ED Legal Letter™

The Essential Monthly Guide to Emergency Medicine Malpractice Prevention and Risk Management

From the publishers of *Emergency Medicine Reports* and *ED Management*

Thomson American Health Consultants Home Page—http://www.ahcpub.com For more information, call (800) 688-2421. CME for Physicians—http://www.cmeweb.com

THOMSON
AMERICAN HEALTH CONSULTANTS

EMTALA revisions provide clearer explanation of critical terms

By **Mark S. Moy, MD, JM,** Department of Emergency Medicine, Hinsdale Hospital, Hinsdale, IL; Clinical Assistant Professor, Department of Emergency Medicine, University of Chicago.

Editor's note: *Since 1985, the Emergency Medical Treatment and Labor Act (EMTALA) has provided patients with care regardless of their ability to pay. Horror stories of the dumping of indigent trauma patients prompted federal intervention and subsequent regulation to protect patients. It has been both a blessing and burden for emergency physicians. Difficulties in interpreting the regulations and inconsistent interpretations by regional Centers for Medicare & Medicaid Services (CMS) offices, as well as conflicting circuit and appellate courts rulings, only have promulgated more questions. Finally, the long-awaited final rule interpretations arrived and went into effect Nov. 10, 2003. They provide clarification on several issues. While these may be called the final rules, CMS has stated that further interpretive guidelines, as well as regional instruction on interpretation, will follow. For now, these final rules will be used as the definitive guidelines for all to use. Hopefully, they will help provide a uniform application of EMTALA in every region and court jurisdiction.*

Introduction

There has been controversy and confusion about the interpretation of EMTALA and its application to the practice of medicine since its inception in 1985. CMS issued in the May 9, 2002, *Federal Register* additional proposed rules intended to clarify and revise certain unclear and controversial EMTALA issues. CMS stated, "These reiterations and clarifying changes are needed to ensure uniform and consistent application of policy and to avoid any misunderstanding of EMTALA requirements by individuals, physicians, or hospital employees."[1]

After receiving public comments submitted during the next several months, CMS released the eagerly anticipated final version of the rules in the Sept. 9, 2003, *Federal Register.*

Prior Authorization

Historical Perspective. EMTALA initially did not address managed care issues because managed care was in its infancy when Congress passed EMTALA in 1985. Since then, managed care has become the dominant form of health care insurance and delivery. For years, the managed care requirement for prior authorization conflicted with EMTALA's dictate that all individuals who present to the hospital for care must be provided a medical screening examination and stabilizing care. Emergency departments (EDs) would transfer or discharge patients without treatment when the managed care company refused authorization. This practice resulted in numerous lawsuits and EMTALA violations and fines.

The predecessor to CMS, the Health Care Financing Administration (HCFA), stated in its 1998 revised *State Operations Manual:*

> *A hospital may not refuse to screen an enrollee of a managed care plan because the plan refuses to authorize treatment or to pay for such screening, and treatment. Likewise, the managed care plan cannot refuse to screen and treat or appropriately transfer individuals not enrolled in the plan who come to plan hospitals that participate in the Medicare program.*[2]

The U.S. Department of Health and Human Services (HHS) further mandated this requirement in a Special Advisory Bulletin issued Nov. 10, 1999.[3] The bulletin, issued jointly by the HHS Office of Inspector General (OIG) and CMS, states emphatically:

> *Notwithstanding the terms of any managed care agreements between plans and hospitals, the anti-dumping statute continues to govern the obligations of hospitals to screen and provide stabilizing medical treatment to individuals who come to the hospital seeking emergency services . . . no contract between a hospital and a managed care plan can excuse the hospital from its anti-dumping statute obligations.*[4]

Due to the strict wording of these dictates by CMS, hospitals were confused about when they actually can contact managed care companies. Many hospital administrators felt that they were precluded from contacting managed care companies until the medical screening examination and/or stabilization for an emergency medical condition was complete. However, there often are indistinct lines about when a medical screening examination ends and stabilization begins; also, stabilization may continue well after admission to the hospital.

- **Proposed Rules *(Federal Register*, May 9, 2002):**
  CMS proposed to clarify:
  - — when a hospital may seek information from an insurer;
  - — when the emergency physician may contact the patient's managed care provider.

Final Rules *(Federal Register,* Sept. 9, 2003):

CMS changes the Code of Federal Regulations (CFR) in 489.24 (d)(4) to state:

4) Delay in examination or treatment.

i) A participating hospital may not delay providing an appropriate medical screening examination required under paragraph (a) of this section or further medical examination and treatment required under paragraph (d)(1) of this section in order to inquire about the individual's method of payment or insurance status.

ii) A participating hospital may not seek, or direct

ED Legal Letter™, ISSN 1087-7341, is published monthly by Thomson American Health Consultants, 3525 Piedmont Road N.E., Bldg. 6, Suite 400, Atlanta, GA 30305.

Vice President/Publisher: Brenda Mooney
Editorial Group Head: Valerie Loner
Managing Editor: Allison Mechem
Production Editor: Nancy McCreary
GST Registration Number: R128870672.
Periodicals postage paid at Atlanta GA 30304.
POSTMASTER: Send address changes to ***ED Legal Letter,*** P.O. Box 740059, Atlanta, GA 30374.

Back issues: $82. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date.

