

individual to the community plan hospital. An example of a community wide plan would be a trauma system hospital. A trauma system is a comprehensive system providing injury prevention services and timely and appropriate delivery of emergency medical treatment for people with acute illness and traumatic injury. These systems are designed so that patients with catastrophic injuries will have the quickest possible access to an established trauma center or a hospital that has the capabilities to provide comprehensive emergency medical care. These systems ensure that the severely injured patient can be rapidly cared for in the facility that is most appropriately prepared to treat the severity of injury.

Community plans are designed to provide an organized, pre-planned response to patient needs to assure the best patient care and efficient use of limited health care resources. Community plans are designed to augment physician's care if the necessary services are not within the capability of the hospital but does not mandate patient care nor transfer patterns. Patient health status frequently depends on the appropriate use of the community plans. The matching of the appropriate facility with the needs of the patient is the focal point of this plan and assures every patient receives the best care possible. Therefore, a sending hospital's appropriate transfer of an individual in accordance with community wide protocols in instances where it cannot provide stabilizing treatment would be deemed to indicate compliance with §1867.

If an individual seeking care is a member of a managed health care plan (e.g., HMO, PPO or CMP), the hospital is obligated to comply with the requirements of § 489.24 regardless of the individual's payor source or financial status. The hospitals is obligated to provide the services necessary to determine if an EMC is present and provide stabilizing treatment if indicated. This is true regardless if the individual is enrolled in a managed care plan that restricts its enrollees' choice of health care provider. EMTALA is a requirement imposed on hospitals, and the fact that an individual who comes to the hospital is enrolled in a managed care plan that does not contract with that hospital has no bearing on the obligation of the hospital to conduct an MSE and to at least initiate stabilizing treatment. A managed health care plan may only state the services for which it will pay or decline payment, but that does not excuse the hospital from compliance with EMTALA.

42 CFR § 489.24 (b) defines **stabilized** to mean

"... 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 (1) of that definition, that a woman has delivered the child and the placenta."

The regulation sets the standard determining when a patient is stabilized.

If a hospital is unable to stabilize an individual within its capability, an appropriate transfer should be implemented. To be considered stable the emergency medical condition that caused the individual to seek care in the dedicated ED must be resolved, although the underlying medical condition may persist. For example, an individual

presents to a hospital complaining of chest tightness, wheezing, and shortness of breath and has a medical history of asthma. The physician completes a medical screening examination and diagnoses the individual as having an asthma attack that is an emergency medical condition. Stabilizing treatment is provided (medication and oxygen) to alleviate the acute respiratory symptoms. In this scenario the EMC was resolved and the hospital's EMTALA obligation is therefore ended, but the underlying medical condition of asthma still exists. After stabilizing the individual, the hospital no longer has an EMTALA obligation. The physician may discharge the individual home, admit him/her to the hospital, or transfer (the "appropriate transfer" requirement under EMTALA does not apply to this situation since the individual has been stabilized) the individual to another hospital depending on his/her needs. The preceding example does not reflect a change in policy, rather it is a clarification as to when an appropriate transfer is to be implemented to decrease hospitals risk of being in violation of EMTALA due to inappropriate transfers.

An individual will be deemed stabilized if the treating physician or QMP attending to the individual in the emergency department/hospital has determined, within reasonable clinical confidence, that the emergency medical condition has been resolved.

For those individuals whose EMCs have been resolved the physician or QMP has several options:

- Discharge home with follow-up instructions. An individual is considered stable and ready for discharge when, within reasonable clinical confidence, it is determined that the individual has reached the point where his/her continued care, including diagnostic work-up and/or treatment, could be reasonably performed as an outpatient or later as an inpatient, provided the individual is given a plan for appropriate follow-up care as part of the discharge instructions. The EMC that caused the individual to present to the dedicated ED must be resolved, but the underlying medical condition may persist. Hospitals are expected within reason to assist/provide discharged individuals the necessary information to secure the necessary follow-up care to prevent relapse or worsening of the medical condition upon release from the hospital; or
- Inpatient admission for continued care.

Hospitals are responsible for treating and stabilizing, within their capacity and capability, any individual who presents him/herself to a hospital with an EMC. The hospital must provide care until the condition ceases to be an emergency or until the individual is properly transferred to another facility. An inappropriate transfer or discharge of an individual with an EMC would be a violation of EMTALA.

