

[Fla. Stat. § 395.1041.]

§ 395.1041. Access to emergency services and care: Hospitals and Other Licensed Facilities

(1) **LEGISLATIVE INTENT.**—The Legislature finds and declares it to be of vital importance that emergency services and care be provided by hospitals and physicians to every person in need of such care. The Legislature finds that persons have been denied emergency services and care by hospitals. It is the intent of the Legislature that the agency vigorously enforce the ability of persons to receive all necessary and appropriate emergency services and care and that the agency act in a thorough and timely manner against hospitals and physicians which deny persons emergency services and care. It is further the intent of the Legislature that hospitals, emergency medical services providers, and other health care providers work together in their local communities to enter into agreements or arrangements to ensure access to emergency services and care. The Legislature further recognizes that appropriate emergency services and care often require followup consultation and treatment in order to effectively care for emergency medical conditions.

(2) **INVENTORY OF HOSPITAL EMERGENCY SERVICES.**—The agency shall establish and maintain an inventory of hospitals with emergency services. The inventory shall list all services within the service capability of the hospital, and such services shall appear on the face of the hospital license. Each hospital having emergency services shall notify the agency of its service capability in the manner and form prescribed by the agency. The agency shall use the inventory to assist emergency medical services providers and others in locating appropriate emergency medical care. The inventory shall also be made available to the general public. On or before August 1, 1992, the agency shall request that each hospital identify the services which are within its service capability. On or before November 1, 1992, the agency shall notify each hospital of the service capability to be included in the inventory. The hospital has 15 days from the date of receipt to respond to the notice. By December 1, 1992, the agency shall publish a final inventory. Each hospital shall reaffirm its service capability when its license is renewed and shall notify the agency of the addition of a new service or the termination of a service prior to a change in its service capability.

(3) **EMERGENCY SERVICES; DISCRIMINATION; LIABILITY OF FACILITY OR HEALTH CARE PERSONNEL.**—

(a) Every general hospital which has an emergency department shall provide emergency services and care for any emergency medical condition when:

1. Any person requests emergency services and care; or
2. Emergency services and care are requested on behalf of a person by:
 - a. An emergency medical services provider who is rendering care to or transporting the person; or
 - b. Another hospital, when such hospital is seeking a medically necessary transfer, except as otherwise provided in this section.

(b) Arrangements for transfers must be made between hospital emergency services personnel for each hospital, unless other arrangements between the hospitals exist.

(c) A patient, whether stabilized or not, may be transferred to another hospital which has the requisite service capability or is not at service capacity, if:

1. The patient, or a person who is legally responsible for the patient and acting on the patient's behalf, after being informed of the hospital's obligation under this section and of the risk of transfer, requests that the transfer be effected;
 2. A physician has signed a certification that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another hospital outweigh the increased risks to the individual's medical condition from effecting the transfer; or
 3. A physician is not physically present in the emergency services area at the time an individual is transferred and a qualified medical person signs a certification that a physician, in consultation with personnel, has determined that the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual's medical condition from effecting the transfer. The consulting physician must countersign the certification;
- provided that this paragraph shall not be construed to require acceptance of a transfer that is not medically necessary.

(d)1. Every hospital shall ensure the provision of services within the service capability of the hospital, at all times, either directly or indirectly through an arrangement with another hospital, through an arrangement with one or more physicians, or as otherwise made through prior arrangements. A hospital may enter into an agreement with another hospital for purposes of meeting its service capability requirement, and appropriate compensation or other reasonable conditions may be negotiated for these backup services.

2. If any arrangement requires the provision of emergency medical transportation, such arrangement must be made in consultation with the applicable provider and may not require the emergency medical service provider to provide transportation that is outside the routine service area of that provider or in a manner that impairs the ability of the emergency medical service provider to timely respond to prehospital emergency calls.

3. A hospital shall not be required to ensure service capability at all times as required in subparagraph 1. if, prior to the receiving of any patient needing such service capability, such hospital has demonstrated to the agency that it lacks the ability to ensure such capability and it has exhausted all reasonable efforts to ensure such capability through backup arrangements. In reviewing a hospital's demonstration of lack of ability to ensure service capability, the agency shall consider factors relevant to the particular case, including the following:

- a. Number and proximity of hospitals with the same service capability.
- b. Number, type, credentials, and privileges of specialists.
- c. Frequency of procedures.
- d. Size of hospital.

4. The agency shall publish proposed rules implementing a reasonable exemption procedure by November 1, 1992. Subparagraph 1. shall become effective upon the effective date of said rules or January 31, 1993, whichever is earlier. For a period not to exceed 1 year from the effective date of subparagraph 1., a hospital requesting an exemption shall be deemed to be exempt from offering the service until the agency initially acts

to deny or grant the original request. The agency has 45 days from the date of receipt of the request to approve or deny the request. After the first year from the effective date of subparagraph 1., if the agency fails to initially act within the time period, the hospital is deemed to be exempt from offering the service until the agency initially acts to deny the request.