THOMSON
AMERICAN HEALTH CONSULTANTS

Subscriber Information

Customer Service: (800) 688-2421
Customer Service E-Mail Address: customerservice@ahcpub.com
Editorial E-Mail Address: allison.mechem@thomson.com
World Wide Web: http://www.ahcpub.com

Subscription Prices
United States: $489 per year
Multiple Copies:
2-9 additional copies: $391 each.
10+ copies: $293 each.
Canada: $519 per year plus GST
Elsewhere: $519 per year

Accreditation

Thomson American Health Consultants is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide CME for physicians. American Health Consultants (AHC) designates this educational activity for up to 18 credit hours in Category 1 credit toward the AMA Physician's Recognition Award. ***ED Legal Letter™*** is also approved by the American College of Emergency Physicians for 18 hours of ACEP Category 1 credit. This CME activity was planned and produced in accordance with the ACCME Essentials.

This continuing education program is sponsored by Thomson American Health Consultants, which is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing for approximately 18 contact hours. Provider #CEP10864.

Questions & Comments

Please contact **Allison Mechem,** Managing Editor, at allison.mechem@thomson.com or (404) 262-5589.

Now available on-line at www.ahcpub.com/online.html

Statement of Financial Disclosure

To reveal any potential bias in this publication, and in accordance with Accreditation Council for Continuing Medical Education guidelines, Dr. Hubler (executive editor); Advisory Board members Ball, Bitterman, Blaylock, Finerty, Lawrence, Montgomery, Moore, Severson, D. Sullivan, W. Sullivan, Weaver , and Dr. Moy (author) have reported no relationships with companies having ties to the field of study covered by this CE/CME program.

an individual to seek, authorization from the individual's insurance company for screening or stabilization services to be furnished by a hospital, physician, or nonphysician practitioner to an individual until after the hospital has provided the appropriate medical screening examination required under paragraph (a) of this section, and initiated any further medical examination and treatment that may be required to stabilize the emergency medical condition under paragraph (d)(1) of this section.

iii) *An emergency physician or nonphysician practitioner is not precluded from contacting the individual's physician at any time to seek advice regarding the individual's medical history and needs that may be relevant to the medical treatment and screening of the patient, as long as this consultation does not inappropriately delay services required under paragraph (a) or paragraphs (d)(1) and (d)(2) of this section.*

iv) *Hospitals may follow reasonable registration processes for individuals for whom examination or treatment is required by this section, including asking whether an individual is insured and, if so, what that insurance is, as long as that inquiry does not delay screening or treatment. Reasonable registration processes may not unduly discourage individuals from remaining for further evaluation.*[5]

Discussion

CMS does not change the basic EMTALA requirement that there be no delay in the provision of a medical screening examination or stabilizing treatment while obtaining insurance information. However, the wording allows concurrent communication with an insurance carrier as long as such action does not delay or negatively affect the patient's ongoing medical care. CMS also added the phrase "nonphysician" to accommodate the provision of emergency medical services by nonphysicians such as nurse practitioners. The ED physician may contact the patient's managed care provider at any time to discuss medical issues as needed to optimally care for the patient. This will not be seen as an attempt to contact the provider for authorization to treat. Reasonable registration processes may proceed concurrently with the patient's treatment as long as such action does not delay examination or treatment. CMS cautions that any information gathered by the registration process that reveals financial liability on the patient's part never should be used to coerce the patient to stop treatment.

'Comes to the ED' Clarification

Historical Perspective. The EMTALA statute states that: ". . . if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition,"[6] then EMTALA is activated. A plain reading of the wording "comes to the emergency department" would lead one to assume that a patient needs to physically arrive at the ED. However, due to court rulings and federal administrative decisions, the term "comes to" had been expanded to include, broadly, anywhere on hospital property within 250 yards of the main hospital building, off-campus hospital facilities that offer acute care, and hospital-owned ambulances.

- **Proposed Rules (*Federal Register*, May 9, 2002):**
  In these, CMS proposed to clarify:
  — that an individual can "come to the emergency department," creating an EMTALA obligation on the part of the hospital, in one of two ways: 1) The individual can present at a hospital's dedicated ED (DED) and request examination or treatment for a medical condition; or 2) the individual can present elsewhere on hospital property in an attempt to gain access to the hospital for emergency care (i.e., at a location that is on hospital property but is not part of a DED), and request examination or treatment for what they believe to be an emergency medical condition.
  — the definition of "DED" so that any hospital department meeting the definition of DED must comply with EMTALA's requirements just as the formal ED. These other departments would include such areas as the labor and delivery department, urgent care centers, and psychiatric unit of a hospital.
- **Final Rules *(Federal Register,* Sept. 9, 2003):**
  The final rules will change the CFR in 489.24 (a) to state:

Comes to the emergency department means, with respect to an individual who is not a patient (as defined in this section), the individual —

1) Has presented at a hospital's DED, as defined in this section, and requests examination or treatment for a medical condition, or has such a request made on his or her behalf. In the absence of such a request by or on behalf of the individual,

a request on behalf of the individual will be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs examination or treatment for a medical condition.