If a hospital is alleged to have violated EMTALA by transferring an unstable individual without implementing an appropriate transfer according to §489.24(e), and the hospital believes that the individual was stable (EMC resolved) the burden of proof is the responsibility of the transferring hospital. When interpreting the facts the surveyor should assess whether or not the individual was stable. Was it reasonable to believe that the transferring hospital should have been knowledgeable of the potential complications

during transport? To determine whether the individual was stable and treated appropriately surveyors will request that the QIO physician review the case.

If the treating physician is in doubt that an individual's EMC is stabilized the physician should implement an appropriate transfer (see Tag A409) to prevent a potential violation of EMTALA, if his/her hospital cannot provide further stabilizing treatment.

If a physician is not physically present at the time of transfer, then the qualified medical personnel (as determined by hospital bylaws or other board-approved documents) must consult with a physician to determine if an individual with an EMC is to be transferred to another facility for further stabilizing treatment.

The failure of a receiving facility to provide the care it maintained it could provide to the individual when the transfer was arranged should not be construed to mean that the individual's condition worsened as a result of the transfer.

In the case of psychiatric emergencies, if an individual expressing suicidal or homicidal thoughts or gestures, if determined dangerous to self or others, would be considered to have an EMC.

Psychiatric patients are considered stable when they are protected and prevented from injuring or harming him/herself or others. The administration of chemical or physical restraints for purposes of transferring an individual from one facility to another may stabilize a psychiatric patient for a period of time and remove the immediate EMC but the underlying medical condition may persist and if not treated for longevity the patient may experience exacerbation of the EMC. Therefore, practitioners should use great care when determining if the medical condition is in fact stable after administering chemical or physical restraints.

A hospital's EMTALA obligation ends when a physician or qualified medical person has made a decision:

- That no emergency medical condition exists (even though the underlying medical condition may persist);
- That an emergency medical condition exists and the individual is appropriately transferred to another facility; or
- That an emergency medical condition exists and the individual is admitted to the hospital for further stabilizing treatment.

(ii) **For transfer of the individual to another medical facility in accordance with paragraph (e) of this section.**

**Interpretive Guidelines: §489.24(d)(1)(ii)**

When a hospital has exhausted all of its capabilities in attempting to resolve the EMC, it must effect an appropriate transfer of the individual (see Tag A409).

42 CFR § 489.24 (b) defines **transfer** to mean

“... the movement (including the discharge) of an individual outside a hospital’s facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who has been declared dead or leaves the facility without the permission of any such person. If discharge would result in the reasonable medical probability of material deterioration of the patient, the emergency medical condition should not be considered to have been stabilized.”

If an individual is admitted as an inpatient, EMCs must be stabilized either by the hospital to which an individual presents or the hospital to which the individual is transferred. If a woman is in labor, the hospital must deliver the baby and the placenta or transfer appropriately. She may not be transferred unless she, or a legally responsible person acting on her behalf, requests a transfer and a physician or other qualified medical personnel, in consultation with a physician, certifies that the benefits to the woman and/or the unborn child outweigh the risks associated with the transfer.

If the individual’s condition requires immediate medical stabilizing treatment and the hospital is not able to attend to that individual because the emergency department is operating beyond its capacity, then the hospital should transfer the individual to a hospital that has the capability and capacity to treat the individual’s EMC.

**(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**

**Interpretive Guidelines: §489.24(d)(2)(i)**

A hospital’s EMTALA obligation ends when the individual has been admitted in good faith for inpatient hospital services whether or not the individual has been stabilized. An individual is considered to be “admitted” when the decision is made to admit the individual to receive inpatient hospital services with the expectation that the patient will remain in the hospital at least overnight. Typically, we would expect that this would be documented in the patient’s chart and medical record at the time that a physician signed and dated the admission order. Hospital policies should clearly delineate, which practitioners are responsible for writing admission orders.

A hospital continues to have a responsibility to meet the patient emergency needs in accordance with hospital CoPs at 42 C.F.R. Part 482. The hospital CoPs protect individuals who are admitted, and they do not permit the hospital to inappropriately discharge or transfer any patient to another facility. The hospital CoPs that are most relevant in this case are as follows: emergency services, governing body, discharge planning, quality assurance and medical staff.

