
Supplement to Providing Emergency Care Under Federal Law: EMTALA

April 2004

This document is a supplement to *Providing Emergency Care Under Federal Law: EMTALA*, published in January 2001 by the American College of Emergency Physicians.

The purpose of the supplement is twofold, as follows:

- To explain the changes made to the EMTALA regulations (effective November 10, 2003), and
- To point out some parts of the book that are affected by these changes.

Although the author provides explanations and summaries of the law and final regulations in this supplement, the supplement is in no way intended to explain EMTALA in its entirety, or all of the nuances associated with how it affects the delivery of care in emergency departments. The supplement addresses only those areas of the regulations that were changed. It should be read in conjunction with the original 2001 publication.

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How the supplement is organized

- **Background**—The portion of the supplement written by the original author, Robert A. Bitterman, MD, JD, FACEP, begins on page S3. Here he provides background information on EMTALA regulatory and enforcement activity since the book was published in January 2001.
- **Executive Summary**—Following the background section is a stand-alone executive summary of the main facets of the new regulations.
- **In-Depth Discussion**—After the executive summary is a more in-depth discussion of the final regulations and related issues. Within this area are references to the sections of the original 2001 publication that are significantly affected by the new regulations. The original publication has an extensive index that can be used to find other discussions of these issues not specifically referred to in the supplement.
- **Transfer Form**—A new, more user-friendly transfer form is on page S20. This replaces the transfer forms in Appendix 3 of the original 2001 publication.
- **References** can be found on page S25.
- **Author Contact Information** is on page S26.

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Supplement to Providing Emergency Care Under Federal Law: EMTALA

Robert A. Bitterman, MD, JD, FACEP

Background

This supplement is written primarily to incorporate the final regulations governing EMTALA into the 2001 ACEP publication, *Providing Emergency Care Under Federal Law: EMTALA*. The final regulations were issued by the Centers for Medicare and Medicaid Services (CMS, formerly known as the Health Care Financing Administration, or HCFA) in September 2003 and went into effect November 10, 2003.¹ They were published in *Federal Register* (68 *Federal Register* 53221-53264) and can be downloaded and printed from the following Web page: <http://a257.g.akamaitech.net/7/257/2422/14mar20010800/edocket.access.gpo.gov/2003/pdf/03-22594.pdf>.

EMTALA has continued to evolve and remains a complex compliance issue for hospitals and physicians. Since publication of the ACEP book, there had been few substantive changes in the legal interpretations or recommendations provided in the book up until CMS issued these new regulations.

Over the past few years, CMS has published a number of memoranda, called “Survey and Certification letters,” to clarify its policies regarding EMTALA. The topics addressed include definition of hospital “capacity” and responsibilities of hospitals to accept patients in transfer; certification of false labor; on-call requirements and simultaneous call; bioterrorism and EMTALA; and policy clarification on hospital-owned and operated ambulances participating in emergency medical services.²

The Office of Inspector General (OIG), also a branch of the Department of Health and Human Services (HHS), surveyed hospital emergency departments to measure their understanding of the law (abysmal) and examined the

enforcement of the law by CMS (widely inconsistent). The General Accounting Office (GAO) reported on the impact of EMTALA on hospital emergency departments, access to care, and the delivery of emergency care, and also examined enforcement of the law by both CMS and the OIG.³

The government further scrutinized EMTALA enforcement through the HHS Secretary’s Regulatory Reform Advisory Committee, which singled out the EMTALA regulations for study on ways to lessen the burden of the regulations on health care providers without changing the intent of the law.⁴

CMS originally proposed the new regulations on May 9, 2002, responding to concerns of lack of understanding over what the law and CMS’s regulations required, and a consensus that the regulations had expanded beyond the original intent of the statute.⁵ CMS was also concerned that the EMTALA regulations could be exacerbating the problems of emergency department overcrowding and the difficulties hospitals were experiencing in obtaining a reasonable complement of on-call physician specialists to the emergency department. Widespread inconsistent enforcement of the requirements of EMTALA existed across state and CMS regions (confirmed by the OIG and GAO studies), and conflicting court opinions further exacerbated those inconsistencies.

CMS expressly solicited comments from hospitals, physicians, patients, and beneficiary groups, and comments it received—a whopping 650 or more submissions, and most in the final days of the comment period. CMS delayed publication of the final rule so it could adequately address the comments offered by providers and the public, and incorporate various recommendations of the Secretary’s Regulatory Reform Advisory Committee. At the same time,

CMS had no intention of lessening the protections afforded all individuals under the Act.

CMS finally published the new final EMTALA regulations on September 9, 2003, and the regulations became effective November 10, 2003.¹ It also issued interim guidelines to instruct the state survey agencies and the CMS regional offices on how to enforce the law under the new regulations, which, unfortunately, contain confusing or misleading language on the legal interpretation of “stabilization.” However, CMS intends to review all the issues and publish more complete interpretive guidelines later this year.⁶

Shortly after CMS issued its final regulations, Congress passed the massive Medicare Prescription Drug Improvement and Modernization Act in December 2003.⁷ Included in the Medicare Act were four provisions related to EMTALA, as follows:

- Amended EMTALA to require the Secretary of HHS to establish a procedure to notify hospitals and physicians when an investigation under EMTALA was closed.
- Provides \$1 billion over 4 years to help hospitals cover the costs of EMTALA-mandated emergency services for undocumented immigrants (which will primarily benefit southwestern hospitals near the Mexico border).
- Requires CMS to obtain a prior review by the state peer review organization before making a compliance determination as part of the process of terminating the hospital’s participation under Medicare for EMTALA violations, and to provide a copy of the organization’s report to the hospital or physician under investigation.
- Directs the Secretary of HHS to establish a technical advisory committee to review issues related to EMTALA and its implementation. The advisory group will be

composed of 19 members, to serve for 30 months after the date of its first meeting. Its general responsibilities include reviewing EMTALA regulations, providing advice and recommendations to the Secretary with respect to the regulations and their application to hospitals and physicians, solicit comments and recommendations from hospitals and physicians and the public regarding implementation of the regulations, disseminate information on the application of such regulations to hospitals, physicians, and the public. As of April 1, 2004, HHS had not yet constituted the committee.

The federal courts have also weighed in regarding the interpretation of the law, primarily in civil suits against hospitals for damages individuals suffered as a result of the hospital’s or physician’s violation of the statute. In two separate appellate court cases, the judges refused to apply EMTALA to inpatients, markedly diminishing the liability of hospitals and physicians for the care of patients with emergency medical conditions.⁸

On the other hand, the US Court of Appeals, Ninth Circuit, which governs the west coast states, overturned a district court’s ruling in the case of *Arrington v Wong*,⁹ which could have significant ramifications for physician and hospital liability in providing telemetry medical direction to ambulance units.

While the publications and enforcement actions of CMS and certain court cases have refined the interpretation and requirements of EMTALA, the new final regulations promulgated by CMS will certainly have the greatest impact on the substantive issues, enforcement actions, and applicability of the law for hospitals and physicians. As such, this supplement primarily addresses CMS’s new regulations.

Executive Summary

Robert A. Bitterman, MD, JD, FACEP

The Centers for Medicare and Medicaid Services (CMS) published new regulations governing Medicare-participating hospital responsibilities for providing emergency care under the Emergency Medical Treatment and Labor Act (EMTALA) in September 2003. The new regulations went into effect November 10, 2003.

Definitions

CMS revised the definitions of “comes to the emergency department” and “a hospital with an emergency department” and added new definitions for a “dedicated emergency department,” “hospital property,” “inpatients,” and “patient.” The practice of hospital-based emergency medicine is determined by these statutory and regulatory definitions, so health care providers must understand the legal lingo and incorporate it into everyday practices.

Application of EMTALA

The application of the law now depends upon “which door” of the hospital the patient presents seeking medical care.

Presentation to a Hospital’s Dedicated Emergency Department

CMS redefined emergency care areas as “dedicated emergency departments.” A dedicated emergency department is defined as any department or facility of the hospital, regardless of whether it’s on or off-campus, that is licensed by the state as an emergency department; or is held out to the public as a place that provides care for emergency medical conditions on an unscheduled basis; or actually does provide care for emergency medical condi-

tions a certain percentage of the time.

Units qualifying as dedicated emergency departments include a hospital’s typical emergency department, labor and delivery unit, psychiatric intake center, and potentially urgent care centers. CMS intended EMTALA to apply to urgent care centers; however, urgent care centers do not hold themselves out as able to provide care for true emergency medical conditions, *as that term is defined by the statute*. Thus, in the author’s opinion, the typical urgent care center will not likely meet the new regulatory definition of a dedicated emergency department, and therefore will not have to comply with EMTALA. CMS may readdress this issue further.