2) Has presented on hospital property, as defined in this section, other than the DED, and requests examination or treatment for what may be an emergency medical condition, or has such a request made on his or her behalf. In the absence of such a request by or on behalf of the individual, a request on behalf of the individual will be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs emergency examination or treatment.[7]

Discussion

Any hospital department (whether on or off-campus) that meets the definition of a DED by meeting at least one of the CMS requirements **(see Table 1, above right)** must comply with all of EMTALA's clinical and administrative requirements. The EMTALA clinical requirements include: 1) the medical screening examination; 2) stabilizing treatment; and 3) transfer restrictions. In addition, these other departments also must act like formal EDs and provide the following administrative requirements:

- Adopt a compliance policy to ensure compliance with EMTALA;
- Adopt a policy specifying which medical personnel are qualified to perform the medical screening examination;
- Maintain a list of on-call physicians;
- Post signs informing the public of the hospital's EMTALA obligations;
- Maintain a central log of all individuals who come to the ED; and
- Keep records of persons transferred to or from the hospital for at least five years from the date of transfer.

Hospitals must make a close evaluation of each of their departments to see if any department meets the definition of a DED. Examples of other departments that may meet the definition are urgent care centers, ambulatory care centers, family medicine centers, obstetric evaluation departments, and psychiatric outpatient departments. The state licensing requirement simply would apply to the formal ED of the hospital.

Table 1. CMS Definition of 'DED'

CMS defines a dedicated emergency department in 489.24 (b) as any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements:

1. It is licensed by the state in which it is located under applicable state law as an emergency room or emergency department;
2. It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or
3. During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.[8]

However, if hospital signage or advertising presents the department as a care center where patients may arrive without a scheduled appointment for medical care or if the number of these nonscheduled patient care interventions reach the one-third rule in a calendar year, then that department must act exactly as if it were a formal ED for EMTALA purposes.

Nonemergency Services in the DED

Historical Perspective. The EMTALA statute states: ". . . if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department…"[9] The courts have uniformly interpreted this general wording of "any individual" to mean that, although it is a Medicare law, EMTALA is not limited to Medicare patients, but applies to every patient who comes to the ED, whether he or she is indigent, uninsured, on Medicare, or insured. A hospital may violate EMTALA when it provides different treatment to any patient for whatever reason. Hospitals became confused when patients arrived in the ED for obvious nonemergency treatments such as simple suture removal. Does the hospital violate EMTALA if it allows a nurse to remove the sutures on a well-healing wound but the ED physician does not perform a medical screening examination? Can a hospital refer patients who present to the ED for such nonemergency services as preventive care services, pharmaceutical services, laboratory testing (which would include

blood draws for law enforcement purposes), or x-rays to a primary care or specialty clinic for care of the nonemergency condition without violating EMTALA?

• Proposed Rules (*Federal Register,* May 9, 2002):

CMS proposed to state that if an individual comes to a hospital's DED and a request is made on his or her behalf for examination or treatment for a medical condition, but the nature of the request makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an "emergency medical condition" as defined in the regulations.

• Final Rules (*Federal Register,* Sept. 9, 2003):

CMS will change the CFR at 489.24 (c) to state:

c) *Use of DED for nonemergency services. If an individual comes to a hospital's DED and a request is made on his or her behalf for examination or treatment for a medical condition, but the nature of the request makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition.*[10]

Discussion

EMTALA requirements end for a patient once the hospital determines he or she is stable without an emergency medical condition after an appropriate medical screening examination. CMS now distinguishes between an individual who presents for emergency care and an individual who presents for nonemergency services. If a patient presents for nonemergency care, the screening examination may be limited to: 1) the individual's stating he is not seeking emergency care; and 2) brief questioning by a qualified medical person sufficient to establish that there is no emergency condition. The hospital's EMTALA requirements would be satisfied.

CMS does not specify the nature of the "qualified medical person" performing the initial questioning. The hospital is free to determine its own criteria for the qualified medical person, who could be a physician or a nurse as long as that person has had sufficient training to make a proper decision. Hospitals are not obligated to provide screening services beyond those needed to determine that there is no emergency medical condition. That patient may be treated accordingly (suture removal by a nurse) or referred to the appropriate department (e.g., laboratory for blood draw, radiology for x-rays, pharmacy, physical therapy, etc.) or even discharged to an appropriate clinic or other care setting designated to properly provide the appropriate services. CMS cautions that it will review cases individually to assure that hospitals are not using this avenue to avoid EMTALA requirements.

CMS cautions that a patient visit for nonemergency care may change into an emergency situation. If an individual were to tell the hospital staff at the laboratory or radiology department that he or she needed emergency care (e.g., he or she develops chest pains during a blood draw), EMTALA then would be triggered. EMTALA also would apply if, in the absence of a verbal request, the individual's appearance or behavior were such that a prudent layperson observer would believe the individual needed examination or treatment for an emergency medical condition (e.g., a patient passes out during a blood draw).

Nonhospital DED Presentations

Historical Perspective. The definitions of "comes to" and "emergency department" have been taken in the most expansive sense by CMS to prevent a hospital from avoiding EMTALA liability when a patient technically did not enter through the ED. Hospital property, for EMTALA purposes, has come to include any other department where emergency medical conditions are treated, such as ambulatory care or ambulatory surgical units.

