

EMTALA FINAL RULE **Issued September 9, 2003; Effective November 10, 2003**

The Centers for Medicare and Medicaid Services (CMS) has issued its Final Rule regarding policy clarifications of the Emergency Medical Treatment and Labor Act (EMTALA)¹. The Final Rule largely addresses the concerns of the AMA, which worked in partnership with several national medical specialty societies to ensure that key EMTALA burdens would be lifted. Highlights of the Final Rule include:

ON-CALL REQUIREMENTS

Many of the on-call requirements have been positively revised.

A hospital² must maintain an on-call list of physicians on its medical staff. The list is to be comprised: (1) in a manner that best meets the needs of the patients who receive care under EMTALA; and (2) in accordance with the hospital's resources, which includes the availability of on-call physicians.

Thus, conditions of Medicare participation are: a hospital must maintain the above-mentioned list and physicians on the list must respond when called. However, there are now excusable reasons why a physician may not respond to the Emergency Department when called. **Hospitals can now permit physicians: (1) to schedule elective surgery during the time they are on-call; and (2) to have simultaneous on-call duties among different hospitals in the community.** If a physician is unable to respond to call due to performing surgery or responding to call at another facility, then he/she is not required to respond because the situation would be considered beyond the physician's control.

Under EMTALA, physicians are not required to take call or to be on-call at all times.

Hospitals must have written policies and procedures in place: (1) to respond to situations when a particular specialty is not available; (2) to respond to situations when an on-call physician cannot respond due to circumstances out of his control; and (3) to provide that emergency services are available to meet patients' needs if it permits physicians to schedule elective surgery during on-call duties or allows physicians to have simultaneous on-call duties.

Comments accompanying the Final Rule state that although *not* required, one approach to satisfy the above "policies and procedures" requirement, would be for a hospital to have referral agreements with other hospitals to facilitate appropriate transfers of patients who require specialty physician care that is not available within a reasonable period of time at the facility where the patient first presents.

TRIGGERING EMTALA: "DEDICATED EMERGENCY DEPARTMENT," "HOSPITAL PROPERTY," & GROUND/AIR AMBULANCES

EMTALA is triggered when an individual who is not a patient presents to the "**dedicated emergency department**" requesting an examination or treatment for a *medical condition*. EMTALA is also triggered when an individual who is not a patient presents on "**hospital property**" requesting an examination or treatment for an *emergency medical condition*. In both scenarios, if the individual is unable to make the request, then the request is considered to have been made if a "prudent layperson" would believe that an examination or treatment would be necessary.

¹ EMTALA is found at 42 USC 1395dd or Section 1867 of the Social Security Act.

² EMTALA applies to hospitals that participate in Medicare and that offer emergency services.

The Final Rule *created* the definition of a “**dedicated emergency department**” (DED). A DED is any department or facility (whether or not it is located on the hospital’s main campus) that: (1) is licensed by the State as a DED; (2) holds itself out to the public as providing emergency care on an urgent basis without requiring prior appointments (such as a labor and delivery department or a psychiatric unit); or (3) during the past calendar year, provided at least one-third of its outpatient services for emergency care on an urgent basis without requiring prior appointments.

Where an individual arrives at a hospital’s DED and requests an examination or treatment for what is clearly a non-emergency condition, EMTALA regulations require only that qualified personnel screen the individual to verify that in fact no emergency medical condition exists.

The Final Rule also *clarified* the definition of “**hospital property**” to mean the entire main hospital campus. This includes parking lots, sidewalks and driveways. This does not include other areas or structures of the hospital’s main building that are not part of the hospital (such as non-medical facilities, the offices of physicians, and others who separately participate under Medicare.)

The Final Rule *changed* when a patient is considered to have presented to the hospital when he is in a **ground or air ambulance** that is owned and operated by the hospital. Previously, whenever an individual was in an ambulance owned and operated by a hospital, then the patient was considered to have presented to the hospital and EMTALA was triggered. There are now two exceptions to that rule. Thus, an individual is *not* considered to have presented to the hospital: (1) if an ambulance is operated under communitywide emergency medical service (EMS) protocols that direct it to transport the patient to another hospital; or (2) if an ambulance is operated at a physician’s direction who is not affiliated with the hospital that owns the ambulance.

Lastly, a patient is considered to have presented to the hospital when he is in a **ground or air ambulance** that is not hospital-owned, but on hospital property at the dedicated emergency department for the purpose of an examination and treatment.

PRIOR AUTHORIZATION

The Final Rule *clarified* that a hospital cannot delay treatment to inquire into a patient’s ability to pay or to seek “**prior authorization**” for the provision of services from an insurer. Reasonable registration processes are permitted as long as: (1) there is no resulting delay in screening or treatment and (2) the registration does not act to discourage the patient from further treatment. An emergency physician may contact a patient’s physician at any time to seek information regarding the patient’s medical history; however, this cannot inappropriately delay screening and stabilization.

EMTALA DOES NOT APPLY: BEGUN OUTPATIENT SERVICES & ADMITTED AS INPATIENT

It is now clear that EMTALA never applies to an individual who: (1) has begun to receive outpatient services from the hospital; or (2) has been admitted in good-faith as an inpatient.

EMTALA OBLIGATION ENDS

EMTALA obligations end once an individual is stabilized, appropriately transferred to another hospital/facility or admitted to the hospital as an inpatient. No material changes were made to the “transfer” rule under EMTALA.