The rules for application of EMTALA to dedicated emergency departments include the following:

- Any individual (who is not already a hospital patient) presents to the dedicated emergency department.
- There is a request for examination or treatment of a medical condition (It is not required that the presentation be for an *emergency* medical condition for EMTALA to apply at a dedicated emergency department.)
- The request may be made by anyone, such as the patient, family, medics, or a babysitter. CMS also added a new method for triggering a request: if an objective prudent layperson observed the person and believes the person needs and is seeking care for a medical condition. This section triggers the application of EMTALA when the hospital is on notice by virtue of the individual’s presentation or behavior, rather than by their expressed request, that the individual is seeking examination and treatment for a medical condition.
- EMTALA applies in these situations; the hospital must provide a medical screening examination and stabiliza-

tion or appropriate transfer if an emergency medical condition is detected.

- The EMTALA-related requirements apply to these dedicated emergency departments (post signs, maintain medical records of transfers, maintain an on-call list, keep a central log, and report inappropriate transfers of unstable patients to CMS).

Presentation to Hospital Property Other Than the Dedicated Emergency Department

CMS revised the definition of “hospital property” to include presentations on hospital properties outside the dedicated emergency department. These include the parking lot, driveway, sidewalks, persons who “go to ground” in the cafeteria, radiology, lab, or the emergency department waiting room, or presentations anywhere else on the hospital property other than the dedicated emergency department. The confusing “250-yard rule” still exists, but CMS did limit its applicability.

CMS specifically excluded certain hospital non–dedicated emergency department facilities on hospital property such as physicians’ offices, skilled nursing facilities, other entities that participate separately under Medicare, and other nonmedical facilities on campus.

The rules for application of EMTALA to presentation to the hospital outside the dedicated emergency department include the following:

- “Comes to the emergency department” means anywhere on hospital property other than the dedicated emergency department (unless the area is specifically exempt). Request for examination and treatment must be for an emergency medical condition (as opposed to presentation to dedicated emergency department, which may be for any medical condition, not necessarily an emergency medical condition).
- The request can be made by anyone, including the patient, family, medics, or anybody else on behalf of the patient or by way of the objective prudent layperson standard for an emergency medical condition.
- EMTALA applies; the hospital must provide an MSE and stabilization or an appropriate transfer.
- The EMTALA-related requirements do not apply. (In areas other than dedicated emergency departments, the hospital is not required to post signs, maintain transfer records, list physicians on call, keep a central log, or report inappropriate transfers.)

Presentation to Hospital-Owned Off-Campus Provider-Based Facilities

CMS eliminated application to those types of facilities and other “departments of a provider” that were never intended or structured to manage emergency medical conditions, such as dialysis centers, rehabilitation units,

lab and radiology centers, or primary care clinics. These facilities should have written policy and procedures for appraisal of emergencies and arranging transfers when appropriate.

Presentation via Hospital-Owned and Operated Ambulance or Helicopter

Under the new regulations, if the hospital’s ambulances or helicopters operate under community-wide EMS protocols, or if telemetry direction of the ambulances is provided by physicians independent of the hospital, then CMS will not consider the patient to have “come to the hospital’s emergency department” unless and until the ambulance actually brings the patient onto hospital property. Previously CMS applied EMTALA whenever or wherever a patient presented to a hospital-owned and operated ambulance.

Presentation via Non-Hospital-Owned and Operated Ambulance or Helicopter

A non-hospital-owned ambulance has come to the hospital’s emergency department, for purposes of triggering EMTALA, once it reaches hospital property, provided there is also a request for services at that hospital. EMTALA applies in these situations even if the medics ignore the hospital’s diversionary status or direct orders to divert from their facility.

Common Scenarios for Which CMS Eliminated Application of EMTALA

Inpatients

EMTALA no longer applies to the treatment or stabilization of inpatients, regardless if directly admitted to the floor, directly admitted via the emergency department, or boarded in the emergency department awaiting bed placement. Even if the inpatient is brought down to the emergency department, the law does not apply. The caveat to this new rule is that the patient must actually be formally admitted. CMS doesn’t consider patients admitted to “observation status” to count as “admitted” patients, and thus EMTALA still applies to the care of observation patients, such as patients in emergency department chest pain units.

Scheduled Outpatients

CMS also eliminated application of EMTALA for scheduled outpatient encounters at the hospital that unexpectedly deteriorate into an emergency medical condition. The key here is that the outpatient encounter must have actually begun to eliminate the application of the law.

Off-Campus Facilities

Hospital-owned off-campus facilities that typically do not offer emergency services do not have to comply with EMTALA. The exception may be provider-based urgent care centers; the CMS position on this will be clarified in the future.

On-Campus Facilities

CMS now exempts certain hospital non-dedicated emergency department facilities on hospital property from the duty to comply with EMTALA. These include physician's offices, skilled nursing facilities, other entities that participate separately under Medicare, and other nonmedical facilities on campus. Provider-based urgent care centers might or might not be exempt, depending on how one reads the new regulations. (See the dedicated emergency department section on pages S5 and S6 for the author's opinion.)

National Emergencies

CMS will not sanction a hospital that inappropriately transfers a patient during a federally declared national emergency. (This does not include local public health emergencies.)

Use of the Dedicated Emergency Department for Nonemergency Services

CMS attempted to avoid application of EMTALA to persons coming to the emergency department for reasons other than seeking emergency care. However, the language of the new regulation really didn't change anything. The hospital still must perform a medical screening examination of the extent necessary to determine if an emergency medical condition exists, regardless if the patient's presenting complaint appears to be for a nonemergent condition.

Prior Authorization, Financial Inquiries, and Emergency Department Registration Issues

CMS explicitly banned prior authorization for managed care plans before completion of the medical screening examination and commencement of stabilizing treatment. Hospitals may only obtain authorization for payment from insurance entities "concurrently" with stabilization of the patient.

CMS added a new "no delay in examination or treatment" rule, which states that emergency physicians and other providers may contact the patient's prior physician for medical advice "as long as this consultation does not inappropriately delay screening or stabilization services." This new rule subjects hospitals to EMTALA enforcement for conduct totally outside the scope of the statute. The

law unambiguously states that delay of patient screening or stabilization must be on account of the patient's insurance status in order to be a violation of EMTALA.

CMS will continue to allow hospitals to conduct reasonable registration procedures in the emergency department, including collecting insurance data, provided that it does not delay their access to screening or stabilization and that the process does not "unduly discourage individuals from remaining for further evaluation."

Bedside registration is probably necessary under the existing regulatory scheme to avoid "no delay" violations.

Hospital On-Call Physician Requirement

CMS attempted to clarify the circumstances in which physicians, particularly specialty physicians, must serve on a hospital's medical staff on-call list to the emergency department. CMS expects its clarification to provide hospitals "flexibility" to determine how best to maximize available physician resources, taking into account the availability of on-call physicians and the financial or other resources available to the hospital.

CMS noted that Medicare does not set requirements on how frequently hospital physicians must take call, stating that there is no predetermined ratio (such as the "rule of three") used to determine acceptable on-call coverage of the emergency department. Instead, CMS will consider all relative facts and circumstances in analyzing whether a hospital's on-call coverage is acceptable. CMS offered no guidance on what is acceptable coverage, but rescinded its earlier mandate that if the hospital offers any inpatient services then it must also offer those services to emergency department patients.

Hospitals must establish policy and procedures to address unavailability of on-call physicians, whether that unavailability is known in advance, such as a hospital has no neurosurgical coverage on a particular night, or rises unexpectedly, such as inability to reach the physician listed on call.

CMS will also let hospitals allow physicians to schedule elective surgery while on call, take call simultaneously at more than one hospital, or exempt senior status physicians from on-call duties, but it quickly restricts this flexibility by stating the hospital is still required "to provide that emergency services are available to meet the needs of patients with emergency medical conditions."

Hospitals 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 under EMTALA. This language is open to interpretation retrospectively by CMS and is an invitation to litigation by patients injured as a result of lack of emergency department on-call physician specialty coverage.

In-Depth Discussion of the Final EMTALA Regulations and Related Issues

Robert A. Bitterman, MD, JD, FACEP

Introduction

On September 9, 2003, the Centers for Medicare and Medicaid Services (CMS) published new final regulations governing Medicare-participating hospital responsibilities for providing emergency services under the Emergency Medical Treatment and Labor Act (EMTALA). The new regulations became effective November 10, 2003.¹

CMS originally proposed the new regulations on May 9, 2002, and purposely solicited comments from hospitals, physicians, patients, and beneficiary groups. It delayed publication of the final rule so it could adequately address the comments offered by providers and the public, and incorporate into various recommendations of the HHS Secretary's Regulatory Reform Advisory Committee.

Overall, the new rules are more rational and less burdensome. More "bright lines" exist, so hospitals will be more certain of when the law does and does not apply. And true to its word, CMS did not compromise existing protections of patients seeking care at Medicare-participating hospitals.

Specifically, the new regulations eliminate application of EMTALA to hospital inpatients and to off-campus and on-campus facilities that typically do not offer emergency services.

CMS unequivocally prohibits prior authorization for payment before completion of the medical screening examination and commencement of stabilizing treatment, citing EMTALA's "no delay in examination or treatment on account of insurance" rule. However, it also went beyond the scope of the statute to add language to the no-delay regulations that might increase regulatory and civil liability for emergency physicians (and hospitals) related to the

timing of contacting a patient's private physician for input into medical decision-making.