Even if a patient is only on hospital property, such as the parking lot, sidewalk, or driveway; in a public street; or is in a hospital department within the 250-yard area of the main hospital building, he or she was considered to have "come to the hospital" and therefore was protected by EMTALA requirements. Any person on hospital property who *requests* care for a possible emergency condition triggers EMTALA obligations for the hospital.

The major impetus for the creation of the 250-yard rule involved the incident of a boy who died across an alley from Ravenswood Hospital in Chicago when ED personnel refused to leave hospital property to provide care.[11]

CMS cited Ravenswood for an EMTALA violation and fined the hospital $40,000 even though the

250-yard rule was not in effect at the time. The hospital also had to settle a subsequent lawsuit for millions of dollars.

Hospitals have become confused about to how EMTALA applies to the many patients who come to the hospital for routine outpatient nonemergency services. Do EMTALA obligations begin if a patient comes to the hospital for routine x-rays and then develops chest pains? What of the patient who is in the hospital for medical services such as outpatient surgery but subsequently develops chest pain or an anesthesia complication?

• Proposed Rules (*Federal Register*, May 9, 2002):

CMS proposed to confirm that if an individual on hospital property for other reasons develops a possible emergency condition and requests treatment either directly or indirectly (e.g., by collapsing), the hospital incurs EMTALA obligations for that patient's possible emergency condition. The hospital must proceed to provide a medical screening examination as well as needed stabilizing treatment and transfer restrictions.

CMS also proposed that EMTALA would not apply to an individual who experiences what may be an emergency medical condition if the individual already is receiving medical care as an outpatient. This may apply to a patient who comes to the hospital for outpatient surgery and develops an emergency condition, because such individuals already are patients of the hospital.

• Final Rules (*Federal Register*, Sept. 9, 2003):

CMS will define hospital property in the CFR in 489.24(b) so that any individual on the property who requests treatment for a potential emergency condition will trigger EMTALA obligations:

> *Hospital property means the entire main hospital campus as defined in Sec. 413.65(b) of this chapter, including the parking lot, sidewalk, and driveway, but excluding other areas or structures of the hospital's main building that are not part of the hospital, such as physician offices, rural health centers, skilled nursing facilities, or restaurants, shops, or other nonmedical facilities.*[12]

CMS also will change the CFR in 489.24 (b) to state that an exception to EMTALA application would be for outpatients defined as:

1) An individual who has begun to receive outpatient services as part of an encounter, as defined in Sec. 410.2 of this chapter, other than an encounter that the hospital is obligated by this section to provide.[13]

Discussion

Hospitals have other areas where acute care is provided. Patients come to the hospital and request examination and treatment at ambulatory care areas for antibiotic infusions and vaccinations, pediatric clinics, chemotherapy clinics, cardiac centers for medication infusions, outpatient surgery for minor procedures, pain clinics, and so on. Normally, physicians who can offer a medical screening examination do not always staff these areas. To avoid EMTALA complications, the hospital should draft forms for the patient to sign at the initiation of outpatient therapy stating specifically that he or she is not requesting acute emergency care. Otherwise, an EMTALA medical screening examination technically would be required.

Hospitals need to draft policies and procedures to address EMTALA's interaction with patients who come to the hospital only for testing or therapeutics. The policy should mention the hospital's intent to provide a medical screening examination to all who request such care. This is especially important when patient come to the ED for such tests and care during off-hours such as nights and weekends. The policy should clarify that it is the ordering physician, not the emergency physician, who has the responsibility to follow up on the test results.

CMS has clarified that EMTALA would not apply to outpatients (as defined in 42 CFR 410.2) who already are under medical care and develop potential emergency conditions. An outpatient, for example, undergoing a biopsy procedure and develops hypotension would be treated directly by the anesthesiologist and/or the attending surgeon. EMTALA obligations such as transfer restrictions would not be activated. Importantly, CMS states further that even if an outpatient with an emergency medical condition is transported to the DED for further care, EMTALA still is not triggered. CMS notes that such an outpatient who experiences what may be an emergency medical condition after the start of the outpatient encounter with a health professional would already have all the protections afforded to patients of a hospital under the Medicare hospital conditions of participation (CoP) found in 42 CFR 482. Hospitals that fail to provide treatment to these patients already face termination of their Medicare provider agreements for a violation of the CoP. CMS also states that these patients are already protected by state malpractice laws as well as under general rules of ethics governing the medical

Table 2. Responding to Emergencies

When formulating a response policy for the hospital campus, hospitals need to consider the following:

- The safety of staff members to leave hospital property
- Whether workers' compensation will cover injuries to staff off hospital property
- Whether state "Good Samaritan" laws will protect staff members from liability when they come to the aid of off-property individuals
- Whether hospital liability insurance will cover or indemnify staff who commit negligence in the course of responding to an off-site emergency
- Whether, when ED staff respond to an emergency 250 yards away, there will be sufficient staff left within the ED to care for patients who already are within the department
- How far off hospital property the emergency staff is expected to respond, vs. calling community emergency medical services
- Whether hospital staff are properly trained to provide emergency care in the streets outside the department
- Whether the policy allows flexibility based on staff judgment
- What equipment needs to be brought to the scene
- Which personnel are expected to respond — only nurses, or must the ED physician also respond?

profession. Hospitals should draft specific policies to address situations where outpatients develop acute emergency conditions. **(See Table 2, above.)**

Applicability of EMTALA to Inpatients

Historical Perspective. Congress created EMTALA in 1985 to address a perceived problem of patient dumping. From the start, it was not clear whether EMTALA applied to inpatients (either direct admissions or from the ED). The U.S. Supreme Court seemed to answer the question indirectly in *Roberts v. Galen of Virginia*[14] by ruling in 1997 that EMTALA still could apply even when a patient had been treated for six weeks in the hospital before being transferred.

