EMTALA or Not? Diagnostic Testing “Round Trip\Back Transfer”

Sending a patient to a different facility (hospital or diagnostic center) for testing with the expectation of returning for final disposition.

This is a common scenario, but not straightforward. There are several nuances impacting the regulatory aspects, as well as certain standard of care challenges.

Short Answer:

CMS addressed this specific issue in its EMTALA “Guidance to Surveyors”. EMTALA may apply to the sending facility “transport\transfer” and although unlikely to apply to the “receiving\testing” facility related to the “back transfer”. See long answer for details.

Most importantly, you need a policy with regard to both sending & receiving patients for “diagnostic services only”. You may have one & just unaware, but if you do not have a policy (for both), put it on your “to do list”.

The policy for the sending facility needs to address EMTALA, other Medicare Certificate of Participation (CoP) requirements, state regulations, The Joint Commission (TJC) standards, community standards of care & perhaps other requirements for such “transports” (i.e. movement of a patient with the intent of returning to the original facility).

The receiving facility policy needs to address the same transfer issues related to the “back transfer” and in addition several other issues, including the process for managing the order request\availability, monitoring of patients while onsite, how results are addressed\conveyed to sending facility, and most importantly how to manage untoward situations.

Under EMTALA, a “transfer” is defined as “movement of an individual” (see below), so from a statutory standpoint the “transport” (at least in the forward direction) is likely to be considered a “transfer”. This assumes the receiving facility bills under a different Medicare provider number. If it is the same number (e.g. FSED to “mothership” hospital), then EMTALA technically does not apply (although other regulations may).

Long Answer:

Although this specific scenario is not addressed in the EMTALA statute or regulations (other than general transfer requirements), CMS did address it in the EMTALA “Interpretive Guidelines” (see below). NOTE: While instructive as to how CMS may enforce EMTALA, the Interpretive Guidelines do not have the force of law or regulation and typically cannot be used as an effective defense.

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<td>If an individual is moved to a diagnostic facility located at another hospital for diagnostic procedures not available at the transferring hospital, and the hospitals arrange to return the individual to the transferring hospital, the transfer requirements must still be met by the sending hospital. The recipient hospital is not obligated to meet the EMTALA transfer requirements when implementing an appropriate transfer back to the transferring hospital. However, it is reasonable to expect the recipient hospital with the diagnostic capability to communicate (e.g., telephonic report or documentation within the medical record) with the transferring hospital its findings of the medical condition and a status report of the individual during and after the procedure.</td>
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Breakdown of EMTALA Requirements:

NOTE: Medical Screening Examination (MSE), Emergency Medical Condition (EMC), “stable”, and “transfer” are defined in EMTALA, which may differ from common medical vernacular & understanding.

The MSE sole purpose is to determine if an EMC exits. If an EMC exist, you must “stabilise” within the capacity & capability of your entire hospital. NOTE: There is a nuance in the statute between “stabilization” & “treatment”. While certain “treatments” may be required to stabilize the EMC, EMTALA does not require that you necessarily resolve or provide definitive treatment. In other words, you are only required to provide care necessary to “within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer”. This why you can “discharge” (also considered a “transfer”) patients with a “stabilized EMC” and EMTALA does not apply.

Nevertheless, assuming an EMC, if you contemplate transfer (for any reason) you must determine if the EMC is “stable” or “unstable”.

If there is no EMC (e.g. contusion in which a fracture has been ruled out) or the EMC has been “stabilised” (e.g. a fracture that has been splinted & definitive care arranged on an outpatient basis), then the patient can be discharged (albeit still considered a “transfer” under EMTALA).

If there is an EMC and you contemplate a “transfer” to a different facility, you may (technically) do so for any reason as long as the patient is “stable” since EMTALA does not apply to “EMTALA-stable” patients. However, if you have not yet ruled out an EMC (i.e. MSE not yet complete) or the EMC is “unstable”, you must perform a formal “appropriate” EMTALA transfer in which the benefits of the transfer are outweighed by the risks (see regulation below).

42CFR489.24 (b) Definitions.

Transfer means the movement (including the discharge) of an individual outside a hospital’s facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (i) has been declared dead, or (ii) leaves the facility without the permission of any such person.

