

**ALABAMA HOSPITAL ASSOCIATION**  
**Annual Meeting**  
**EMTALA - Proposed Changes**  
**June 20, 2002**

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1. Proposed Revisions to the Regulations

On May 9, 2002, the Centers for Medicare and Medicaid Services (CMS) published significant proposed revisions to the regulations under the Emergency Medical Treatment and Active Labor Act (EMTALA) as part of the proposed rule on Medicare Inpatient Prospective Payment. The deadline for comments on the proposed changes is July 8, 2002.

2. Overview of the Revisions

The proposed rules:

1. Codify certain provisions previously published as a statement of HHS policy (Special Advisory Bulletin on Managed Care 11/10/99, 64 Fed. Reg. 61353).
2. Clarify when EMTALA is applicable to hospital inpatients and/or outpatients.
3. Modify the “250 yard” rule to provide that off-site locations that do not routinely provide emergency services are not subject to EMTALA requirements.
4. Clarify when specialty physicians must serve on hospital medical staff “on-call” lists. (Addresses “rule of 3”).
5. Clarify the responsibilities of hospital-owned ambulances.
6. Clarify that an emergency physician is not prohibited from contacting the patient’s physician.
7. Add a requirement to contact the Medicare + Choice organization after an enrollee is stabilized.

8. Clarify when a hospital is obligated under EMTALA based on the location to which a patient presents.
  9. Address use of the Emergency Department for non-emergency services.
  10. Clarify application of EMTALA to certain outpatients who request examination on treatment for an emergency medical condition.
  11. Adds the concept of a “prudent layperson”.
3. Explanation of Significant Portions of Proposed Rules
    1. Codifying Special Advisory Bulletin on Managed Care.
      - (1) Special Advisory Bulletin dated November 10, 1999 (64 Fed. Reg. 61353) addressed a number of issues not previously reflected in the statute or the regulations, informing providers of HHS’ policy with regard to application of certain portions of the antidumping statute. The proposed rules adopt two particular provisions from the Special Bulletin:
        - (1) A hospital may not seek, or direct a patient to seek, authorization from the patient’s insurance company for screening or stabilization services to the patient until after the hospital has provided the appropriate medical screening examination and “initiated” any further medical examination or treatment that may be required to stabilize the emergency medical condition.
        - (2) An emergency physician is not precluded from contacting the patient’s physician at any time to seek advice regarding the patient’s medical history and needs that may be relevant to the medical treatment and screening of the patient as long as his consultation does not inappropriately delay services.
    2. Application to hospital inpatients.
      - (1) The new regulations address a number of issues previously raised with respect to the application of EMTALA to inpatients of the hospital who were (i) not admitted to the hospital through the emergency department, and (ii) inpatients of the hospital who were admitted through the emergency department, were subsequently stabilized for transfer, but were not discharged or transferred. More specifically, the rule provides:

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- (1) If a patient has been screened and found to have an emergency medical condition (EMC), has not been stabilized (as defined by EMTALA) and is admitted to the hospital as an inpatient, EMTALA would apply to the patient until the EMC is stabilized.
- (2) In the case of an inpatient admitted with an EMC which was subsequently stabilized (for purposes of transfer of the patient even though the patient is never transferred), if the period of stability is documented by relevant clinical data in the patient's medical record, then EMTALA would not apply to any subsequent decline or new EMC.
- (3) With respect to an inpatient admitted for elective (non-emergency) diagnosis or treatment, EMTALA would not apply to the patient even in the event of a subsequent EMC.

(2) The revisions to the rule clarify that EMTALA ceases to apply once a patient's EMC has been stabilized. However providers should be careful to document "relevant clinical data" in the medical record indicating stabilization of the EMC for a period of time. Sporadic or brief periods of stability are not adequate to satisfy the hospital's responsibilities under EMTALA.

(3) The proposed regulations also address the situation where a patient comes to the emergency department for a non-emergency service. The proposal states that if an individual comes to a hospital emergency department and a request is made for examination or treatment of 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 only required 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".

### 3. Patients at locations other than a dedicated emergency department.

(1) Consistent with the increasing use of outpatient services, individuals routinely come to hospitals as outpatients for non-emergency medical purposes. If such a patient arrives at a department or facility other than the dedicated emergency department on the hospital campus, the comments indicate that it is assumed that patient is not seeking emergency care and EMTALA would not apply. However, an EMTALA obligation would arise with respect to a patient presenting in such non-emergency department and requesting examination or treatment for what "may be" an emergency

medical condition. Such request will be considered to exist if the individual requests examination or treatment for what the patient believes to be an emergency medical condition.