In *Roberts*, Wanda Johnson, who was not insured, was seriously injured after being hit by a truck. After six weeks of inpatient care, the hospital transferred her to a skilled nursing facility across the state line in Indiana. The patient developed urosepsis the day after transfer. She then was transferred to Midwest Medical Center in Indiana, where she remained as an inpatient for several more months. Johnson's aunt, Jane Roberts, filed suit in 1993 seeking damages under EMTALA, alleging that the hospital transferred her in an unstable condition because of her lack of insurance. The local District Court, as well as the Appeals Court for the Sixth Circuit, ruled in favor of the defense that EMTALA did not apply. However, the Supreme Court overruled both lower courts and stated that EMTALA still could apply. Although ruling on an improper motive issue for EMTALA, the Supreme Court seemed to imply that EMTALA still applies after six weeks of inpatient care.

In contrast to *Roberts*, the Court of Appeals of the Ninth Circuit ruled in the 2002 case of *Bryant v. Adventist Health System,*[15] that the EMTALA patient stabilization requirement ends when an ED patient is admitted for inpatient care, absent evidence that the admission was done to avoid EMTALA requirements. In *Bryant,* the parents of David Bryant brought him to the ED of Redbud Community Hospital for a respiratory infection. The ED physician interpreted David's chest x-ray as acute pneumonia, treated him with antibiotics, and discharged him home after he appeared stable. The next day, a radiologist found the presence of a lung abscess on the chest x-ray. The hospital called the family and admitted David to the hospital, but he eventually died from his illness. The family sued the hospital, alleging that the hospital violated EMTALA by discharging David in an unstable condition after the first ED visit and by failing to stabilize his condition after admission to the hospital. The district court ruled for the hospital, stating that Redbud could not be liable under EMTALA merely because its medical staff failed to detect an emergency medical condition. The district court also ruled that once Redbud admitted David for inpatient care, the family's remedies for David's alleged inadequate medical care were under state malpractice laws, not EMTALA. The Court of Appeals concurred with the lower court rulings.

• Proposed Rules *(Federal Register*, May 9, 2002):

CMS proposed that EMTALA does not apply to hospital inpatients except in the case where a patient had already triggered EMTALA by coming to the hospital requesting care for an emergency medical condition and the patient was admitted as an inpatient without that condition having been stabilized.

• Final Rules *(Federal Register,* Sept. 9, 2003):

CMS will adopt in the final rules at 489.24 (b) that in the wording "*Comes to the emergency department means, with respect to an individual who is <u>not</u> a patient . . .,"* CMS further defines "patient" by defining "inpatient" as "an individual who is admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services

as described in Sec. 409.10(a) of this chapter with the expectation that he or she will remain at least overnight and occupy a bed even though the situation later develops that the individual can be discharged or transferred to another hospital and does not actually use a hospital bed overnight."[16]

Regarding ED patients who are admitted to the hospital, CMS will amend the CFR at 489.24 (d)(2) to state:

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.[17]

Discussion

CMS agreed with the rulings in *Bryant v. Adventist Health System.* It establishes in the final rules that EMTALA will not apply to patients routinely admitted to the hospital. Additionally, CMS went further than their proposed rules from May 2002 by stating that EMTALA obligations end for an ED patient once the patient is admitted to the hospital. The proposed rules had stated EMTALA would still be active for an ED patient admitted with an unstabilized emergency medical condition until that condition is stabilized. Once admitted to the hospital, CMS reasoned that EMTALA protection is no longer needed because state malpractice tort laws then protect a patient as well as CoPs. CMS may terminate the Medicare provider agreement with a hospital for violations of CoPs. CMS cautions that the patient must be admitted in good faith for further necessary medical care. CMS expects the patient will be admitted at least overnight for further care. A hospital cannot admit a patient from the ED with an unstable condition only to immediately transfer him or her in an attempt to use this rule to avoid EMTALA obligations.

CMS distinguishes the Supreme Court ruling in *Roberts* by pointing out that the Court was ruling on the improper motive issue in EMTALA application. It ruled that a patient does not have to prove that a hospital acted with an improper motive such as discrimination on the basis of payment issues to find EMTALA violation. It just so happened that the patient in question was an inpatient. The Court did not address the issue of when a hospital's EMTALA obligation to stabilize an individual ends. CMS, therefore, believes its interpretation is not inconsistent with the ruling in *Roberts.*

Applicability to Off-Campus Hospital Departments

Historical Perspective. Currently, EMTALA applies to all off-campus departments of a hospital when an individual presents at that department for emergency medical care. In the CFR, CMS stated:

> *Off-campus departments: If an individual comes to a facility or organization that is located off the main hospital campus but has been determined under Sec. 416.35 of this chapter to be a department of the hospital and a request is made on the individual's behalf for examination or treatment of a potential emergency medical condition as otherwise described in paragraph (a) of this section, the hospital is obligated in accordance with the rules in this paragraph to provide the individual with an appropriate medical screening examination and any necessary stabilizing treatment or an appropriate transfer.*[18]

This ruling created significant administrative difficulties for hospitals. All off-campus departments including physical therapy, radiology, or laboratory sites would have to comply with EMTALA's requirements including signage, logs, on-call lists, etc. In addition, hospitals had to designate a "qualified medical person" to provide screening examinations and stabilization treatments. If these departments did not staff physicians or nurses, then specific protocols had to be provided for nonmedical personnel to follow in the case of an individual presenting with emergency medical conditions.