## APPENDIX B: AHCA Application for Hospital Emergency Service Exemption



### APPLICATION FOR HOSPITAL EMERGENCY SERVICE EXEMPTION

#### INSTRUCTIONS

1. Type or print in ink.
2. Attach additional pages if necessary.
3. Complete all sections.
4. Sign and date the form. (If an incomplete form is submitted, the exemption request will be denied.)
5. Mail completed form and all supporting documentation to:

Agency for Health Care Administration  
Hospital & Outpatient Services Unit  
2727 Mahan Drive, Mail Stop #31  
Tallahassee, FL 32308

#### SECTION I

1. For each service exemption requested, a separate application must be submitted.
2. An exemption request must be submitted for every service that you propose to provide on a part-time basis, and are unable to provide either directly or indirectly through arrangement with another hospital or physician, on a 24 hour per day, 7 day per week basis.

#### SECTION II

1. List all professionals at your hospital that are credentialed to perform the service for which you are requesting an exemption.
2. For each professional listed, include the full name, license number, specialty type, credentials and the privileges held at the hospital.
3. Attach a copy of the hospital bylaws concerning medical staff privileges.

#### SECTION III

1. Provide the number of patients presenting at the emergency department and receiving services at your hospital for the past 12 months, related to the exemption request.
2. Provide the number of patients presenting at your hospital's emergency department and transferred to another facility to receive services for the past 12 months, related to the exemption request.
3. Provide the number of patients diverted to other hospitals for emergency treatment for the past 12 months, related to the exemption request.
4. Provide the number of patients receiving services on an inpatient basis for the past 12 months, related to the exemption request.
5. Provide a projection of the number of emergency procedures related to the exemption request to be performed in your hospital's emergency department for the upcoming 12 months.

#### SECTION IV

1. List all hospitals within 50 miles that have the capability to provide the service on a 24 hour per day, 7 day per week basis, related to the exemption request.
2. Include the name of each hospital and the distance in miles it is located from your hospital.

#### SECTION V

1. Document all attempts made by your hospital to enter into agreements with other hospitals or physicians to provide the service on a 24 hour per day, 7 day per week basis. Attach copies of all documentation to support your initiatives. Document all efforts that have taken place in the past 12 months to recruit additional physicians. Include all other information that you feel is pertinent to why your hospital cannot provide the service 24 hours per day, 7 days per week.

AHCA 3000-1 (REVISED JUNE 1, 2004)



**APPLICATION FOR HOSPITAL  
EMERGENCY SERVICE EXEMPTION**

Name of Facility	Name of Facility Owner / Licensee
Authorized Representative/Contact Person	Address
Mailing Address	Mailing Address
City, State and Zip Code	City, State and Zip Code
Telephone (       )	Telephone (       )
<p>I. SERVICE CATEGORY FOR WHICH EXEMPTION IS REQUESTED (NOTE: A SEPARATE APPLICATION IS REQUIRED FOR EACH SERVICE CATEGORY)</p>    	
<p>II. PROFESSIONALS CREDENTIALLED TO PROVIDE THE SERVICE (INCLUDE NAME, LICENSE NUMBER, SPECIALTY TYPE, CREDENTIALS, AND PRIVILEGES) (ATTACH A COPY OF THE HOSPITAL BYLAWS CONCERNING MEDICAL STAFF PRIVILEGES).</p>          	

EMERGENCY SERVICE EXEMPTION CONTINUED – PAGE 3	
V. (CONTINUED FROM PAGE 2)	
<p>SIGNATURE OF AFFIRMATION</p> <p>I, _____ HEREBY AFFIRM THAT THE INFORMATION PROVIDED ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT ANY FALSE STATEMENTS ARE SUBJECT TO PUNISHMENT PURSUANT TO S. 837.06, F.S.</p>	
<p>_____ SIGNATURE OF CHIEF EXECUTIVE OFFICER</p>	<p>_____ DATE</p>

AHCA 3000-1 (REVISED JUNE 1, 2004)