4. Availability of on-call physicians.

- (1) The proposed regulation provides that “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 patients. Physicians, including specialists and subspecialists, are not required to be on-call at all times. The hospital must have written policies and procedures in place to respond to situations in which a particular speciality is not available or the on-call physician can not respond because of circumstances beyond the physician’s control.”
- (2) The comments to the proposed regulation specifically provide that there is no determined “ratio” that CMS uses to identify how many days a hospital must provide medical staff on-call coverage based on the number of physicians in that particular specialty on staff. The comments specifically state that there is no “rule of 3” - if there are at least three physicians on staff in a given specialty, the hospital must provide 24 hour 7 day a week coverage.
- (3) Relevant factors in determining appropriate level of on-call coverage include the number of physicians on staff, other demands on those physicians, the frequency with which the hospital’s patients typically require services of on-call physicians and the provisions made by the hospital for situations in which a physician in a particular specialty is not available or the on-call physician is unable to respond.
- (4) The comments specifically provide that physicians, including specialists and subspecialists, are not to be on-call at all times and that the hospital must have policies and procedures to be followed when a particular speciality is not available or the on-call physician cannot respond because of situations beyond his or her control.

5. Applicability to hospital owned ambulances.

- (1) The proposed regulation modifies the existing rule that, if an individual is in an ambulance owned and operated by a hospital, the individual is considered to have “come to the hospital’s emergency department” even if the ambulance is not on hospital premises. Recognizing that certain local EMS protocols will directly conflict with the current regulation, the proposal provides an exception in the situation where a hospital owned ambulance is operated under a community wide EMS protocol requiring the ambulance to

transport the patient to a hospital other than the hospital owning the ambulance. In this case the individual is considered to have come to the emergency department of the hospital to which the individual was ultimately transported, at the point in time that the individual is physically brought on to the hospital property.

6. ER physicians contact with the patient’s physician.
  - (1) The proposed regulation specifically provides that the emergency physician is not precluded from contacting the patient’s physician at any time to seek advice regarding the patient’s medical history and needs that may be relevant to the medical treatment and screening of the patient, provided such consultation does not inappropriately delay services required under EMTALA.
7. Responsibility to contact Medicare + Choice Organizations.
  - (1) The proposed rule adds a new EMTALA requirement with respect to stabilized patients enrolled in Medicare + Choice organizations.
  - (2) If an enrollee of a Medicare + Choice organization is treated for any emergency medical condition, is stabilized, and needs further hospital care, “the hospital must promptly contact the Medicare + Choice organization to obtain preapproval of the further hospital care.”
8. When EMTALA is applicable.
  - (1) The proposed regulations modify and/or clarify those certain circumstances under which EMTALA obligations will arise.
  - (2) The regulations add the concept of a “prudent layperson observer”. If an individual presents at the hospital’s dedicated emergency department and is unable to request examination or treatment for a medical condition, such 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, EMTALA will be invoked.
  - (3) If such an individual presents on “hospital property” and requests an examination or treatment for what may be an emergency medical condition EMTALA will be invoked. In the absence of a request by the individual or on the individual’s behalf, such request 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.

- (4) The new proposed rules provide that a request for examination and treatment may be implied when a prudent layperson observer would believe that an individual needs examination and treatment for a medical condition. Note that there is a slightly different standard for the implied request when an individual presents in the designated emergency department as opposed to elsewhere on hospital premises. Presentment in the emergency department where the individual’s appearance or behavior indicates that the individual needs examination or treatment for **a medical condition** is a broader standard than where the individual presents elsewhere on the hospital property and the individual’s appearance or behavior indicates that “the individual needs **emergency** examination or treatment”.
- (5) A definition for the term **hospital property** has been added providing that hospital property means the entire main hospital campus, including parking lots, sidewalks and driveways, but excluding other areas or structures located within 250 yards of the main building but not part of the hospital. Therefore physician offices, rural health centers, skilled nursing facilities and other entities that participate separately under Medicare are not part of the hospital property even when located within 250 yards of the main building. Thus, a patient in a private physician office “located within 250 yards of the main building” who develops an emergency medical condition has not presented to the hospital for purposes of EMTALA.

9. Use of the emergency department for non-emergency services.

- (1) The proposed regulations provide if an individual comes to the hospital’s emergency department and requests (or request is made on his or her behalf) an 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 an individual presenting in that manner to determine that the individual does not have an emergency medical condition.
- (2) The comments also provide that all EMTALA screenings must not necessarily be equally extensive, pointing out that the statute plainly states that the objective of an appropriate medical screening examination is to determine whether or not an emergency medical condition exists. Therefore, hospitals are not obligated to provide screening services beyond those needed to determine there is no emergency medical condition.

- (3) The comments to the proposed regulation provide explicitly that CMS expects in most such cases that an individual's statement that he or she is not seeking emergency care, together with "brief questioning by qualified medical personnel" would be sufficient to establish that there is no emergency medical condition and that the hospital's EMTALA obligation would thereby be satisfied.

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