The final rule also allows hospital-owned ambulances that operate within local community EMS systems greater flexibility regarding where they transport patients, typically to the closest appropriate hospital. Unfortunately, though, CMS missed an opportunity with the new EMS regulations to resolve the *Arrington* problem created by the US Court of Appeals, Ninth Circuit, on the west coast. (See pages S13 and S14.)⁹

CMS attempted to clarify the circumstances in which physicians, particularly specialty physicians, must serve on the hospital's on-call list. It expects the clarifications to improve access to physician services for all hospital patients by permitting hospitals local flexibility to determine how best to maximize available physician resources.

While the new regulations are quite capacious, several important issues were not addressed, such as the unique issues surrounding the screening, stabilization, and transfer of psychiatric patients. CMS might address these and other issues at a later date.

CMS did recently issue interim guidance directions to state surveyors and regional offices regarding enforcement of the law, and intends to formally revise its interpretive guidelines within the next year.^{6,10} However, it will take some time to shake out the interpretation and the application of the new regulations through CMS enforcement actions and the courts.

Caveats and Definitions

"The statutory definition renders irrelevant any medical definition." —Judge in *HHS v Burditt*¹¹

A number of caveats must be kept in mind. First, the

new regulations do not change the law—only how CMS interprets and enforces the law. The actions of CMS might or might not change how the courts interpret the law. Second, only the actual regulations are controlling, not the CMS preamble or its explanations of the regulations. However, the preamble is a worthwhile read, since it reflects the government’s thinking and rationale regarding interpretation of the law and also portends how they intend to enforce it!

Third, the new regulations do not constitute the entire regulations for EMTALA. The new regulations add, subtract, or modify the old regulations; those sections left unchanged still exist and remain in force.

Finally, the devil is in the details—specifically, CMS’s extensive regulatory definitions of common medical terms. CMS changed the definitions of “comes to the emergency department” and “hospital with an emergency department.” It added new definitions of “patient,” “inpatient,” “hospital property,” and “dedicated emergency department.”¹ No less than 15 common medical terms are now legally defined by the statute and CMS regulations, and many of the government’s definitions mean something appreciably different than what is generally understood by practicing health care professionals.

Moreover, the practice of emergency medicine is essentially defined by these statutory and regulatory definitions, not by professional standards set by hospitals and physicians, so we emergency physicians must understand the legal lingo and incorporate it into our everyday practices and documentation techniques in order to avoid regulatory and civil liability under the law.

Chapters 3 and 4 of the original 2001 publication are affected by these changes, specifically, pages 15-19, 26, 27, 29-31. (See also specific terms listed in the Index, pages 291-305.)

Figure 1. The General Rules of EMTALA.

42 CFR 489.24: Special responsibilities of Medicare hospitals in emergency cases.¹⁵

In the case of a hospital that has an emergency department, if an individual, other than a patient, comes to the emergency department the hospital must—

- (a) provide an appropriate medical screening examination within the capability of the hospital’s emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists; and
- (b) If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment, or an appropriate transfer.

Additionally, the hospital may not delay access to screening, stabilizing treatment, or an appropriate transfer in order to inquire about the patient’s method of payment or insurance status.^{13,15}

General Rules Applicable to Hospitals and Emergency Departments

The general rules of EMTALA were not changed by the new regulations. Hospitals must still provide medical screening examinations (MSEs) and stabilizing treatment or appropriate transfers, and must do so without economic discrimination (See Figure 1).^{12,13} Similarly, the hospital’s duty to comply with the so-called EMTALA-related requirements was not changed. (See Figure 2).¹⁴

What CMS did change is the application of the general rules. CMS now defines the hospital’s EMTALA duties depending on where the person presents to the hospital and the nature of the person’s request for services. In essence, whether EMTALA applies now depends on “which door” of the hospital individuals enter, and whether they are asking for examination or treatment for a medical condition or are truly seeking emergency care.

CMS delineated four different presenting scenarios in the new regulations. Individuals may present to:

- The hospital’s “dedicated emergency department,” a newly defined entity,
- Hospital property other than the dedicated emergency department,
- Hospital-owned and operated ambulances, or
- Provider-based entities of the hospital, typically hospital-owned off-campus facilities.

Each specific location has its own regulatory nuances and issues to consider when determining the application and scope of EMTALA.¹

CMS also carved out exceptions to the general rules to effectively limit application of the law in a much more rational manner than previously structured in the old regulations.

Figure 2. EMTALA-Related Duties of Hospital Dedicated Emergency Departments.¹⁴

- Comply with EMTALA and the regulations.
- Report receipt of inappropriate transfers of unstable patients to CMS.
- Post EMTALA signs in designated emergency care areas.
- Maintain medical records of transfers into and out of the hospital.
- Maintain a list of physicians who are on call to assist in stabilizing patients with emergency medical conditions.
- Keep a central log of persons presenting for examination or treatment.

Each of the four scenarios must still meet the basic two “prongs” required to trigger the EMTALA duty to provide an MSE, as follows:

- An individual must “come to the emergency department,” and
- “Request examination or treatment.”

Chapter 4 of the original 2001 publication discusses EMTALA requirements for the medical screening examination in depth. Specifically, pages 26 and 27-30 are affected by the final regulations.

Presentation to a Dedicated Emergency Department

“Comes to the Emergency Department” Prong

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 dedicated emergency department, 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; ... [Emphasis added]¹

Dedicated emergency department 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 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.¹

These new regulations eliminate application of EMTALA to both off-campus facilities and on-campus facilities that typically do not offer emergency services. Instead, CMS

limits application of the law to traditional emergency departments and facilities that hold themselves out to the public as providing emergency care, and defines both types of entities as a dedicated emergency department. CMS believes these changes will enhance the quality and promptness of emergency care by permitting individuals presenting to the nonemergency facilities to be referred to appropriately equipped emergency facilities close to such outpatient clinics.

A dedicated emergency department is what physicians and nurses would naturally think of as a “real” emergency department. A dedicated emergency department may be on the hospital’s campus or be off campus. So a hospital’s real emergency department and any freestanding emergency departments meet the definition of a dedicated emergency department.

Other areas of the hospital that now constitute dedicated emergency departments include labor and delivery units, pediatric emergency departments, and psychiatric emergency departments or typical psychiatric intake centers. These locations hold themselves out to the public as providing care for patients presenting with emergency medical conditions. Even if a facility does not hold itself out as providing care for emergency medical conditions, CMS will still apply EMTALA to the facility if it actually does provide care for emergency medical conditions in a certain percentage of its patient encounters (dedicated emergency department criteria 3).

The controversial question under the new dedicated emergency department definition is whether urgent care centers will meet the definition and be required to comply with EMTALA. First, if an urgent care center is operated independently of the hospital, such as under a separate Medicare provider number, (even though a health care system/hospital may own it), EMTALA will not apply because the urgent care center will not meet the legal definition of a “hospital” for purposes of attaching EMTALA duties.

Second, even if an urgent care center is operated as a provider-based department or facility of a hospital, EMTALA should not apply because the usual urgent care center would not meet the legal definition of a dedicated emergency department. Urgent care centers typically do not hold themselves out as providing care for patients with emergency medical conditions, as that term is defined by law.¹⁶

The statutory definition of emergency medical condition is:

- “(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

- (i) placing the health of the individual in serious jeopardy,
- (ii) serious impairment to bodily functions, or
- (iii) serious dysfunction of any bodily organ or part;...¹⁶

Nor would urgent care centers come anywhere close to providing the threshold of one third of their encounters to individuals with true emergency medical conditions, as that term is defined by law. These facilities neither “hold themselves out” nor actually take care of heart attacks, strokes, major trauma, or other typical emergencies deliberately directed to “real” emergency departments.

CMS intended its new regulations to apply EMTALA to urgent care centers, so stay tuned for further regulatory guidance on this issue.

“Request” Prong

Assuming an individual has presented to a dedicated emergency department, there must also be a “request for examination or treatment of a medical condition” before any EMTALA duty is triggered.

There are two important points to understand about the request prong at a dedicated emergency department. First, the request may be for examination or treatment of a medical condition; the law does not say for an *emergency* medical condition—a very important distinction, which is commonly misunderstood by hospitals, attorneys, and commentators.¹⁷ (See pages 35-36 of the book.)

Second, the request may be made by anyone, and it may be expressed or implied by word or by deed. The request may be made by the patient, a family member, a medic, a babysitter, or anyone. It doesn’t have to come from the patient. Additionally, in absence of an actual request, CMS will presume a request exists if a prudent layperson observer would believe the individual needs examination or treatment for a *medical condition*. At a dedicated emergency department, the regulations do not require that the prudent layperson observer believe the patient needs examination or treatment for an *emergency* medical condition.

CMS recognizes that hospital personnel must be aware of the individual’s presence and appearance or actions that indicate a need for examination or treatment for a medical condition before the hospital would incur a duty to screen the individual under EMTALA.¹

Here is a summary of the application of EMTALA to a dedicated emergency department:

- Individual presents to the dedicated emergency department, and
- There is a request for examination or treatment for a *medical condition*—
 - By the patient, family, medics, or anyone else on behalf of the patient, or

- By way of the objective prudent layperson standard.
- EMTALA applies. The hospital must provide an MSE and stabilization or transfer.
- The EMTALA-related requirements apply to these dedicated emergency department areas (see Figure 2).