- **Proposed Rules (*Federal Register,* May 9, 2002):**

CMS proposed to clarify and simplify application to off-campus departments by applying EMTALA only to those off-campus hospital departments that meet their new definition of DED. Other off-campus departments that do not meet the definition of DED would not be obligated to follow EMTALA rules.

- **Final Rules (*Federal Register,* Sept. 9, 2003):**

CMS proceeded with their 2002 proposal for EMTALA to encompass only those off-campus hospital departments that would be perceived by individuals as appropriate places to go for emergency care. CMS will amend the CFR at 489.24 (b)(4) to state that DED means any department or facility of the

hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the requirements found in **Table 1**.

Discussion

This new ruling is a welcome clarification for hospitals. It is reasonable and appropriate for EMTALA to apply specifically to off-campus departments that function and operate like an ED. CMS cautions that off-campus departments that do not meet their definition of a DED still must provide appropriate care for patients with emergency conditions (a patient presents for physical therapy and develops chest pains). CMS will adopt, as final, a new Sec. 482.12 (f)(3) that provides that the governing body of a hospital must assure that the medical staff have written policies and procedures in effect with respect to off-campus departments for appraisal of emergencies and referrals, when appropriate.

EMTALA and On-Call Requirements

Historical Perspective. The CMS *State Operations Manual* for investigators of EMTALA violations states:

> *The purpose of the on-call list is to ensure that the emergency department is prospectively aware of which physicians, including specialists and subspecialists, are available to provide treatment necessary to stabilize individuals with emergency medical conditions. If a hospital offers a service to the public, the service should be available through on-call coverage of the emergency department.*[19]

Congress originally enacted EMTALA to target hospitals and EDs, but further cases over the following years established that common causes of unstable transfers from the ED were necessitated by the refusal of on-call physicians to provide care. The infamous case of *Burditt v. U.S. Department of Health and Human Services*[20] occurred in 1986 when the on-call obstetrician, Dr. Burditt, refused to provide care for a patient who was in labor with hypertension. Dr. Burditt ultimately had to pay a fine of $20,000 when the Fifth Circuit Court of Appeals affirmed a fine levied by the Department of Health and Human Services. Hospitals continued to be confused as to exactly how it is to fulfill its EMTALA on-call responsibilities. With a limited number of specialists on staff, does a hospital have to provide on-call services 24 hours a day, seven days a week, and 365 days a year?

• Proposed Rules *(Federal Register,* May 9, 2002)

CMS proposed to clarify its policies on EMTALA requirements regarding the availability of on-call physicians. In the May 9, 2002, proposed rule, CMS proposed to add to Sec. 489.24 (a) a new paragraph to specify that each hospital has the discretion to maintain the on-call list in a manner to best meet the needs of its patients. This proposed paragraph further specified that physicians, including specialists and subspecialists (for example, neurologists), are not required to be on call at all times, and that the hospital must have policies and procedures to be followed when a particular specialty is not available or the on-call physician cannot respond because of situations beyond his or her control.

• Final Rules *(Federal Register,* Sept. 9, 2003)

CMS will adopt the final rules in 489.24 (j) to state:

j) Availability of on-call physicians.

1) Each hospital must maintain an on-call list of physicians on its medical staff in a manner that best meets the needs of the hospital's patients who are receiving services required under this section in accordance with the resources available to the hospital, including the availability of on-call physicians.
2) The hospital must have written policies and procedures in place:

i) To respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control; and

ii) To provide that emergency services are available to meet the needs of patients with emergency medical conditions if it elects to permit on-call physicians to schedule elective surgery during the time that they are on call or to permit on-call physicians to have simultaneous on-call duties.[21]

Discussion

The final CMS rules allow considerable flexibility for hospitals to fulfill their on-call requirements of EMTALA. CMS did not prescribe how many hours a specialist must be on call for the hospital. CMS believes that specific on-call issues are local decisions that should be made at the individual hospital level through coordination between the hospitals and their staffs of physicians. CMS also states that EMTALA already provides penalties for physicians who negligently violate the on-call requirements of the Act. CMS

emphasizes that hospitals also have a responsibility to penalize any physician who refuses to provide on-call responsibilities.

CMS allows a specialist to be on call for several hospitals simultaneously. Neurosurgeons would take call for several rural hospitals simultaneously to provide a wide area of coverage. If prohibited from such a practice, many rural hospitals would be left without any coverage at all. The feeling is that some overlapping coverage is better than no coverage at all. In a letter submitted in June 13, 2002,[22] CMS states that when the on-call physician is simultaneously on call at more than one hospital in the geographic area, all hospitals involved must be aware of the on-call schedule, as each hospital independently has an EMTALA obligation. In addition, the letter clarifies that hospitals must have policies and procedures to follow when an on-call physician is simultaneously on call at another hospital and is not available to respond. Hospital policies may include, but are not limited to, procedures for backup on-call physicians, or the implementation of an appropriate EMTALA transfer.