Emergency medical condition means—

(1) 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—
   (i) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
   (ii) Serious impairment to bodily functions; or
   (iii) Serious dysfunction of any bodily organ or part; or
(2) With respect to a pregnant woman who is having contractions—
   (i) That there is inadequate time to effect a safe transfer to another hospital before delivery; or
   (ii) That transfer may pose a threat to the health or safety of the woman or the unborn child.

Stabilized means, with respect to an “emergency medical condition” as defined in this section under paragraph (1) of that definition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility or, with respect to an “emergency medical condition” as defined in this section under paragraph (2) of that definition, that the woman has delivered the child and the placenta.

To stabilise means, with respect to an “emergency medical condition” as defined in this section under paragraph (1) of that definition, to 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, with respect to an “emergency medical condition” as defined in this section under paragraph (2) of that definition, the woman has delivered the child and the placenta.

42CFR489.24 (e) 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 (e)(2) of this section); and

   (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;

   (B) A physician (within the meaning of section 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 woman or the unborn child, from being transferred. The certification must contain a summary of the risks and benefits upon which it is based; or

   (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 (e)(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.

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;

   (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;

   (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 (e)(1)(ii) of this section, and the name and address of any on-call physician (described in paragraph (g) 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

   (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.

“Round Trip” Transfer (Transport) for Diagnostic Testing = “Unstable Transfer”

In this scenario under EMTALA, the MSE has not as yet been completed, so you cannot say with certainly (in most cases) that there is no EMC, or if there were an EMC that it is “stable”. Therefore, it may be prudent to assume there is an “unstable EMC”. So, if you are “moving” the patient “outside a hospital's facilities”, under EMTALA it may meet the definition of an “unstable transfer” depending on the facts and circumstances, even if the intent is for the patient to eventually return to the sending facility. Therefore, to be EMTALA compliant it may be prudent
to perform a formal “appropriate” transfer. How this is accomplished will depend on various factors, ergo the need for a well-thought-out hospital policy on BOTH sides of the interaction.

Technical Exceptions: As noted above, EMTALA does not apply if both facilities are under the same Medicare Provider Number (even if miles apart). EMTALA also would not apply to inpatients. Again, practical circumstances may dictate otherwise.

“Back Transfer” (Transport) after Diagnostic Testing = Multiple Possibilities

While EMTALA likely may apply to the sending hospital, does it apply to the receiving (diagnostic) facility? It depends and there are technical & practical answers.

Technical (murky) Answer: Based on the “appropriate transfer” requirements, the receiving facility will need to “accept” the patient and verify they have the capability\capacity for the requested treatment. Contrary to common EMTALA misperception, that acceptance does not require a physician. Anyone designated by the hospital to accept can do so. In this case it will likely be someone in radiology or outpatient admitting.

For EMTALA to be encumbered at the receiving hospital there are very technical requirements, including undefinable nuances if the individual does not present to the “Dedicated ED” (DED). The following assumes the individual is presenting to an outpatient department (e.g. radiology) that is NOT a DED.

1) If the individual is coming from another hospital from inpatient status, EMTALA does not apply to either hospital. CMS has been very definitive in this determination; although some EMTALA experts disagree with their interpretation (aka courts may disagree as well).

2) If the individual is coming from another ED (or observation status) for a scheduled outpatient (OP) test, EMTALA does not apply once the OP encounter has begun. This is because, at that point, the individual is technically a “patient”, no longer meets the definition of “comes to the ED”, and is protected by all the other Medicare Certificate of Participation (CoP) regulations. However, for the OP “encounter” to official begin, the individual must have “direct personal contact between a patient and a physician, or other person who is authorized by State licensure law . . . to order or furnish hospital services for diagnosis or treatment of the patient.” For many hospitals, this means a nurse has assessed the individual. Whether radiology technician (not all states license them) contact would qualify may be debatable. These nuances beg for a well-written policy that is followed to the letter.

3) However, up until the “OP encounter begins”, if the individual (not as yet a “patient”) requests (or someone on their behalf or a prudent medical person would assume) evaluation & treatment beyond what has already been scheduled, this may trigger an EMTALA obligation and require a trip to the ED.

So in most instances, a scheduled “incoming transfer” solely for outpatient diagnostic services, EMTALA would (technically) not apply to that visit. But, this does not mean the hospital does not have other obligation to the patient under Medicare CoPs, state laws, TJC, and community standards of care.