Presentation to Hospital Property Other Than the Dedicated Emergency Department

“Comes to the Emergency Department” Prong

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

- (2) Has presented on hospital property, as defined in this section, other than the dedicated emergency department, 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;... [Emphasis added]^{1,18}

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 other entities that participate separately under Medicare, or restaurants, shops, or other nonmedical facilities. [Emphasis added]^{1,18}

The statutory definition, then, of “campus” is the physical area immediately adjacent to the provider’s main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider’s campus.¹⁹

This section applies EMTALA to presentations on hospital property outside the dedicated emergency department. These areas include the parking lot, driveway, and sidewalks; persons who go to ground in the cafeteria, radiology, the lab, or the emergency department waiting room; or presentation anywhere else on hospital property outside of the dedicated emergency department. The confusing 250-yard rule is not dead, because the definitions still include it as part of the hospital’s property. CMS did, however, limit the rule’s applicability, as noted below.

“Request” Prong

The request for examination or treatment must be for a

possible *emergency* medical condition, unlike presentations to the dedicated emergency department, which may be for any medical condition, not necessarily an *emergency* medical condition. The request may come from anyone, same as requests made at a dedicated emergency department. Also, in absence of an actual request, CMS will presume a request exists if a prudent layperson observer would believe the individual needs examination or treatment for an *emergency* medical condition. Therefore, no matter how the request is made, it must be for an *emergency* medical condition at locations other than the dedicated emergency department before the hospital incurs any EMTALA duty to screen or stabilize the individual.

Exceptions

CMS exempts certain hospital non-dedicated emergency department facilities on hospital property from the duty to comply with EMTALA, including physician offices, skilled nursing facilities, other entities that participate separately under Medicare, and other nonmedical facilities on campus.¹ Thus, the fast food restaurant (eg, Chick-fil-A, Burger King) in the basement of the hospital does not have to comply with EMTALA.

Affects pages 18-19, 29-31.

Here is a summary of the application of EMTALA to presentations to the hospital outside the dedicated emergency department:

- “Comes to the emergency department” means anywhere on hospital property other than a dedicated emergency department (unless the area is specifically exempted), *but*
- The request for examination or treatment must be for an *emergency* medical condition.
- The request can be made by the patient, family, medics, or anyone else on behalf of the patient, or by way of the objective prudent layperson standard.
- EMTALA applies. The hospital must provide an MSE and stabilization or transfer.
- But, the EMTALA-related requirements do *not* apply (ie, Figure 2 does not apply).

Affects pages 27-31 of the book.

Application of EMTALA to Ambulances and EMS Systems

Presentation via Hospital-Owned and Operated Ambulance

The final rule also modifies the responsibilities of hospital-owned ambulances that operate within local community EMS systems. Generally, if the hospital owns and operates a ground or air ambulance, then an individual has “come to the hospital’s emergency department” once the individual is in the ambulance seeking examination or treatment for a *medical condition* (not necessarily an

emergency medical condition) at the hospital’s dedicated emergency department, even if the ambulance is not on hospital grounds.¹

Under the new regulations, however, if the hospital’s ambulance is operated under community-wide EMS protocols, or if telemetry direction of the ambulance is provided by a physician independent of the hospital, then CMS will not consider the patient to have “come to the hospital’s emergency department” unless and until the ambulance brings the patient onto the hospital’s property.¹ The new regulations essentially codify an earlier CMS policy clarification memorandum on the subject, so they do not represent a distinct change in policy on behalf of the agency.^{1,20}

Thus, hospital-owned ambulances can now transport patients to other hospitals, typically the closest appropriate hospital, which will increase needed flexibility in EMS systems and allow the use of these resources more efficiently for the benefit of their communities.

Affects pages 19, 33-35, 38.

Presentation via a Non-Hospital-Owned and Operated Ambulance

A non-hospital-owned ambulance has “come to the hospital’s emergency department” for purposes of triggering EMTALA once it reaches hospital property, even if the medics ignore the hospital’s diversionary status or direct orders to divert. There must also be a request for services at that hospital, though; both basic EMTALA prongs are still required. The statutory language defining “comes to the emergency department” in this situation is as follows:

- (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 dedicated emergency department. 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 emergency department.”^{1,21} [Emphasis added]

Unfortunately, CMS missed an opportunity in the new EMS regulations to resolve the *Arrington* problem created

by the US Court of Appeals, Ninth Circuit. The appellate court in *Arrington v Wong* held that mere telemetry contact by an ambulance, not owned by the hospital or on hospital property, constituted coming to the emergency department and triggered the hospital's duty to screen and stabilize the patient under EMTALA.⁹ The court ruled that the hospital could not divert the ambulance unless it did not have the staff and capability to accept and care for the patient in its emergency department. In essence, the court held that the language underlined here delineates the *only* time a hospital could divert an ambulance and stay in compliance with the law instead of reading the language as an *example* of when a hospital may divert an ambulance in compliance with EMTALA.

To date, the Ninth Circuit, which governs the west coast states, is the only circuit court in the country to rule that a phone contact from an ambulance means that the patient has "come to the emergency department."

If CMS affirms the *Arrington* decision or other courts adopt the interpretation of the Ninth Circuit, it could preempt the ability of the individual states to legislatively provide qualified or Good Samaritan immunity to EMS medical oversight physicians and hospitals for provision of this community service. Most states currently do provide some liability protection in this arena: CMS's sanction of expansion of EMTALA to medical oversight decisions would preempt those protections because of the supremacy clause of the US Constitution.

In its proposed regulations, CMS stated it would not comment on the *Arrington v Wong* decision.⁵ However, this section of the final regulations codifies the very language that led to the erroneous decision in *Arrington*.¹ CMS could have made the issue clear by simply deleting the emphasized (underlined) language from its regulations and removed any potential liability for hospitals and physicians for EMS telemetry direction. As the regulations now exist, CMS may potentially increase the regulatory and civil liability of hospitals and physicians providing EMS direction.

Furthermore, the language of the regulations states that the hospital may not divert the ambulance if it can accept "any additional patients."¹ What if the hospital has the capacity to accept medical patients, but not major trauma patients at that time, and the ambulance calling is asking to bring in a trauma case? It would be appropriate to divert the ambulance because that hospital at that time would not be an appropriate place to take the patient. Often hospitals are able to accept some types of patients, such as nonurgent cases, but not the type of patient in the ambulance, such as a major trauma case or patient in need of a service the hospital lacks, such as neurosurgery. Additionally, patients are often directed to other facilities because of patient preference, family preference, previous extensive treatment at the other facility, physician preferences, and

medically indicated reasons such as required specialty care. It doesn't do the head trauma patient any good to take him to a hospital that doesn't have a neurosurgeon.

Medical oversight decisions are complex and made with inadequate information. They are essentially educated guesses based on experience, training, and judgment, and made in good faith to achieve the best possible care for the patient. If EMTALA attaches to medical oversight decisions, emergency physicians and hospitals might stop participating in community EMS systems. Witness what occurred in Chicago after the *Johnson v University of Chicago* case: there was such uproar from the provider community that the court changed its opinion, because otherwise no one would have participated in EMS medical oversight due to the additional civil liability under EMTALA.²² (Also, see page 34 in the book.) Why would hospitals and physicians risk \$50,000 civil monetary penalties for ordinary negligence, costly Medicare termination investigations and proceedings, and federal civil liability for a service they are providing graciously and gratuitously to their communities?

Affects pages 34-35.

Presentation to Hospital-Owned Provider-Based Facilities Off Campus

Previously, CMS required hospital-owned off-campus facilities such as dialysis centers, rehabilitation units, lab and radiology centers, and primary care clinics to comply with EMTALA, even though these types of facilities were never intended or structured to manage patients with emergency medical conditions.²³ Common sense prevailed in the new regulations, and such facilities no longer have to comply with the law since they don't meet the regulatory definition of a dedicated emergency department.

These nonemergency facilities should still have written policies and procedures for appraisal of emergencies and transfer when appropriate.²⁴ They may also transfer a patient to anywhere deemed appropriate. Previously, CMS expected the hospital's off-campus facilities to transfer the patient back to the main hospital unless doing so would "significantly jeopardize" the life or safety of the patient. And they may use 911 EMS systems to transport patients to area hospitals.

Affects pages 18-19, 26, 27, 29, 31-33.

Exceptions to the Application of EMTALA to Encounters in the Dedicated Emergency Department

To avoid application of the law to medical scenarios not contemplated by Congress when it passed EMTALA, CMS created a number of exceptions to its previous regulations. Thus, even if an individual comes to the dedicated emer-

gency department or requests examination or treatment for a medical condition, EMTALA may not apply in certain circumstances.