CMS also allows a physician to proceed with their private practice and perform elective surgery while on call. Physicians must not use this allowance to game the system (scheduling elective surgeries mainly on on-call days) and avoid EMTALA on-call obligations. CMS maintains that they will evaluate possible violations on a case-by-case basis. As with simultaneous on-call situations, hospitals must have policies and procedures to follow when an on-call physician is unavailable for on-call response.

CMS further clarifies that there is no predetermined "ratio" that CMS uses to identify how many days a hospital must provide medical staff on-call coverage based on the number of physicians on staff for that particular specialty. If a hospital has an insufficient number of a certain specialty on staff, the hospital is not forced to provide 24-hour/seven-day coverage. In particular, CMS emphasizes that it has no rule stating that whenever there are at least three physicians in a specialty, the hospital must provide 24-hour/seven-day coverage. Generally, in determining EMTALA compliance, CMS will consider all relevant factors, including the number of physicians on staff, other demands on these physicians, the frequency with which the hospital's patients typically require services of on-call physicians, and the provisions the hospital has made for situations in which a physician in the specialty is not available or the on-call physician is unable to respond.

CMS does not allow a physician to refuse hospital on-call duties but then remain on call for his own or other physician practices. Being on call for private patients shows that the physician has the ability to take on-call obligations. CMS notes that this practice is discriminatory and violates EMTALA. If a physician wishes to continue to be on call for private patients, they must participate in being on call for all patients.

Applicability to Hospital-Owned Ambulances

Historical Perspective. The 2000 regulations require that a patient must be on hospital property for EMTALA jurisdiction. Such property includes ambulances (and helicopters) owned and operated by the hospital, even if the ambulance is not on hospital grounds.[23]

Under the previous interpretation, any hospital-owned ambulance will have violated EMTALA if it had transported a patient to another hospital even if under local communitywide EMS protocols that may require the transport of individuals to a nearer hospital for proper patient care. The original rule was passed to prevent hospital-owned ambulances from diverting patients to another hospital because of economic reasons, thus avoiding its EMTALA responsibilities. However, the ruling conflicted with communitywide EMS protocols that would require ambulances to transfer to the nearest hospital in situations where a patient's life would be endangered by a longer transport to the hospital that owns the ambulance.

• Proposed Rules *(Federal Register*, May 9, 2002)

Under CMS' proposal, the rule on hospital-owned ambulances and EMTALA does not apply if the ambulance is operating under a communitywide EMS protocol that requires it to transport the individual to a hospital other than the hospital that owns the ambulance. In this case, the individual is considered to have come to the ED of the hospital to which the individual is transported, at the time the individual is brought onto hospital property.

• Final Rules *(Federal Register,* Sept. 9, 2003)

3) . . . Is in a ground or air ambulance owned and operated by the hospital for purposes of examination and treatment for a medical condition at a hospital's DED, even if the ambulance is not on hospital grounds. However, an individual in an ambulance owned and operated by the hospital is not considered to have "come to the hospital's emergency department" if —

ii) The ambulance is operated under community wide emergency medical service (EMS) protocols that direct it to transport the individual to a hospital other than the hospital that owns the ambulance; for example, to the closest appropriate facility. In this case, the individual is considered to have come to the emergency department of the hospital to which the individual is transported, at the time the individual is brought onto hospital property;

ii) The ambulance is operated at the direction of a physician who is not employed or otherwise affiliated with the hospital that owns the ambulance; or

4) Is in a ground or air nonhospital-owned ambulance on hospital property for presentation for examination and treatment for a medical condition at a hospital's DED. However, an individual in a nonhospital-owned ambulance off hospital property is not considered to have come to the hospital's emergency department, even if a member of the ambulance staff contacts the hospital by telephone or telemetry communications and informs the hospital that they want to transport the individual to the hospital for examination and treatment. The hospital may direct the ambulance to another facility if it is in "diversionary status," that is, it does not have the staff or facilities to accept any additional emergency patients. If, however, the ambulance staff disregards the hospital's diversion instructions and transports the individual onto hospital property, the individual is considered to have come to the ED.

Discussion

This new proposed ruling would allow flexibility for proper patient care. For example, the new ruling would accommodate local EMS disaster protocols that require ambulances to be diverted to appropriate hospitals in the system regardless of ambulance ownership. CMS specifies that an individual in an ambulance owned and operated by the hospital is not considered to have "come to the emergency department" if the ambulance is operated under communitywide EMS protocols or EMS protocols mandated by state law that direct it to transport the individual to a hospital other than the hospital that owns the ambulance.

With respect to the situation in which the hospital EMS personnel on board the ambulance determine that transporting the individual to the owner hospital would put the patient's life or safety at risk, CMS recognizes that there may be some situations in which redirection of the ambulance is necessary to protect the life or safety of the individual and that under these circumstances it would not be an EMTALA violation to transport the individual to the closest hospital capable of treating the patient's condition. Additionally, this new ruling should release EMTALA obligations for hospitals that have ambulances and air-transport vehicles that provide taxi service transports between other hospitals neither of which is the home-based hospital. The ambulance or helicopter would be considered to be on loan to the other hospital, thereby transferring the direction of the ambulance to the other hospital.