# ED Referral Process

## Munroe Regional Medical Center Ocala, Florida



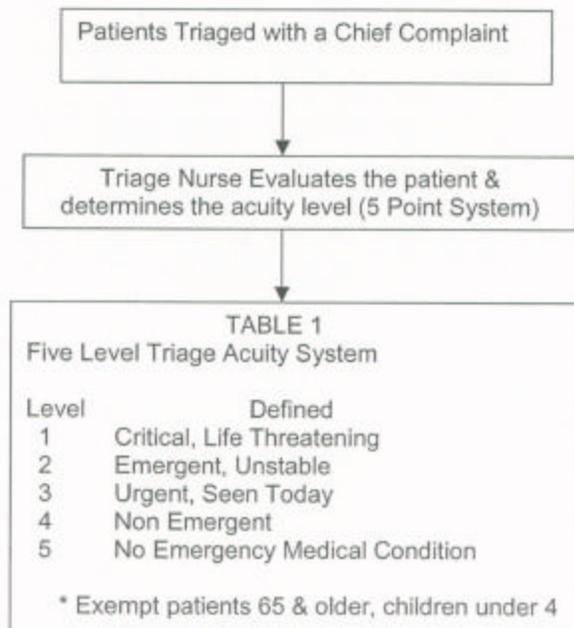
**Executive Summary**

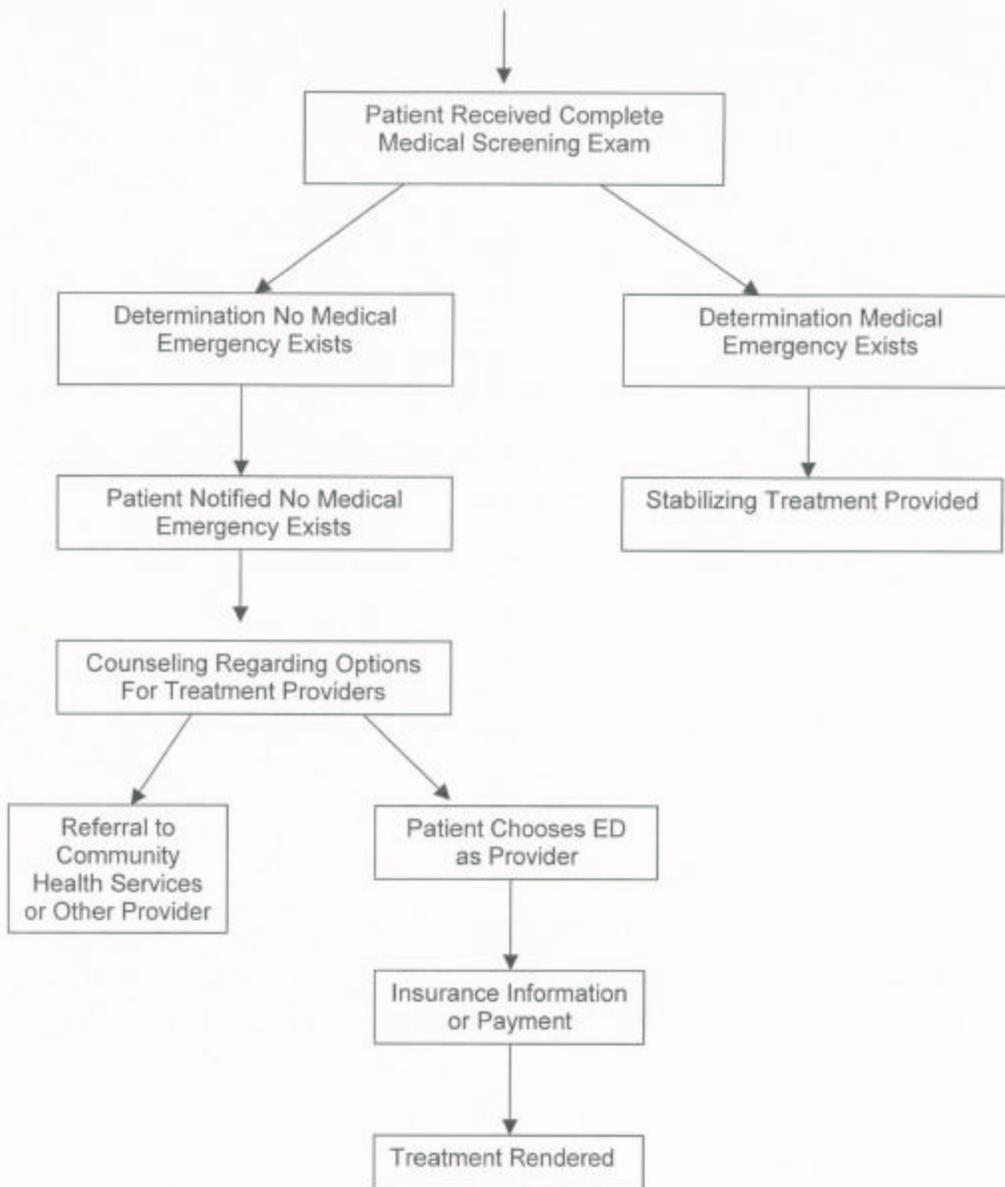
**Emergency Department Referral process  
Non-Emergent Patients**

The hospitals in Ocala, Marion County, Florida, have experienced large numbers of patients seeking primary care for non-emergent conditions in our Emergency Departments (ED). This influx of patients has contributed to frequent overcrowding and delays in care for patients with emergencies. In response, a system has been devised in which patients with non-emergent medical conditions, following a medical screening examination, do not receive further ED assessment or treatment and instead will be referred to community resources or will be required to be financially accountable for this episodic visit.