Use of the Dedicated Emergency Department for Nonemergency Services

In an attempt to avoid application of EMTALA to persons coming to the emergency department for reasons other than seeking emergency care, CMS states “if the nature of the request makes it clear that the medical condition is not of an emergency nature,” then the “hospital is required to only perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an EMC.”¹

This new regulation doesn’t change anything! The hospital is still required to perform an MSE to the extent necessary to determine if an EMC exists. In other words, the hospital must do whatever it takes to decide if an EMC exists in the same manner as would be done for anyone else presenting with the same complaint (the two prongs of an “appropriate” MSE established by the courts—“reasonably calculated” and “uniform”). Thus, all patients presenting with a medical condition must be provided an MSE to determine if that medical condition is an *emergency* medical condition.

Affects pages 36-37, 39-40.

Hospital Inpatients and Patients Admitted via the Dedicated Emergency Department

The new regulations did remove application of the law’s duty to provide stabilizing treatment to hospital inpatients, including direct admissions through the emergency department or those admitted patients being boarded in the emergency department due to hospital overcrowding. CMS did this indirectly by stating that hospital patients, including patients admitted to the hospital, don’t count as individuals who “come to the emergency department” for purposes of triggering EMTALA. CMS defined the term “patient” to include inpatients. The inpatient definition was taken from the Medicare manual; an inpatient is defined as “an individual who is admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services... with the expectation that he or she will remain at least overnight...”¹

It doesn’t matter if the situation changes later and the patient can be discharged or transferred to another hospital and does not actually use the bed overnight. The key element is that the patient must actually be admitted—formally admitted with a documented admission order. A physician’s intent to admit or the patient’s acuity indicating “obviously will be admitted” is not enough to satisfy the definition. Documentation is critical.

CMS doesn’t consider patients admitted to “observation

status” to meet the regulatory definition of “admitted” patients (not admitted for purposes of receiving inpatient services), and thus EMTALA still applies to the care of observation patients, such as patients managed in emergency department chest pain units.²⁵

Therefore, under the new regulations, direct admits sent through or held in the emergency department from a physician’s office, a nursing home, or in transfer from another emergency department or another hospital inpatient setting are no longer covered by EMTALA, even though they have come to the hospital’s emergency department.

Similarly, inpatients admitted for elective (non-emergency) diagnosis or treatment are not covered by EMTALA, even if they later develop an emergency medical condition while in the hospital, and even if brought down to the emergency department for evaluation or treatment of an emergency medical condition.

CMS originally proposed to expand application of EMTALA to inpatients and was reluctant to retract the requirement, fearing that hospitals would just admit patients to circumvent their duties under the law.⁵ Eventually CMS was assured that inpatients already have sufficient protections under other Medicare Conditions of Participation and state laws governing hospital-patient and physician-patient relationships. Also, a number of federal appellate courts held that the plain language of the statute required that a patient be transferred before a hospital incurred a duty to stabilize the patient.⁸

However, EMTALA still applies to private patients sent to the emergency department by physicians for evaluation and treatment or to determine if admission to the hospital is indicated because these patients are not yet formally admitted. The regulations do not change how hospitals should handle private patients in the emergency department.¹ (Also, see pages 25 through 28 of the book.)

Expansion of the law to inpatients would have created enormous liability for hospitals. All inpatient care of patients with emergency medical conditions would potentially subject the hospital to termination of its Medicare provider agreement, civil monetary penalties, and civil liability under EMTALA. Hospitals would have been directly liable for all the actions of its admitting medical staff, and lawsuits brought under EMTALA could have preempted many aspects of a state’s tort reform. Eliminating application of EMTALA to inpatients is a huge contraction of potential hospital liability for civil damages lawsuits.

Affects pages 69-73.

Hospital Outpatients Brought to the Dedicated Emergency Department for Emergency Care

CMS also eliminated application of EMTALA for scheduled outpatient encounters at the hospital that unexpectedly deteriorate into an emergency medical condition.¹ For

example, an ambulatory surgery patient or kidney dialysis patient who develops an emergency complication due to the procedure and is brought to the emergency department for treatment. The key in this scenario is that the outpatient encounter must have actually begun. If a person scheduled for outpatient surgery arrests walking into the hospital, EMTALA still applies because the procedure has not started yet.

Hospital Patients who Present to Hospital Property Other Than the Dedicated Emergency Department

Analogous to inpatients or outpatients brought to the dedicated emergency department, any inpatient or outpatient who develops an emergency medical condition on hospital property does not trigger EMTALA. This includes hospital patients in hospital or non-hospital-owned and operated ambulances. Thus, if an inpatient collapses in the cafeteria and someone screams “Help!” EMTALA does not apply. However, if a visitor collapses there, EMTALA does apply.

National Emergencies

CMS will not sanction a hospital with a dedicated emergency department located in a designated emergency area that inappropriately transfers a person during a national emergency.²⁶ This section only applies to federally declared national emergencies, not local public health emergencies, and the language in the regulations may not protect hospitals from failure-to-screen claims, such as triaging patients to decontamination centers without first providing an appropriate MSE.¹

Prior Authorization, Financial Inquiries, and Emergency Department Registration Issues

CMS explicitly banned prior authorization for managed care plans before completion of the MSE and commencement of stabilizing treatment.¹ This rule essentially codified the agency’s recommendations originally published jointly with the Office of Inspector General (OIG) in a Special Advisory Bulletin in November 1999.²⁷ Hospitals may only obtain authorization for payment from insurance entities “concurrently” with stabilization of the patient.¹

However, under the new regulations, CMS still allows hospitals to conduct reasonable registration procedures in the emergency department, including collecting insurance data. The key is to create parallel tracks for medical and financial issues, and ensure that the financial track never interferes with the medical care in any way. Bedside registration is probably necessary under the existing regulatory scheme to avoid “no-delay” violations, as CMS would

consider any delay in access to the MSE due to diversion to the registration area to be against the law. Waiting for examination and treatment because the emergency department is overwhelmed is not a violation, but waiting for examination because the registration clerks are collecting insurance information could be.

CMS continues to warn hospitals not to coerce patients into leaving before they receive their federally guaranteed right to an MSE, stating “reasonable registration processes may not unduly discourage individuals from remaining for further evaluation.”¹

Collection of co-pays, down payments, ABNs, or signatures on managed care financial forms may constitute such “economic coercion” if not done very carefully. Hospitals must also ensure that staff behavior does not create a hostile environment or constructive denial of the MSE.

[These issues are addressed on pages 12, 52-58, 78, and 150 of the original 2001 publication.](#)

Emergency Physician Contact With the Patient’s Private Physician

CMS also added a new rule, a “no delay in examination or treatment” rule, which states that it is acceptable for an emergency physician to contact the patient’s private physician for medical advice “as long as this consultation does not inappropriately delay” screening or stabilizing services.¹

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 [EMTALA].¹

This new rule will increase hospital regulatory liability, potential civil monetary penalties, and potential civil lawsuits for conduct totally outside the scope of the statute. The language of the law unambiguously states that delay of patient care must be on account of the patient’s insurance status in order to be a violation of EMTALA.¹³

Hospital On-Call Physician Requirement

Clearly the most controversial issue under the new regulations concerns the hospital’s duty to provide on-call physicians for emergency patients in the emergency department. CMS attempted to clarify the circumstances in which physicians, particularly specialty physicians, must serve a hospital’s medical staff on-call list. It expects the clarifications to improve access to physician services for all hospital patients by permitting hospitals local flexibility (“maximum flexibility”) to determine how best to maximize available physician resources.

However, the “maximum flexibility” allowed under the new rule may mean that “maximum uncertainty” will continue to exist regarding what is actually required of hospitals and physicians concerning their on-call duties, and will likely make it still more difficult for emergency physicians to arrange timely access to specialty care for their patients.

The entire new regulations governing on-call issues read as follows:

(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.¹

“Which physicians must take emergency department call, and how often?”

CMS clearly decided to remain above the fray between hospitals and physicians regarding who must take call and how often. CMS pointedly noted that Medicare does not set requirements on how frequently a hospital’s physicians must take call, and that it is up to the hospitals and physicians to decide. “We believe these are local decisions that can be made reasonably only at the individual hospital level through coordination between the hospitals and their staffs of physicians.”¹

It also stated there is no predetermined ratio used to determine acceptable on-call coverage of the emergency department. In other words, the “rule of three” does not exist—the myth that whenever a hospital has at least three physicians of a particular specialty it must provide 24/7 coverage in that specialty. (See page 85 in the book.)

Instead, CMS said it will consider all relevant facts and circumstances in analyzing whether a hospital’s on-call coverage is acceptable. The only guidance it offered in the preamble to the regulations was as follows:

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... We are aware that practice demands in treating other patients, conferences, vacations, days off, and other similar factors must be considered in determining the availability of staff.¹

CMS even retreated from its earlier mandate, that, “If a hospital offers a service to the public, the service should be available through on-call coverage of the emergency department.”^{10,28,29} CMS now deems that “an unrealistically high a standard” and “an unrealistically high burden” to impose on hospitals.¹ CMS wants hospitals to have the flexibility to comply with EMTALA obligations by maintaining a level of on-call coverage that is within their capability, including the financial resources of the hospital (relative to whether the hospital will pay physicians for providing on-call coverage), and the availability of its medical staff.