In the event of a bioterrorist emergency, hospital ambulances may be redirected to other hospitals for other reasons such as containing a biocontamination to a central location or to a hazardous materials center hospital. CMS states the Bioterrorism Act[24] authorizes the government to temporarily waive or modify the application of certain Medicare, Medicaid, and State Children's Health Insurance Program requirements, including requirements for the imposition of sanctions for the otherwise inappropriate transfer of an unstabilized individual, if the transfer arises out of the circumstances of the emergency. CMS added that in the event of such a national emergency, CMS would issue appropriate guidance to hospitals.

Summary

These final rules are welcome clarifications of longstanding controversial areas of EMTALA application to hospitals. On the whole, these new rules are hospital and physician-friendly while maintaining proper protection for patients with emergency medical conditions. CMS has demonstrated reasonableness and common sense in preparing these rules. Physicians and hospitals must not use these new, flexible rules to avoid proper treatment for patients with emergency medical conditions under EMTALA. Doing so would invite a backlash not only from CMS, but also from the courts, legislators, and the public, and would jeopardize all gains. Proper patient care with the patient's medical best interest in mind is the bottom line.

Endnotes

1. 68 *Fed Reg* 53,222 (Sept. 9, 2003).
2. Health Care Financing Administration. *State Operations Manual Provider Certification* (HCFA Pub. 7, Transmittal

CE/CME Objectives

[For information on subscribing to the CE/CME program, contact customer service at (800) 688-2421 or e-mail customerservice@ahcpub.com.]

The participants will be able to:

- identify high-risk patients and use tips from the program to minimize the risk of patient injury and medical malpractice exposure;
- identify a "standard of care" for treating particular conditions covered in the newsletter;
- identify cases in which informed consent is required;
- identify cases which include reporting requirements;
- discuss ways in which to minimize risk in the ED setting.

No. 2, June 1, 1998); Tag #A406.
3. 64 *Fed Reg* 61,353 (Nov. 10, 1999).
4. *Id,* at 61,356.
5. *Supra* note 1, at 53,264.
6. 42 U.S.C. § 1395dd(a).
7. *Supra* note 1, at 53,262.
8. *Supra* note 1, at 53,263.
9. 42 U.S.C. § 1395dd(a).
10. *Supra* note 1, at 53,263.
11. Smallwood L. "Witnesses Say Hospital Refused To Help Dying Teen." *Chicago Tribune,* May 18, 1998 (Metro Chicago); at 1.
12. *Supra* note 1, at 53,263.
13 *Id., at* 53,263.
14. *Roberts v. Galen of Va. Inc.,* 111 F.3d 405, Sixth Cir. (1997), overruled by No. 97-53, U.S.C. (Jan. 13, 1999).
15. *Bryant v. Adventist Health System*, 229 F.3d 1162, Ninth Cir. (2002).
16. *Supra* note 1, at 53,263.
17. *Id.*
18 42 C.F.R. 489.24 (h)(i).
19. *Supra,* note 2, at A404.
20. *Burditt v. United States Dep't of Health & Human Servs.*, 934 F.2d 1362, 1372, Fifth Cir. (1991).
21 *Supra* note 1, at 53,264.
22. CMS Survey and Certification Letter No. S&C-02-35.
23. 42 C.F.R. § 489.24(b).
24. Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (Pub. L. 107-188); June 12, 2002.

CE/CME Questions

5. An individual triggers EMTALA obligations for a hospital by requesting care for a medical condition in any of the following instances *except:*
A. When the individual comes to a "dedicated emergency department."
B. When the individual is present anywhere on hospital property.
C. When the individual is a patient in a hospital-owned ambulance under direction of the hospital.
D. When an individual comes to the hospital for a scheduled outpatient appointment and during the visit develops an emergency medical condition.

6. A hospital does *not* have EMTALA obligations when:
A. A patient passes out at the hospital's physical therapy center.
B. A patient has been admitted to the hospital from the ED for an emergency medical condition.
C. A patient is in a hospital-owned ambulance but is not on the hospital campus.
D. A patient develops obstetric complications while obtaining an ultrasound.

7. A patient who presents to the DED for nonemergency care:
A. Must be provided a full medical screening examination.
B. Cannot be referred to another department.
C. May be evaluated by a nonphysician or qualified medical person.
D. Triggers EMTALA requirements for a hospital.

8. EMTALA is triggered when an individual who requests care for an emergency medical condition presents at any of the following locations on a hospital campus *except:*
A. The hospital parking lot.
B. A skilled nursing facility that operates under a different Medicare agreement.
C. An alley next to the hospital's main building.
D. An ambulatory care center on campus.

Answers: 5-D; 6.-B; 7-C; 8-B.

CE/CME Instructions

Physicians and nurses participate in this continuing medical education/continuing education program by reading the article, using the provided references for further research, and studying the questions at the end of the article. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. There is no need to complete and return a Scantron form. To clarify confusion surrounding any questions answered incorrectly, please consult the source material.

At the conclusion of this semester, you must complete the evaluation form that will be provided at that time, and return it in the reply envelope that will be provided to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you.

In Future Issues: Documentation Errors