Practical Answer: While it should be clear that the patient is at the diagnostic facility solely for the scheduled test, unexpected\untoward events can alter circumstances. For example, who (if anyone) will monitor the patient during the time at the receiving hospital? Suppose the test is positive (perhaps even for an unexpected finding) which might indicate the need for urgent treatment or perhaps for services that will not be available at the sending facility (or perhaps even at the diagnostic facility). Who will determine this and manage ongoing care? Who will communicate results to the sending facility and will that be done before the patient returns in case it might alter disposition? Who will do the necessary paperwork? All good questions, for which the answer is
unlikely to be the radiologist, radiology tech or nurse assigned to the radiology department (assuming there is one).

**42CFR489.24 (a) Applicability of provisions of this section.**

(1) In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) “comes to the emergency department”, as defined in paragraph (b) of this section, the hospital must—

(i) Provide an appropriate medical screening examination within the capability of the hospital’s emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations and who meets the requirements of §482.55 of this chapter concerning emergency services personnel and direction; and

**Interpretive Guidelines §489.24(a)(1)(i)**

A “hospital with an emergency department” is defined in §489.24(b) as a hospital with a dedicated emergency department. An EMTALA obligation is triggered for such a hospital when an individual comes by him or herself, with another person, to a hospital’s dedicated emergency department (as that term is defined above) and a request is made by the individual or on the individual’s behalf, or a prudent layperson observer would conclude from the individual’s appearance or behavior a need, for examination or treatment of a medical condition. In such a case, the hospital has incurred an obligation to provide an appropriate medical screening examination (MSE) for the individual and stabilizing treatment or an appropriate transfer. The purpose of the MSE is to determine whether or not an emergency medical condition exists.

If an individual who is not a hospital patient comes elsewhere on hospital property (that is, the individual comes to the hospital but not to the dedicated emergency department), an EMTALA obligation on the part of the hospital may be triggered if either the individual requests examination or treatment for an emergency medical condition or if a prudent layperson observer would believe that the individual is suffering from an emergency medical condition. The term “hospital property” means the entire main hospital campus as defined in §413.65(a), including the parking lot, sidewalk and driveway or hospital departments, including any building owned by the hospital that are within 250 yards of the hospital).

If an individual is registered as an outpatient of the hospital and they present on hospital property but not to a dedicated emergency department, the hospital does not incur an obligation to provide a medical screening examination for that individual if they have begun to receive a scheduled course of outpatient care. Such an individual is protected by the hospital Conditions of Participation (CoPs) that protect patient’s health and safety and to ensure that quality care is furnished to all patients in Medicare-participating hospital. If such an individual experiences an EMC while receiving outpatient care, the hospital does not have an obligation to conduct an MSE for that patient. As discussed in greater detail below, such a patient has adequate protections under the Medicare CoPs and state law.

If an individual is initially screened in a department or facility on-campus outside of the ED, the individual could be moved to another hospital department or facility on-campus to receive further screening or stabilizing treatment 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 bona fide medical reason to move the individual; and (3) appropriate medical personnel accompany the individual. The same is also true for an individual who presents to the dedicated emergency department (e.g., patient with an eye injury in need of stationary ophthalmology equipment located in the eye clinic) and must be moved to another hospital-owned facility or department on-campus for further screening or stabilizing treatment. The movement of the individual between hospital departments is not considered an EMTALA transfer under this section, since the individual is simply being moved from one department of a hospital to another department or facility of the same hospital.

**Hospitals should not move individuals to off-campus facilities or departments** (such as an urgent care center or
satellite clinic) for a MSE. If an individual comes to a hospital-owned facility or department, which is off-campus and operates under the hospital’s Medicare provider number, §1867 (42 CFR 489.24) will not apply to that facility and/or department unless it meets the definition of a dedicated emergency department. If, however, such a facility does not meet the definition of a dedicated ED, it must screen and stabilize the patient to the best of its ability or execute an appropriate transfer if necessary to another hospital or to the hospital on whose Medicare provider number it is operated. Hospital resources and staff available at the main campus are likewise available to individuals seeking care at the off-campus facilities or departments within the capability of the hospital. Movement of the individual to the main campus of the hospital is not considered a transfer since the individual is simply being moved from one department of a hospital to another department or facility of the same hospital. In addition, a transfer from such an entity (i.e., an off-campus facility that meets the definition of a dedicated ED) to a nonaffiliated hospital (i.e., a hospital that does not own the off-campus facility) is allowed where the facility at which the individual presented cannot stabilize the individual and the benefits of transfer exceed the risks of transfer. In other words, there is no requirement under EMTALA that the individual be always transferred back to the hospital that owns and operates the off-campus dedicated ED. Rather, the requirement of EMTALA is that the individual be transferred to an appropriate facility for treatment.