Nonetheless, CMS fully intends to enforce the on-call mandate, stating, “We will continue to investigate such situations in response to complaints and will take appropriate action if the level of on-call coverage is unacceptably low.”¹ It poignantly noted that a hospital does have the mechanism to enforce on-call coverage by its physicians, as follows:

We further note that physicians who practice in hospitals do so under privileges extended to them by those hospitals, and that hospitals facing a refusal by physicians to assume on-call responsibilities or to carry out the responsibilities they have assumed could suspend, curtail, or revoke the offending physician’s practice privileges.¹

The net result of CMS’s actions is that whether a hospital complies with the on-call mandate of EMTALA will be determined only retrospectively by CMS, typically after someone complains that the hospital didn’t “best meet the needs” of its patients in not forcing the medical staff to provide more emergency department call coverage. Furthermore, CMS’s “best meets the needs” language is an “invitation to litigation” against hospitals for civil damages by patients injured as a result of lack of emergency department on-call physician specialty coverage.

Unavailability of On-Call Physicians

The government does expect the hospital to establish policies and procedures to handle unavailability of on-call physicians, whether that unavailability is known in advance, such as the hospital has no neurosurgical coverage for a particular night, or arises unexpectedly, such as

inability to reach the physician listed on call.¹ Hospitals should also prospectively define the duties of on-call physicians, such as whether call includes responding to inpatient emergencies or accepting certain defined patients in followup from the emergency department.

Elective Surgery, Simultaneous Call, and Exemption for Senior Physicians

CMS also states that hospitals may allow physicians to schedule elective surgery while on call, be on call simultaneously at more than one hospital, or exempt “senior status” physicians from on-call duties, but it quickly restricts this flexibility by stating the hospital is still required “to provide that emergency services are available to meet the needs of patients with emergency medical conditions,” and “as long as the exemption does not affect patient care adversely.”¹

If a physician is on call simultaneously at more than one hospital, then all hospitals involved must be aware of the call schedule and have policies and procedures to follow when the on-call physician is unable to respond.^{1,29,30} Such systems could include backup on-call physicians or transfer of patients to other facilities. Physicians on call for critical access hospitals may not take call simultaneously for other hospitals, because government money paid to critical access hospitals includes money for on-call services.³¹

Midlevel Providers Taking Emergency Department Call

In its preamble, but not in the actual regulations, CMS addressed the issue of hospitals allowing midlevel providers such as physician assistants or nurse practitioners to take call for the hospital’s emergency department.

Both the EMTALA statute and CMS’s regulations distinctly require the hospital to provide on-call *physicians*, so it is clear that the hospital may not allow a midlevel provider to take call *instead* of a physician.³²

The real issue is whether the on-call physician may allow an associated midlevel provider to answer the call from the emergency department or evaluate the patient in the emergency department on the on-call physician’s behalf. A number of physicians, such as pediatricians, orthopedic surgeons, internists, and cardiologists frequently use physician assistants or nurse practitioners in their practices.

CMS agrees that:
circumstances [exist] in which a physician assistant may be the appropriate practitioner to respond to a call from an emergency department... that is providing screening or stabilization mandated by EMTALA... However, any decision as to whether to respond in person or direct the physician assistant to respond should

be made by the responsible on-call physician, based on the individual’s medical needs and the capabilities of the hospital, and would, of course, be appropriate only if it is consistent with applicable State scope of practice laws and hospital bylaws, rules, and regulations.³³

This language has been misinterpreted by some to mean that the on-call physician may decide whether the midlevel provider can answer the page from the emergency department, or respond in person to the emergency department, instead of the on-call physician. The decision of who to speak to by phone or who must present to the emergency department must be left to the emergency physician or other medical staff member requesting the services of the on-call specialists.

CMS agrees, stating:

We believe any disagreement between the two [emergency physician and the on-call specialist] regarding the need for an on-call physician to come to the hospital and examine the individual must be resolved by deferring to the medical judgment of the emergency physician or other practitioner who has personally examined the individual and is currently treating the individual.³⁴

Thus, it’s perfectly appropriate to list the name of the on-call physician on the call panel and the name of the physician’s midlevel provider. For routine admissions or followup care, the emergency physician can contact the midlevel provider to arrange the necessary services. However, for true emergencies or other instances where the emergency physician wants phone consultation from the on-call specialist directly, or needs the specialist to come to the emergency department to evaluate and treat the patient, the emergency physician must be able to contact the specialist directly. The choice of which on-call individual to contact and which one must come to the emergency department must always rest with the physician examining the patient in the emergency department.

“Must on-call physicians respond to inpatient emergencies?”

Since EMTALA no longer applies to inpatients, on-call physicians have no legal duty under EMTALA to come to the hospital to examine or treat inpatients that develop emergency medical conditions. The law doesn’t apply even if the hospital brings the inpatient down to the emergency department in an attempt to attach EMTALA to force the on-call physician to come in and care for the patient. Once the person is admitted and meets the legal status of a “patient” (inpatients are included in the definition of “patient”), then the person cannot “come to the emergency department” under CMS’s definition for purposes of triggering EMTALA. (See the definition of “comes to the emergency department” on page S11.)

It's up to hospitals and their medical staffs to determine how to best provide coverage of inpatient emergencies, and whether the duties of the on-call physicians should extend to the treatment of inpatients who develop emergency medical conditions. CMS emphasized in its preamble to the new regulations that nearly a half dozen Medicare Conditions of Participation protect inpatients, and that CMS could still terminate a hospital from Medicare if its care of inpatients didn't meet the standards of those conditions.³⁵

To summarize, CMS sets no standard for what physician services must be on call, sets no standard for frequency of call by physicians, and reserves the right to make its own determination, retrospectively, of whether the hospital's call system is adequate or "best meets the needs of the hospital's patients" under the law.

The on-call issue is very complex, highly politically and economically charged, and EMTALA is only one issue driving the diminishing provision of on-call services by our nation's physician specialists. The uncompensated care burden, malpractice liability issues, difficulties obtaining payment from managed care entities, and lifestyle issues are probably much more compelling reasons physicians avoid emergency department on-call services.^{36,37}

On-call physician requirements are addressed in detail in Chapter 6, pages 83-102, and are briefly discussed on pages 43, 45-46.

Transferring and Accepting Patients Under EMTALA

Capacity

The new regulations did not substantively change the transfer requirements under the law. In a November 2001 program memorandum CMS did redefine "capacity" for purposes of hospitals deciding whether they must accept patients in transfer from other hospitals unable to manage a patient's EMC. Capacity now includes "whatever a hospital customarily does to accommodate patients in excess of its occupancy limits," instead of the higher standard of "if the hospital has ever done it before."³⁸ (See also pages 113 and 206 of the book.)

This CMS memo also discusses the responsibilities of potential recipient hospitals when asked to accept a patient in transfer.

"Does EMTALA govern the transfer of inpatients? Do higher-level hospitals have to accept transfers of inpatients?"

Under the new regulations, once a patient is admitted, that hospital's EMTALA obligations to the patient end,

including the obligations of the on-call physicians as noted earlier. Thus, the transfer of an inpatient no longer has to meet the requirements of EMTALA. Other Conditions of Participation in Medicare and ordinary state law standards of care, however, will continue to govern these transfers.

If the hospital is unable to stabilize or treat the inpatient's emergency, then it should still transfer the inpatient to a hospital that does have the capability to care for the patient.

This raises the issue of whether higher-level hospitals, or hospitals with "specialized capabilities or facilities," must accept inpatients in transfer when less-capable hospitals can't manage the inpatient's emergency condition. Some hospitals have argued that, since EMTALA ends once the patient is admitted, they have no duty under the law to accept the transfer of patients not under the protection of the law. However, just because one hospital's EMTALA duties end, it does not relieve other hospitals' independent obligations under the law. In other words, one hospital's EMTALA obligations are not derivative of another's EMTALA obligations.

EMTALA's nondiscrimination clause, which delineates a hospital's duty to accept patients in transfer, states:

A participating hospital that has specialized capabilities or facilities ... shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.¹²

The statutory law does not differentiate inpatients from emergency department patients. Thus, if a potential accepting hospital has the capacity to treat an inpatient that the sending hospital can't manage, then it has an independent legal duty to accept that inpatient in transfer.

This issue was not specifically addressed in the new regulations, and CMS has not issued an opinion on the question. It is certain to become a contentious issue with CMS and accepting hospitals, and will undoubtedly lead to litigation in the courts before the issue becomes settled law.

Patient Transfer Form

The 2 pages of transfer forms in the book (in Appendix 3, pages 265 and 267) can be replaced by a more user-friendly 1-page form (see page S20). The form is carefully crafted to meet the legal requirements of the law and to protect physicians and hospitals from regulatory sanctions or from civil litigation related to transfers. It can be used with either a medically indicated transfer or a patient-requested transfer.

Patient transfers are high-risk undertakings; it is strongly encouraged that anyone transferring a patient use such a form.

Emergency Medical Condition (EMC) Identified: (Mark appropriate box(es), then go to Section II)

I. MEDICAL CONDITION: Diagnosis _____

No Emergency Medical Condition Identified: This patient has been examined and an EMC has not been identified.

