³⁷ 747 N.W. 2d 173 (Wis. App. 2008).

³⁸ 2007 U.S. Dist. LEXIS 76954 (W.D. Ark. Oct. 5, 2007).

³⁹ Pub. L. 107-207 (2002), codified at 1 U.S.C. § 8 (2008).

⁴⁰ “In determining the meaning of any Act of Congress, or of any ruling, regulation, or interpretation of the various administrative bureaus and agencies of the United States, the words “person”, “human being”, “child”, and “individual”, shall include every infant member of the species homo sapiens who is born alive at any stage of development.” 1 U.S.C. § 8(a).

⁴¹ “As used in this section, the term “born alive”, with respect to a member of the species homo sapiens, means the complete expulsion or extraction from his or her mother of that member, at any stage of development, who after such expulsion or extraction breathes or has a beating heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, regardless of whether the umbilical cord has been cut, and regardless of whether the expulsion or extraction occurs as a result of natural or induced labor, cesarean section, or induced abortion.” 1 U.S.C. § 8(b).

⁴² 1 U.S.C. § 8(b)

⁴³ 175 F.3d at 177. (“[T]he infant decedent’s arrival in the operating room and the Hospital’s prompt detection of an emergency medical condition, if proven, will suffice to engage the gears of EMTALA’s stabilization and transfer obligations.”)

⁴⁴ 476 F. Supp. 2d at 98.

⁴⁵ *Preston v. Meriter Hospital, Inc.*, 747 N.W. 2d 173 (Wis. App. 2008).

⁴⁶ 747 N.W. 2d at 187-188 (“Birth, the very treatment for which Preston presented, was also treatment affecting [the infant. To conclude that the baby] was not an inpatient at the hospital under EMTALA even though his laboring mother was would defy common sense. . . . We conclude that for purposes of the applicability of the EMTALA screening requirement, when a hospital provides inpatient care to a woman that involves treating her fetus simultaneously, the unborn child is a second inpatient, admitted at the same time as the mother.”).

⁴⁷ 73 Fed. Reg. 23668, et seq.

⁴⁸ 73 Fed. Reg. 23670.

⁴⁹ 73 Fed. Reg. 48434-49083 (Oct. 1, 2008)

⁵⁰ 72 Fed. Reg. 48659-48660 (“[I]f an individual with an unstable emergency medical condition is admitted, the EMTALA obligation has ended for the admitting hospital and even if the individual’s emergency medical condition remains unstabilized and the individual requires special services only available at another hospital, the hospital with specialized capabilities does not have an EMTALA obligation to accept an appropriate transfer of that individual. However, we would like to emphasize that if an individual presents to a hospital with a dedicated emergency department and is found to have an emergency medical condition that requires stabilizing treatment which requires specialized treatment not available at the hospital where the individual presented, and has not been admitted as an inpatient, then another Medicare-participating hospital with the requisite specialized capabilities is obligated under EMTALA to accept the appropriate transfer of this individual so long as it has the capacity to treat the individual.”)

⁵¹ Department of Health and Human Services, Center for Medicare and Medicaid Services, Inpatient Prospective Payment System (IPPS) 2009 Final Rule Revisions to Emergency Medical Treatment and Labor Act (EMTALA) Regulations (March 6, 2009).

⁵² *Moses v. Providence Hospital*, 561 F.3d 573 (6th Cir. 2009).

⁵³ 561 F.3d at 583-4.

⁵⁴ Additional issues related to transfers under EMTALA will be addressed in a later memorandum.

⁵⁵ Hospitals with specialized capabilities or facilities have an obligation to accept appropriate transfers as set forth in 42 CFR § 489.24(f).