**Conclusions:** The above might merely be of academic interest if it were not for real-world examples below. Hospitals must consider these issues and develop policies & procedures to account for multiple possibilities, some of which will be dictated by perhaps unique circumstances.

**Real (somewhat embellished) EMTALA Case Studies:**

**Case Study: Two-year-old with possible intussusception**

2YOM presents with decreased appetite & crampy abdominal pain. No gross blood per rectum, but stool weakly heme positive. Temp normal & abdomen soft. Working diagnosis is intussusception. Abdominal x-ray is non-diagnostic. A general surgeon with peds surgery privileges is on-call, but neither ultrasound nor gastrografin enema are available. While abdominal CT is an option, due to radiation other options are considered. The children’s hospital 15 miles away is contacted and an outpatient ultrasound arranged.

**EMTALA Considerations:**

1) Does the patient have an EMC (refer to the statutory definition)? In this case you do not know, because the MSE is ongoing and there is a need for a diagnostic test (that you do not have) to rule out one possible EMC. Of course there may be other possible EMCS besides intussusception. So for the purposes of EMTALA the patient should be considered to have an EMC until, within a reasonable medical probability, it has been ruled out.

2) Is the patient unstable? Again, refer to the statutory definition, i.e. “within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer”.

a. Although we do not have all the details, in this case one might make a reasonable argument that the patient is “stable” by the statutory definition. That being the case, EMTALA would not apply and you can just do what is best for the patient within the community standards of care. Good documentation is necessary to avoid unanticipated untoward events. Also state law may apply. For example in Arizona there is the statutory concept of “transport” (i.e. a patient sent to another facility for a diagnostic test with the anticipation of returning to the original facility). So there may be certain requirements necessary even though federal law (EMTALA) might not apply.

b. Let’s suppose you (at the sending facility) decide the patient is EMTALA “unstable” (BTW: You do get to decide, not the facility you are calling). In that case you must do an “appropriate transfer” (see statutory requirements, but it’s what we normally refer to as an EMTALA transfer). But in this case, you are not
necessarily requesting “transfer of care”, but simply an outpatient diagnostic test with the expectation the child will return. It is unclear if the facility you call is required to accept the patient (i.e. provide the requested services) under these circumstances. However, if you requested a “transfer of care” (no return expected), then they would have an EMTALA obligation to accept. Nuanced, but different.

c. This leaves the question of “back transfer”. If the ultrasound shows intussusception, is the child now “unstable”? Even if negative, it may become more complicated because you still do not know what’s wrong. Does the receiving hospital have any further obligation to this patient (even if not under EMTALA)? What is the community standard of care?

My Opinion: Irrespective of CMS Interpretive Guidelines, I believe most EPs would believe the receiving hospital would have some obligation to reassess the patient prior to repatriation. While a Qualified Medical Provider (QMP) & full EMTALA MSE may technically not be required, a lot can happened in the 2+ hours all this takes. Then there are issues of exactly what might be available at the original sending hospital. Will the general surgeon be willing to admit, especially since the child just returned from the “children’s hospital”? There may be too many variables to assume simply sending the child back would be reasonable. So this begs the original question. Should you just “transfer care” and allow the referral ED to sort out disposition? “Back transfers” and “pseudo-acceptance” are fraught with landmines (EMTALA & otherwise) and perhaps may not be worth the risk. It’s also probably better care for the patient to complete treatment where they are. I have seen patients transferred 2-3 times before things ultimately get figured out.

Case Study: 75 year-old-male with headache, history of hypertension, taking low dose aspirin

Physical exam normal, but CT is broken. Patient transferred 30 minutes to another hospital (no neurosurgery) for non-contrast brain CT with anticipated return. CT is performed and patient immediately returned, because ambulance crew was standing by. While en route back, the radiologist calls the sending ED physician noting an subdural hematoma. The original sending hospital also does not have neurosurgery. The EP reaches the ambulance crew en route and diverts them to a third hospital. Hospital #3 receives the patient but on that particular day, they also do not have neurosurgery. Patient is ultimately airlifted to a fourth hospital out of state. The patient ultimately does well, but an EMTALA action ensues and the same cannot be said for the hospitals involved.