Patient Stable - The patient has been examined and any medical condition stabilized such that, within reasonable clinical confidence, no material deterioration of this patient's condition is likely to result from or occur during transfer.

Patient Unstable - The patient has been examined, an EMC has been identified and patient is not stable, but the transfer is medically indicated and in the best interest of the patient.

I have examined this patient and based upon the reasonable risks and benefits described below and upon the information available to me, I certify that the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risk to this patient's medical condition that may result from effecting this transfer.

II. REASON FOR TRANSFER: Medically Indicated Patient Requested _____

On-call physician refused or failed to respond within a reasonable period of time.

Physician Name _____ Address _____

III. RISK AND BENEFIT FOR TRANSFER:

| Medical Benefits: | Medical Risks: |
|---|--|
| <input type="checkbox"/> Obtain level of care / service NA at this facility. Service _____ | <input type="checkbox"/> Deterioration of condition en route _____ |
| <input type="checkbox"/> Benefits outweigh risks of transfer | <input type="checkbox"/> Worsening of condition or death if you stay here. There is always risk of traffic delay/accident resulting in condition deterioration. |

IV. Mode/Support/Treatment During Transfer as Determined by Physician – (Complete Applicable Items):

Mode of transportation for transfer: BLS ALS Helicopter Neonatal Unit Private Car Other _____

Agency _____ Name/Title accompany hospital employee _____

Support/Treatment during transfer: Cardiac Monitor Oxygen – (Liters) _____ Pulse Oximeter IV Pump

IV Fluid _____ Rate _____ Restraints – Type _____ Other _____ None

Radio on-line medical oversight (If necessary): Transfer Hospital Destination Hospital Other

V. Receiving Facility and Individual: The receiving facility has the capability for the treatment of this patient (including adequate equipment and medical personnel) and has agreed to accept the transfer and provide appropriate medical treatment.

Receiving Facility / Person accepting transfer _____ Time _____

Receiving MD _____

Transferring Physician Signature _____ Date/Time _____

Per Dr. _____ by _____ RN/ Qualified Medical Personnel Date/Time _____

VI. ACCOMPANYING DOCUMENTATION – sent via: Patient/Responsible Party Fax Transporter

Copy of Pertinent Medical Record Lab/ EKG/ X-Ray Copy of Transfer Form Court Order

Advance Directive Other _____

Report given (Person / title) _____

Time of Transfer _____ Date _____ Nurse Signature _____ Unit _____

Vital Signs Just Prior to Transfer T _____ Pulse _____ R _____ BP _____ Time _____

VII. PATIENT CONSENT TO "MEDICALLY INDICATED" OR "PATIENT REQUESTED" TRANSFER:

I hereby **CONSENT TO TRANSFER** to another facility. I understand that it is the opinion of the physician responsible for my care that the benefits of transfer outweigh the risks of transfer. I have been informed of the risks and benefits upon which this transfer is being made.

I hereby **REQUEST TRANSFER** to _____. I understand and have considered the hospital's responsibilities, the risks and benefits of transfer, and the physician's recommendation. I make this request upon my own suggestion and not that of the hospital, physician, or anyone associated with the hospital.

The reason I request transfer is _____

Signature of Patient Responsible Person _____ Relationship _____

Witness _____ Witness _____

TRANSFER FORM

White: Receiving Facility; **Yellow:** Medical Record; **Pink:** QA

Patient Name:

Date of Birth:

Medical Record Number:

Special Situations: Obstetric and Psychiatric Patients

Obstetric Patients

The new regulations did not specifically address obstetric issues. However, in January 2002, CMS issued a program memorandum on the certification of false labor to clarify CMS's policy regarding the EMTALA requirements of hospitals for women in labor.³⁹ It acknowledges that, under the regulations, designated qualified medical personnel (QMP) such as trained labor and delivery nurses can medically screen patients to determine if an emergency medical condition exists.³⁹

Thus, CMS states that "QMPs can examine a woman and make a diagnosis that a woman is in 'true' labor since 'true labor' is considered an emergency medical condition."³⁹

CMS goes on to specify, however, that "a woman experiencing contractions is in 'true labor' unless a physician certifies that... the woman is in 'false labor.' Therefore, when a QMP diagnoses a woman to be in 'false labor,' a physician is required to certify that diagnosis before the patient can be discharged."³⁹

Under EMTALA, this memorandum is misleading and wholly unnecessary. First, the word "labor" does not appear anywhere in the statutory definition of an emergency medical condition in a pregnant woman.⁴⁰ A woman could be in early active labor yet not have an EMC, *as that term is defined by law*. This is clearly borne out in everyday real medical practice: hospital labor and delivery units routinely send women home in early labor when no complications are found and it is determined safe to allow them to remain at home for a period of time until labor progresses further and warrants hospitalization for observation or delivery.

Since the word labor does not appear in the definition of an emergency medical condition in a pregnant woman, it is not necessary under the law to ever determine if the woman is in "real labor" or "false labor"; it is only necessary to determine if an emergency is present as defined by the statute. Therefore, hospitals should refrain from using the term or determining that "false labor" exists; instead, hospitals should comply with the legal definition of the statute, which is explained in Chapter 8 of the book, and follow the algorithm for screening pregnant women on page 127.

Psychiatric Patients

The issues surrounding the screening, stabilization, and transfer of psychiatric patients, particularly as they interface with state laws and law enforcement transport of these patients, were not addressed in the new regulations. CMS

noted that, "generally, psychiatric patients with emergency medical conditions are treated no differently for purposes of EMTALA than any other individual who presents to the hospital with an emergency medical condition."⁴¹

CMS intends, though, to tackle the EMTALA issues unique to psychiatric patients⁴² in future operating instructions for its state surveyors and regional offices.⁴¹

EMTALA Enforcement

Besides the final EMTALA regulations, a few things have occurred in the enforcement arena.

CMS Training and Educational Efforts to Enhance Consistency of Enforcement

CMS has taken a number of steps to improve the consistency of enforcement across the country. It initiated biennial training, monthly conference calls between Central Office staff and regional offices, issued periodic EMTALA program memoranda, published Web-based resources such as the Med Learning Network, and provided direct access of regional offices and state agency staff to Central Office staff to resolve specific concerns.

Additionally, CMS believes that issuing new final interpretive guidelines (expected late 2004) will also improve consistency of enforcement.

Interim New Interpretive Guidelines for State Survey Agencies and Regional Offices

CMS has already issued interim interpretive guidelines for enforcement of the new regulations.⁶ They can be found on the CMS Web site, at <http://www.cms.hhs.gov/medicaid/survey-cert/letters.asp>. When CMS rewrites the complete interpretive guidelines, it intends to incorporate all prior guidance memoranda as well as the new final regulations.

The interim guidance memo summarized the final rule provisions and listed the survey and certification letters (program memoranda²) available that explain CMS's policies regarding EMTALA.⁶ CMS then attempted to clarify its policy regarding when a patient is stabilized and when the hospital's EMTALA obligation to inpatients ends.

Stabilization Mandate

- (a) Stabilized – Resolution of the Emergency Medical Condition

CMS cites its current State Operations Manual, Appendix 5, page V-24, which states that the physician or QMP determines when a patient is stabilized, and

A patient will be deemed stabilized if the treating physician or QMP attending to the patient in the emergency department/hospital has determined, within reasonable clinical confidence, that the emergency medical condition has been resolved.¹⁰

CMS then states in the interim guidance memo:

To be considered stable, a patient's emergency medical condition must be resolved, even though the underlying medical condition may exist.⁶

Unfortunately, this statement is legally incorrect. There is no requirement under the law that the hospital *resolve* the patient's emergency medical condition. In fact, the hospital isn't even legally required under EMTALA to treat the patient's emergency medical condition; it is only required to *stabilize* the patient's emergency medical condition, as that term is defined by law. The statutory language is quite clear: stabilized means "that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility."⁴³

Thus, in essence, a transferring hospital need only ensure, or be confident that, patients get to the receiving hospital with nothing bad happening to them, regardless if the emergency medical condition has been treated or has not resolved prior to transfer. EMTALA simply wasn't written to force hospitals to treat all patients; it was enacted to prevent them from transferring patients in unstable conditions on account of their insurance status.

Resolution of a patient's emergency medical condition is *only one way* that the patient can be stabilized. If the emergency medical condition no longer exists, then the hospital simply has no further duty to stabilize or transfer that individual patient. CMS's own existing guidelines state, on page V-25, "Stable for transfer or stable for discharge does *not* require the final resolution of the emergency medical condition."¹⁰

(b) Stabilization of Transfers – Requirement to Provide an "Appropriate" Transfer

For transfers between medical facilities, CMS quotes the existing interpretive guidelines:

A patient is stable for transfer if the patient is transferred from one facility to a second facility and the treating physician attending to the patient has determined within reasonable clinical confidence, that the patient is expected to leave the hospital and be received at the second facility with no material deterioration in his/her medical condition, and the treating physician reasonably believes that the receiving facility has the capability to manage the patient's medical condition and any reasonably foreseeable complications of that condition.¹⁰

This interpretation is reasonable, since it means essentially the same as the statutory definition of stabilized. However, CMS then states in the new guidance memo:

Hospitals that transfer patients to recipient hospitals when the patients are considered stable "for transfer," but whose EMCs have not been resolved, are still required to perform an appropriate transfer.

