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CMS Issues Final EMTALA Regulations

The Centers for Medicare and Medicaid Services ("CMS") has now issued final rules (the "Final Regulations") regarding the federal Emergency Medical Treatment and Labor Act ("EMTALA"). The Final Regulations improve guidance and provide clearer standards that appear more consistent with legislative intent. 68 Fed. Reg. 53,222 (Sept. 9, 2003). The Final Regulations modify and clarify the rules previously proposed by CMS in May 2002 (the "Proposed Rules"). 67 Fed. Reg. 31,403, 31,469 (May 9, 2002).

EMTALA applies to all hospitals that participate in the Medicare program and have a "dedicated emergency department." Under EMTALA, hospitals are required to provide an appropriate medical screening examination to any person (i) who comes to a hospital "emergency department" seeking treatment or (ii) who otherwise presents on the hospital campus seeking treatment of an emergent condition. Additionally, if an emergency medical condition is found to exist, EMTALA requires hospitals to provide treatment to stabilize the person's condition. Hospitals and physicians who violate EMTALA may face fines and exclusion from the Medicare program as well as lawsuits brought by patients.

The Final Regulations, which become effective November 10, 2003, specifically address issues relating to the scope of EMTALA, including the application of EMTALA to on-site, off-site and provider-based facilities, the definition of a "patient," the meaning of "comes to the emergency department," hospital-owned ambulances, prior authorization and physician on-call requirements.

Applicability to On-site Services and Off-site or Provider-based Facilities

Previously, EMTALA provided protection to anyone seeking care on "hospital property." Prior to the Proposed Rules, CMS had provided guidance that EMTALA obligations attached when an individual presented at any hospital facility, requesting examination or treatment for an emergency medical condition.

CMS has now clarified that EMTALA protection does not apply to patients who come to provider-based, off-campus departments that do not routinely provide emergency services, *i.e.*, are not "dedicated emergency departments." In regard to on-campus services, the Final Regulations have also clarified that provider entities other than hospitals that are on the main hospital campus (such as skilled nursing facilities and medical office buildings), are not subject to EMTALA.

Protocols for Emergency Patients at Off-campus, Non-emergency Facilities

Under the Final Regulations, at 42 C.F.R. § 482.12(f)(3), hospitals are expected to have "appropriate protocols" in place for dealing with individuals who come to off-campus non-emergency facilities seeking emergency care. If emergency services are provided at the hospital, but not at certain off-campus departments, the hospital must have written policies and procedures in place with respect to such departments in order to assess emergencies and provide appropriate referrals when necessary.

Definition of "Patient"

Significantly, CMS has clarified that EMTALA does not apply to inpatients "who have been admitted in good faith," regardless of whether they are experiencing emergency medical conditions. 42 C.F.R. § 489.24(d)(2). The rationale for this is that since the Medicare Conditions of Participation for hospitals presumably provide adequate, if not better, protection to inpatients, it is not necessary for EMTALA obligations to attach in these cases. Thus, a hospital's obligations under EMTALA end once an individual is admitted on an inpatient basis.

Further, CMS has determined that EMTALA does not apply to outpatients who come to the hospital for non-emergency services. Nor does it apply to patients who have begun to receive scheduled, non-emergency outpatient services at the main hospital campus, prior to seeking examination or treatment for an emergency medical condition (*e.g.*, routine physician visits or physician-ordered testing).

"Comes to the Emergency Department"

The Proposed Rules addressed the phrase "comes to the emergency department" in an effort to clarify under what circumstances hospitals were obligated under EMTALA to screen, stabilize or transfer patients who presented for examination or treatment of an emergency medical condition at areas of the hospital other than the emergency department. The Proposed Rules provided that an individual could "come to the emergency department" either by presenting at a dedicated emergency department or presenting elsewhere on hospital property and requesting examination or treatment for an emergent medical condition.