Case Study: 26 year-old-female with lower abdominal pain, vaginal Bleeding & positive pregnancy test

A local urgent care (i.e. not an EMTALA facility) arranges with hospital outpatient radiology for a pelvic ultrasound to r/o ectopic. Patient has an IV and is sent by ambulance. No specific request is made by the patient or sending physician for an ED evaluation. ED was unaware of the situation.

The ultrasound was performed on the ambulance gurney and the patient returned to the urgent care having spent only about 30 minutes at the hospital. About 30 minutes after that, a frantic radiologist calls the ED to report a ruptured ectopic with massive bleeding. The gravity of the situation becomes clear as about this time the ambulance returned, this time to the ED with CPR in progress.

At trial it was (“successfully”) argued the hospital did not have an EMTALA obligation, because the original request (i.e. patient was not registered as an ED patient – only OP) and she was sent directly back to the urgent care. But because it was an Arizona hospital it was argued the hospital had violated state “transport” regulations that require monitoring and nursing assessment prior to “transport”. This may also be a Joint Commission standard as well.
This is a classic example of a lack of or poorly written hospital policies & procedures. Apparently, no one had ever anticipated what to do if an OP test was actually positive. As part of the hospital’s “EMTALA Plan of Correction”, Policy Option A noted below was adopted, amongst other policy details.

**Case Study: 2 year-old-male with shortness of breath, fever, cough seen by PCP**

2 year old with respiratory distress seen by PCP and sent to the local (closest) hospital for an OP CXR, which revealed a “whiteout” of one lung. Results called to PCP who advised the mother to take the child to the “Children’s Hospital” about 30-40 minutes away. Mother does so and the child codes about 10 minutes prior to arrival. In this case (perhaps contrary to its own guidance), CMS cited the original hospital for an EMTALA violation based on implied request because the results were available before the patient left and a reasonable medical person would have known the child require immediate medical attention and was “unstable” requiring an “appropriate” transfer.

Turns out this was a hospital in the same system as the previous case, so the former adopted policy was refined such that any significant abnormality discovered during an outpatient diagnostic test required an ED evaluation. See Policy Option B below.

**Below are several possible policy solutions to these situations (these are not complete policies).**

NOTE: None of these cases are technically regulated by EMTALA, but are regulated under other Medicare CoPs, perhaps state law, TJC, and community standards of care.

A) Outpatient diagnostic testing referral patients must have a preliminary interpretation prior to being returned back to the originating facility. If the diagnostic test is negative and there is no change in patient condition, they may be returned as planned. Vital signs and nursing assessment must be done prior to repatriation. [NOTE: This is a local state regulatory requirement.] If there is a significant positive finding, contact will be made with the referring provider to determine the best course of action. [NOTE: In this case you are allowing an external provider to determine disposition of a patient technically under the hospital’s care. Something to carefully consider.] If at any time the patient’s condition deteriorates or there is a significant risk for deterioration, the patient will be taken to the ED for further evaluation.

B) Outpatient diagnostic testing referral patients must have a preliminary interpretation prior to being returned back to the originating facility or referred elsewhere. Significant acute abnormality discovered during an outpatient diagnostic test requires an ED evaluation prior to disposition. If the diagnostic test is negative and there is no change in patient condition, they may be returned as planned or as directed by the ordering physician. Vital signs and nursing assessment must be done prior to repatriation. If at any time the patient’s condition deteriorates or there is a significant risk for deterioration, the patient will be taken to the ED for further evaluation.

C) Any patient being directly referred from another medical facility for an outpatient test must be evaluated in the ED before & after the test is performed. Disposition may include transfer back to the originating facility, admission or discharge as determined by the examining physician in consultation with the referring physician. [NOTE: This is the “safest” way to handle such referrals, but depending on resources may be impractical and perhaps “overkill”].

D) Other options may be reasonable depending on local resources & community standards of care. However, if anything goes wrong, everyone will likely be sued. Regardless, documentation, as always, is critical.

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