(e) Except as otherwise provided by law, all medically necessary transfers shall be made to the geographically closest hospital with the service capability, unless another prior arrangement is in place or the geographically closest hospital is at service capacity. When the condition of a medically necessary transferred patient improves so that the service capability of the receiving hospital is no longer required, the receiving hospital may transfer the patient back to the transferring hospital and the transferring hospital shall receive the patient within its service capability.

(f) In no event shall the provision of emergency services and care, the acceptance of a medically necessary transfer, or the return of a patient pursuant to paragraph (e) be based upon, or affected by, the person's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

(g) Neither the hospital nor its employees, nor any physician, dentist, or podiatric physician shall be liable in any action arising out of a refusal to render emergency services or care if the refusal is made after screening, examining, and evaluating the patient, and is based on the determination, exercising reasonable care, that the person is not suffering from an emergency medical condition or a determination, exercising reasonable care, that the hospital does not have the service capability or is at service capacity to render those services.

(h) A hospital may request and collect insurance information and other financial information from a patient, in accordance with federal law, if emergency services and care are not delayed. No hospital to which another hospital is transferring a person in need of emergency services and care may require the transferring hospital or any person or entity to guarantee payment for the person as a condition of receiving the transfer. In addition, a hospital may not require any contractual agreement, any type of preplanned transfer agreement, or any other arrangement to be made prior to or at the time of transfer as a condition of receiving an individual patient being transferred. However, the patient or the patient's legally responsible relative or guardian shall execute an agreement to pay for emergency services or care or otherwise supply insurance or credit information promptly after the services and care are rendered.

(i) Each hospital offering emergency services shall post, in a conspicuous place in the emergency service area, a sign clearly stating a patient's right to emergency services and care and the service capability of the hospital.

(j) If a hospital subject to the provisions of this chapter does not maintain an emergency department, its employees shall nevertheless exercise reasonable care to determine whether an emergency medical condition exists and shall direct the persons seeking emergency care to a nearby facility which can render the needed services and shall assist the persons seeking emergency care in obtaining the services, including transportation services, in every way reasonable under the circumstances.

(k)1. Emergency medical services providers may not condition the prehospital transport of any person in need of emergency services and care on the person's ability to pay. Nor may emergency medical services providers condition a transfer on the person's ability to pay when the transfer is made necessary because the

patient is in immediate need of treatment for an emergency medical condition for which the hospital lacks service capability or when the hospital is at service capacity. However, the patient or the patient's legally responsible relative or guardian shall execute an agreement to pay for the transport or otherwise supply insurance or credit information promptly after the transport is rendered.

2. A hospital may enter into an agreement with an emergency medical services provider for purposes of meeting its service capability requirements, and appropriate compensation and other reasonable conditions may be negotiated for these services.

(l) Hospital personnel may withhold or withdraw cardiopulmonary resuscitation if presented with an order not to resuscitate executed pursuant to s. 401.45. Facility staff and facilities shall not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation pursuant to such an order. The absence of an order not to resuscitate executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation as otherwise permitted by law.

(4) RECORDS OF TRANSFERS; REPORT OF VIOLATIONS.—

(a)1. Each hospital shall maintain records of each transfer made or received for a period of 5 years. These records of transfers shall be included in a transfer log, as well as in the permanent medical record of any patient being transferred or received.

2. Each hospital shall maintain records of all patients who request emergency care and services, or persons on whose behalf emergency care and services are requested, for a period of 5 years. These records shall be included in a log, as well as in the permanent medical record of any patient or person for whom emergency services and care is requested.

(b) Any hospital employee, physician, other licensed emergency room health care personnel, or certified prehospital emergency personnel who knows of an apparent violation of this section or the rules adopted under this section shall report the apparent violation to the agency within 30 days following its occurrence.

(c) A hospital, government agency, or person shall not retaliate against, penalize, institute a civil action against, or recover monetary relief from, or otherwise cause any injury to:

1. A physician or other person for reporting in good faith an apparent violation of this section or the rules adopted under this section to the agency, hospital, medical staff, or any other interested party or government agency;

2. A physician who refuses to transfer a patient if the physician determines, within reasonable medical probability, that the transfer or delay caused by the transfer will create a medical hazard to the patient; or

3. A physician who effectuates the transfer of a patient if the physician determines, within a reasonable medical probability, that failing to transfer the patient will create a medical hazard to the patient.