The hospitals in Ocala, Florida (Munroe Regional Medical Center [Private-not-for Profit] and Ocala Regional Medical Center [Private-for Profit] have collaborated and joined forces for this patient population in all ED's in Ocala to access the appropriate Community Resources.

The process is as follows:





The Medical Screening decisions by the Emergency Registered Nurse and Physician are based solely on history & clinical assessment; financial status is not revealed during the intake process.

Prior to implementation, community education was done in the form of public notice in the local newspaper & numerous editorial comments, & interviews with hospital administration.

The implementation has been met with many challenges. Physician support has been a slow process with only about 25% of patients eligible being referred. We anticipate this to increase as we change the "stay & pay" option to all patients without an emergency being referred to a lower level of care.

Attachments:

1. References
2. AHCA approval letters
3. Patient letters
4. Patient referral guide
5. CHS information
6. Munroe referral data
7. MSE performance data
8. Public Notice



H:\SUBFILE\HELENERDEPT\Exec Sumry ED Refri proc non emerg.doc

## REFERENCES

- Standwood, Al, et.al. "Non Emergent ED Patients Referred to Community Resources After Medical Screening Exam", Journal Emergency Nursing, August, 2004.
- Tanable, P., "The Emergency Severity Index 5-Level Triage System Scores Predict ED Resources Consumption", Journal Emergency Nursing, February, 2004.
- Policy Statement, American College of Emergency Physicians, "Resource Utilization in the ED", ACEP. Resource Utilization.
- HCA, Gulf Coast Division, Medical Screening Exams by Qualified Medical Persons in the ED.
- American College of Emergency Physicians, Emergency Severity Index Triage System, Approved September, 2003.
- State Operations Manual, Appendix V, Interpretive Guidelines, Responsibilities of Medicare Participating Hospitals in Emergency Cases, 5-21-04.



JES BUSH, GOVERNOR

ALAN LEVINE, SECRETARY

February 21, 2005

Dyer T. Michell, Chief Executive Officer  
Munroe Regional Medical Center  
1500 S.W. 1<sup>st</sup> Avenue  
Ocala, FL 34478

James B. Wood, Chief Executive Officer  
West Marion Community Hospital  
4600 S.W. 46<sup>th</sup> Court  
Ocala, FL 34474

Dear Mr. Michell and Mr. Wood:

Based upon information provided the Agency and our recent conference call, it is my pleasure to approve your proposal for an Emergency Department (ED) referral process in Ocala, Florida. Specifically, Munroe Regional Medical Center, Ocala Regional Medical Center, TimberRidge ED, and West Marion Community Hospital wish to implement a program to reduce the use of the emergency rooms for non-emergencies.

The federal Emergency Medical Treatment and Labor Act (EMTALA) requires emergency rooms screen any patient presenting for medical services. If the screening determines an emergency medical condition exists, the provider must either stabilize the condition or appropriately transfer the patient to a facility that can stabilize the condition. If the screening determines an emergency medical condition does NOT exist, the hospital's obligation to provide services ends. This group of hospitals in Ocala want to implement a referral program for those patients who do not have an emergency medical condition. Once the screening is completed, the patient would be notified no emergency medical condition exists. Counseling would be provided regarding their options for treatment providers. Ideally, a referral would be made to a practice called Community Health Services or another provider in the community. If the patient chooses instead to receive treatment at the emergency room, they would be sent to the finance office to provide insurance information or payment. Treatment would not be provided until financial arrangements are complete. Patients under age 4 and 65 or older would be exempt from this referral process.

Based upon our review, we have determined the proposal as presented does not violate any hospital state licensure or federal certification requirement. With respect to Medicaid, if a Medicaid recipient presents to an emergency room and the EMTALA screening determines no emergency medical condition exists, Medicaid pays for the screening and whichever services

---

2727 Mehan Drive • Mail Stop #1  
Tallahassee, FL 32306



Visit AHCA online at  
[ahca.myflorida.com](http://ahca.myflorida.com)