The Final Regulations clarify and expand the definition of "dedicated emergency department." A "dedicated emergency department" is defined as any department or facility of the hospital, whether situated on or off the main hospital campus, that 1) is licensed by the state as an emergency room or emergency department, 2) is held out to the public as a place that provides care for emergency medical conditions without requiring an appointment, or 3) during the previous calendar year, has provided at least one-third of all its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring scheduled appointments. In the Preamble to the Final Regulations, CMS reiterated that urgent care centers would meet this definition.

Hospital-Owned Ambulances

Prior to the Proposed Rules, CMS's view was that "coming to the emergency department" encompassed situations in which an individual was in an ambulance owned and operated by a hospital.

In response to provider concerns regarding hospital-owned ambulances operating under community-wide EMS protocols (*i.e.*, protocols that may require ambulances to transfer an individual to a hospital other than the hospital that owns the ambulance), CMS suggested a more limited application to hospital-owned ambulances. The Proposed Rules provided an exception in the case of hospital-owned ambulances operating under such community-wide EMS protocols, whereby the transported individual would be considered to have come to the emergency department of the hospital to which he was transported. Thus, EMTALA would apply to the destination hospital, rather than the hospital owning the ambulance, but only once the patient is on hospital property.

The Final Regulations codify this approach in 42 C.F.R. §489.24(b)(3). The Final Regulations also clarify that EMTALA does not apply if an ambulance is operated at the direction of a physician who is neither an employee nor an affiliate of the hospital owning the ambulance.

Prior Authorization/Stabilization

Previously, EMTALA specifically prohibited hospitals from delaying screening or stabilization services in order to inquire about a patient's method of payment or insurance status. This was interpreted to preclude hospitals from seeking authorization from a patient's insurance company for screening services or services required to stabilize an emergency medical condition until after they had completed the appropriate medical screening examination required by EMTALA and initiated any procedures necessary to stabilize the patient.

The Final Regulations now clarify the matter by allowing hospitals to seek authorization concurrently with the provision of stabilizing treatment, although hospitals still cannot delay treatment in order to obtain authorization, and are still responsible under EMTALA for providing stabilizing treatment even if the patient's insurer denies the authorization to treat. This change in EMTALA does not supersede existing state law managed care payor requirements, which generally require payors to reimburse for emergency services even if the hospitals did not seek authorization. However, CMS's announcement that hospitals may lawfully seek payor authorization for emergent patients opens the door for state health and insurance departments to choose to modify their rules. It should be noted that the stabilization services mentioned in the Final Regulations do not necessarily require examination by a physician; they may be furnished by non-physician

staff, such as triage nurses. (Although hospitals could always be liable under EMTALA if the screening or stabilization services are inadequate.)

The scope of the stabilization requirements under EMTALA could require hospital emergency rooms to provide pharmaceutical services. CMS, in the Preamble to the Final Regulations, uses the example of a patient maintained on psychiatric medication, presenting at the emergency department with homicidal or suicidal ideation because he has run out of medication. If the individual's situation is determined to be emergent and the dispensing of medication is necessary for stabilization, EMTALA would apply and require the hospital to dispense the medication, regardless of the patient's ability to pay for the pharmaceuticals.

Physician On-call Requirements

EMTALA requires that Medicare-participating hospitals maintain "on-call lists" — lists of physicians who are available as needed to treat emergency room patients.

With the Proposed Rules, CMS intended to clarify the circumstances in which physicians, particularly specialists, must serve on hospital medical staff "on-call" lists. Under the Final Regulations, hospitals have discretion to develop on-call lists in a way that best meets the needs of their communities and their patients, taking into account existing hospital resources and the availability of on-call physicians. 42 C.F.R. §489.24(j)(1). In addition, the Final Regulations provide that as long as hospitals have policies ensuring adequate emergency coverage, they may allow physicians to schedule elective surgery during their on-call times or to undertake simultaneous on-call duties at more than one hospital. CMS anticipates that this increased flexibility will facilitate easier access to physician services.

Conclusion

The Final Regulations, while still providing patients with the protection intended by EMTALA, help to clarify many issues and areas of concern for hospitals.

Edward S. Kornreich
212.969.3395
ekornreich@proskauer.com

Rachel Wilgoren
212.969.3797
rwilgoren@proskauer.com