Unfortunately, this statement is also contradictory

to the statute. "Appropriate" transfers are required by EMTALA only for patients whose conditions have *not* been stabilized.⁴⁴ EMTALA simply does not control the transfer of stable patients, regardless of whether the stable patient still has an emergency medical condition.

CMS follows the previous sentence in the interim guidance memo with the comment:

An inappropriate transfer of an individual with an EMC would be a violation of the hospital's EMTALA obligation.⁶

This sentence needs to have the word "unstable" inserted before the term "EMC" to make it legally correct.

"When does a hospital's obligation to inpatients end under EMTALA?"

In the interim guidance memo, CMS states that a hospital's EMTALA obligation ends when a "physician or qualified medical person had made a decision:

1. That no emergency exists;
2. That an emergency exists which requires transfer to another facility, or the patient requests transfer to another facility (the EMTALA obligation rests with a transferring facility until arrival at the receiving facility); or
3. An emergency exists and the patient is admitted to the hospital for further stabilizing treatment."⁶

An additional scenario of when the hospital's obligation under EMTALA ends should be added to CMS's list:

4. An emergency medical condition exists, which requires (or does not require) transfer to another facility but has been stabilized (as defined by law).

One clinical example illustrates the legal principles related to EMTALA's stabilization mandate: Assume a 53-year-old man presents to the emergency department with chest pain. The emergency physician performs a medical screening examination and determines the man is suffering an acute myocardial infarction. All would agree that this patient has an emergency medical condition. Assume further that the emergency physician decides the patient would be better *treated* with coronary angioplasty/stent at a hospital 15 minutes away rather than thrombolytic therapy at his facility. Lastly, assume that the emergency physician believes that the patient's clinical condition is such that at that time the patient can be safely transferred to the nearby facility for the procedure.

Since within "reasonable medical probability," "no material deterioration" of the patient's condition is likely to result from or occur due to the transfer, the patient is "stable" at the time of transfer, and therefore EMTALA does not govern this transfer in any way. This is true even though the patient clearly has an emergency medical condition that has not been resolved or completely treated. The decisions on when to transfer the patient, where to

transfer the patient, how to communicate with the accepting facility, what data to send with the patient, and what transport equipment and personnel are used to transfer the patient are simply not governed by EMTALA, but instead by other criteria, such as ordinary standards of care.

If the patient is stable at the time of transfer, then there is no legal requirement to provide an “appropriate” transfer under EMTALA. However, clearly it is sound medical practice to follow the tenets of EMTALA since all the elements of an “appropriate” transfer delineated by EMTALA are exactly the same as all the elements required to provide quality medical care to our patients and meet the prevailing standard of care.

From the provider’s perspective, we are already subject to a plethora of sanctions and possible lawsuits related to our transfer decisions; we don’t warrant further loss of time, energy, expense, and reputation due to an investigation under EMTALA for conduct that falls outside the scope of the statute as written by Congress.

Under the law, stabilized means “that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility.”⁴³ This definition is clear and comprehensible by both clinicians and the courts alike; it would be beneficial to all parties, including CMS, if the statutory definition alone was used to determine if hospitals and physicians complied with EMTALA.

Please see Chapter 3 of the book, especially pages 74-76.

No court has changed its interpretation of the statutory definition of stabilized, and to date no court has adopted or accepted the interpretation of stabilized or “resolution of the EMC” requirement as currently outlined in CMS’s interim guidance memo.

OIG Expands the Evidence Allowed to Assess Monetary Penalties Against Providers

The OIG expanded its ability to impose civil monetary penalties for EMTALA violations, effective April 17, 2002.⁴⁵ When determining sanctions, the OIG and administrative law judges may now consider not only the alleged violation, but also “other instances” of failing to provide appropriate emergency medical screening, stabilization, or appropriate transfer. Previous rules only permitted fines based on the alleged violation and other “offenses,” not other “instances,” which restricted the OIG to consideration of incidents that resulted in convictions or judicial or administrative decisions.

OIG Enforcement

The most important government enforcement case since publication of the book is *Inspector General v St Anthony Hospital*. The US Court of Appeals, Tenth Circuit,

upheld the OIG’s \$35,000 civil monetary penalty against St. Anthony’s Hospital for failure of its emergency physician and on-call thoracic surgeon to accept an appropriate patient in transfer. The case is worthwhile reading for receiving hospitals, on-call physicians, emergency physicians, or anyone delegated the authority to accept or reject transfers on behalf of a hospital.⁴⁶

This case modifies but doesn’t change the meaning of pages 92, 111, 113-114, and 173.

The Medicare Prescription Drug Improvement and Modernization Act of 2003

When Congress passed the Medicare prescription bill,⁷ it also addressed some provider concerns related to EMTALA enforcement. First, the bill amended EMTALA to require the Secretary of HHS to establish a procedure for CMS to notify hospitals and physicians when an investigation under EMTALA is closed. (The OIG already typically sends a letter to the hospital or physician under investigation informing of the agency’s intent to proceed or close the case without seeking penalties.)

Second, the bill required CMS to obtain a prior review by the state’s peer review organization (or PRO, but since renamed the “quality improvement organization,” or QIO) *before* making a compliance determination as part of the process of terminating the hospital’s participation under Medicare for violating EMTALA. The Secretary should provide a copy of the peer review report to the hospital or physician consistent with the confidentiality requirements imposed under Medicare.

Providers believed that many inappropriate investigations and citations by CMS could be avoided if CMS were required to obtain true peer review before determining whether the hospital or physician violated the statute. Prior to passage of the Medicare prescription bill, such early peer review (called the “5-day PRO”) was optional, but not mandatory.

Last, the Secretary of HHS will establish a technical advisory committee to review issues related to EMTALA and its implementation. The advisory group will be composed of 19 members and serve for 30 months. Its general responsibilities include reviewing EMTALA regulations, providing advice and recommendations to the Secretary with respect to the regulations and their application to hospitals and physicians, soliciting comments and recommendations from hospitals, physicians, and the public regarding implementation of the regulations, and disseminating information on the application of such regulations to hospitals, physicians, and the public. As of April 1, 2004, HHS had not yet created the committee.

Civil Enforcement by Individuals and Hospitals

Civil Cases

The number of civil cases filed against hospitals under an EMTALA theory of liability has steadily increased. The logic behind the increased litigation correlates with the predictions in Chapter 12 of the book.

The most notable cases are *Bryant v Adventist Health System* and *Harry v Marchant*.⁸ In each instance, a US appellate court refused to apply EMTALA to inpatients. These cases were cited by CMS as contributing to its decision to abandon the application of EMTALA to inpatients.

Also notable was the Ninth Circuit case of *Arrington v Wong*, which overturned the district court's ruling.⁹ For a detailed discussion of the potential civil liability ramifications of this case, read the section on application of EMTALA to non-hospital-owned ambulances in this supplement. [The Arrington decision changes the sections in the book at pages 34 and 190-191.](#)

The largest jury award to date occurred in the case of *Smith v Botsford Hospital* in Detroit, Michigan.⁴⁷ A federal district court jury awarded the plaintiffs more than \$5 million for the hospital's failure to stabilize a patient's fractured femur sustained in a rollover motor vehicle crash. The patient died from blood loss shortly after transfer from the hospital's emergency department, and the jury determined that the patient was not stable, as defined by law, at the time of transfer from the hospital.⁴⁷

The *Smith* case was remarkable in that an EMS incident report, which was exceedingly detrimental to the hospital, was admissible at trial, but a favorable state peer review physician's report was not admissible. Also, no standard

of care evidence was allowed at trial; the entire case was determined on an objective standard, for the jury to decide, of whether the patient was stable or unstable at the time of transfer.⁴⁷

Furthermore, since the lawsuit was brought under federal law, not ordinary state malpractice law, Michigan's tort reform laws were preempted. Most importantly, the federal district court judge held that Michigan's \$375,000 cap on noneconomic damages did not apply because he determined that a lawsuit for damages under EMTALA is a statutory liability claim, not a malpractice claim.⁴⁷

Next Steps Planned by CMS

CMS plans public presentations to explain the new regulations to health care providers and will revise its interpretive guidelines and retrain CMS regional offices/state survey agencies regarding proper enforcement of the law and the regulatory changes.⁶ CMS will also consider further reforms "as necessary" since it didn't address issues such as when hospitals must accept patients in transfer, psychiatric concerns, enforcement, and PRO/QIO issues.¹

Conclusions

CMS is to be commended for its attitudinal shift and implementation of a substantial number of positive changes for providers without diminishing protection of individuals seeking emergency care. However, the new regulations may exacerbate the existing on-call crisis, and CMS is still expanding the regulations beyond the scope of the statute. Whether the new rules result in more accurate and consistent enforcement of the law appears hopeful, but remains to be determined.

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