(5) PENALTIES.—

(a) The agency may deny, revoke, or suspend a license or impose an administrative fine, not to exceed \$10,000 per violation, for the violation of any provision of this section or rules adopted under this section.

(b) Any person who suffers personal harm as a result of a violation of this section or the rules adopted hereunder may recover, in a civil action against the responsible hospital administrative or medical staff or personnel, damages, reasonable attorney's fees, and other appropriate relief. However, this paragraph shall

not be construed to create a cause of action beyond that recognized by this section and rules adopted under this section as they existed on April 1, 1992.

(c) Any hospital administrative or medical staff or personnel who knowingly or intentionally violates any provision of this section commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

(d)1. Any hospital, or any physician licensed under chapter 458 or chapter 459, who suffers a financial loss as a direct result of a violation by a physician or a hospital of a requirement of this section may, in a civil action against the physician or the hospital, obtain damages for financial loss of charges and such equitable relief as is appropriate, including reasonable attorney's fees and costs.

2. If the defendant prevails in an action brought by the hospital or physician pursuant to this paragraph, the court may award reasonable attorney's fees and costs to the defendant.

(e) A physician licensed under chapter 458 or chapter 459 who negligently or knowingly violates any requirement of this section relating to the provision of emergency services and care shall be deemed in violation of the provisions of such chapters for any of the following violations:

1. Failure or refusal to respond within a reasonable time after notification when on call.
2. Failure or refusal to sign a certificate of transfer as required by this section.
3. Signing a certificate of transfer stating that the medical benefits to be reasonably expected from a transfer to another facility outweigh the risks associated with the transfer, when the physician knew or should have known that the benefits did not outweigh the risks as required by this section.
4. Misrepresentation of an individual's condition or other information when requesting a transfer.

Any fine collected for a violation of this section, including any fine collected from a physician licensed under chapter 458 or chapter 459, shall be deposited into the Public Medical Assistance Trust Fund.

(f) In determining whether a licensee is deemed in violation of this section and in assessing any penalties for violation, the agency shall consider, and the licensee may offer as an affirmative defense or in mitigation, whether the licensee has established that the alleged violation arose from the unanticipated changes in service capability or other factors beyond the licensee's control.

(6) RIGHTS OF PERSONS BEING TREATED. —

(a) A hospital providing emergency services and care to a person who is being involuntarily examined under the provisions of s. 394.463 shall adhere to the rights of patients specified in part I of chapter 394 and the involuntary examination procedures provided in s. 394.463, regardless of whether the hospital, or any part thereof, is designated as a receiving or treatment facility under part I of chapter 394 and regardless of whether the person is admitted to the hospital.

(b) Each hospital with an emergency department shall develop a best practices policy to promote the prevention of unintentional drug overdoses. The policy may include, but is not limited to:

1. A process to obtain the patient's consent to notify the patient's next of kin, and each physician or health care practitioner who prescribed a controlled substance to the patient, regarding the patient's overdose, her or his location, and the nature of the substance or controlled substance involved in the overdose.

2. A process for providing the patient or the patient's next of kin with information about licensed substance abuse treatment services, voluntary admission procedures under part IV of chapter 397, involuntary admission procedures under part V of chapter 397, and involuntary commitment procedures under chapter 394.
3. Guidelines for emergency department health care practitioners authorized to prescribe controlled substances to reduce the risk of opioid use, misuse, and addiction.
4. The use of licensed or certified behavioral health professionals or peer specialists in the emergency department to encourage the patient to seek substance abuse treatment.
5. The use of Screening, Brief Intervention, and Referral to Treatment protocols in the emergency department.

This paragraph may not be construed as creating a cause of action by any party.

(7) **EMERGENCY ROOM DIVERSION PROGRAMS.**—Hospitals may develop emergency room diversion programs, including, but not limited to, an “Emergency Hotline” which allows patients to help determine if emergency department services are appropriate or if other health care settings may be more appropriate for care, and a “Fast Track” program allowing nonemergency patients to be treated at an alternative site. Alternative sites may include health care programs funded with local tax revenue and federally funded community health centers, county health departments, or other nonhospital providers of health care services. The program may include provisions for followup care and case management.

History.—s. 6, ch. 88-186; s. 1, ch. 89-296; s. 68, ch. 91-224; s. 4, ch. 91-249; ss. 24, 25, 98, ch. 92-289; s. 30, ch. 96-169; s. 2, ch. 96-199; s. 10, ch. 96-223; s. 182, ch. 98-166; s. 2, ch. 99-331; s. 1, ch. 2000-295; s. 5, ch. 2004-297; s. 3, ch. 2017-54; s. 89, ch. 2020-2.

Note.—Former s. 395.0142.