New EMTALA Regulations

The Centers for Medicare and Medicaid Services ("CMS") recently issued a final rule attempting to clarify the responsibilities of Medicare-participating hospitals under the Emergency Medical Treatment and Active Labor Act ("EMTALA"), the patient antidumping statute. EMTALA is a federal law that requires Medicare-participating hospitals that offer emergency services to provide screening and, if appropriate, stabilization, of those persons who “come to the emergency department” and request (or someone requests on their behalf) examination or treatment for a medical condition. CMS addresses the following important areas in the final rule: (1) defining more specifically when someone "comes to the emergency department" within the meaning of EMTALA; (2) defining a “dedicated emergency department”; (3) requiring a “good faith” admission before the EMTALA obligation ends; (4) relying on the medical record to determine whether true stabilization occurred; (5) explaining that EMTALA does not apply to inpatient and outpatient treatment situations; (6) addressing physician on-call requirements; and (7) permitting limited forms of contact with an individual's insurer or other health care providers while the individual is in the emergency department.

Under the final rule, CMS gives a specific meaning to the phrase “comes to the emergency department.” It means that an individual presents to a “dedicated emergency department” within the meaning of EMTALA; (2) defining a “dedicated emergency department”; (3) requiring a “good faith” admission before the EMTALA obligation ends; (4) relying on the medical record to determine whether true stabilization occurred; (5) explaining that EMTALA does not apply to inpatient and outpatient treatment situations; (6) addressing physician on-call requirements; and (7) permitting limited forms of contact with an individual's insurer or other health care providers while the individual is in the emergency department.

A “dedicated emergency department” is defined under the rule as any department or facility (on or off the main campus) that meets any of the following requirements:

1. Is licensed by the state as an emergency room or department;
2. Holds itself out as providing care for emergency medical conditions on an urgent basis, without a previously scheduled appointment; or
3. In the immediately preceding calendar year, based on a representative sample of patient visits, at least one-third of all outpatient visits were for treatment of emergency medical conditions on an emergency basis without a previously scheduled appointment.

Additionally, the rule explains that when a person is on the main campus, but not in a dedicated emergency department, and is unable to articulate a request for examination or treatment (for example, he is unconscious), CMS will apply a reasonable lay person test to determine whether or not, based on the individual’s appearance or condition, he needs examination or treatment for an emergency medical condition. Even though the rule limits a hospital's off-campus EMTALA obligations to "dedicated emergency departments," it requires hospitals to have written policies and procedures that address providing assistance and referrals in cases of emergencies in these off-campus areas.
EMTALA Regulations, continued

CMS notes that departments other than “traditional” emergency departments may meet one or more of these criteria, and cites to labor and delivery and to psychiatry as examples.

CMS also states that the EMTALA obligation ceases once a hospital has “in good faith” admitted a patient, even before stabilization has occurred. The good faith requirement is intended to prevent a hospital from “admitting” a patient without any real intention of treating the patient further and then transferring or discharging the patient without meeting EMTALA’s stabilization requirement. CMS also states that the stabilization requirement is not met in cases of “transient stabilization” (going in and out of apparent stability), and that medical record documentation will control the determination of whether or not the patient was stabilized.

CMS also clarifies in the rule that EMTALA does not apply when a person develops an emergency medical condition while receiving services as an inpatient (has been admitted for bed occupancy for delivery of inpatient services) or an outpatient under circumstances other than those governed by EMTALA. For example, if a person is admitted as an inpatient for scheduled elective treatment, or as an outpatient if the outpatient has begun an “encounter” (direct contact with a health care provider), EMTALA does not apply. CMS reminds the provider community that although EMTALA would not apply to emergencies that arise in these situations, the protections afforded by the Medicare conditions of participation would still apply.

The final rule addresses physician on-call requirements, but this is one area where guidance is not as specific as in the rest of the rule. For example, no guidance is given on how the regulations will be enforced when physician coverage is not available. Hospitals are still required to maintain a call list, but they may do so in whatever manner meets the needs of its patient community and is consistent with the hospitals’ capabilities. Additionally, if a hospital permits physicians to be on call for more than one hospital at a time and to perform elective surgery while on call, it must have written policies and procedures for how it will meet the needs of individuals with emergency medical conditions. It must also have written policies and procedures for handling those situations in which a particular specialty is not covered, and when a physician cannot respond to a call because of circumstance beyond the physician’s control. For example, a hospital is permitted to enter into a transfer arrangement for those specialties for which the hospital cannot obtain adequate on-call coverage. Moreover, hospitals are not required to provide coverage 24/7 for every specialty, and CMS has no specific rule that if there are a certain number of physicians in a specialty, there must be 24/7 coverage of that specialty. CMS will look at the size of the staff, demands on the physicians, how often patients typically need on-call physician services, and how the hospital deals with situations in which a particular specialty is not available, to decide EMTALA compliance issues.

The final rule also addresses the conflict between EMTALA’s prohibition against delaying screening or stabilization services to inquire about a method of payment or insurance status of the individual and the requirement of some managed care plans that prior authorization be obtained before covered hospital services may begin. CMS states in the rule that it will permit the hospital to have concurrent contact with an insurer once stabilization is in progress, and it will permit a physician or other provider to contact other health care providers to consult for treatment, as long as these steps do not delay screening and stabilization. Additionally, hospitals may follow “reasonable registration processes,” such as asking a patient if he is insured and by what insurer, as long as there is no delay in screening or treatment and the patient is not “unduly” discouraged from further evaluation.

The effective date of the final rule is November 10, 2003. It can be found at 68 Fed. Reg. 53222 (9/9/03).

Notes and Notices:
Republican leaders in Congress have set October 17, 2003 as the deadline for the Medicare prescription drug bill compromise. Both the Senate and House versions of the bill address the importation of prescription drugs from Canada.

The federal government has agreed to accept electronic Medicare claims in HIPAA non-compliant format after October 16, 2003, because of the low percentage of successful conversions that have occurred to date.