On August 29, 2003, the Centers for Medicare and Medicaid Services (“CMS”) issued a Final Rule clarifying hospital obligations to patients who request treatment for emergency medical conditions under the Emergency Medical Treatment and Active Labor Act (“EMTALA”). CMS published the Final Rule in the Federal Register on September 9, 2003, and it will become effective November 10, 2003. In general, according to the National Association of Public Hospitals and Health Systems (“NAPH”), the Final Rule is more sensitive to the realities of hospital operations than the existing regulations.

**GENERAL OVERVIEW & SUMMARY OF FINAL RULE’S KEY PROVISIONS**

- **WHEN DOES EMTALA APPLY TO A HOSPITAL:** The Final Rule adds a new regulatory paragraph clarifying that an EMTALA obligation is created through one of two triggering events: (1) an individual presents at a hospital’s “dedicated emergency department” to request examination or treatment for a medical condition [does not have to be for an emergency condition] or (2) the individual presents elsewhere on hospital property and requests examination or treatment for an *emergency* medical condition.

- **WHAT IS A “DEDICATED EMERGENCY DEPARTMENT”:** A department or facility will fall within the Final Rule’s new designation of a “dedicated emergency department”: (1) if, during the immediately preceding calendar year, a representative sample of patient visits indicates that the department or facility provided at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent, non-appointment, basis; (2) if the department or facility is licensed by a State as an emergency department; or (3) if the department or facility is held out to the public as appropriate places to go for the care of emergency medical conditions on an urgent basis without a scheduled appointment. Notably, the Final Rule’s “dedicated emergency department” encompasses areas of a hospital outside the traditional, and expressly titled, emergency department, including labor and delivery departments, psychiatric units, or other departments, whether located on or off campus. A hospital’s “urgent care center” is also subject to EMTALA if it meets the definition of a “dedicated emergency department.”
**EMTALA WILL APPLY WHEN A PERSON PRESENTS TO A DEDICATED EMERGENCY DEPARTMENT FOR ANY MEDICAL CONDITION OR WHEN A PERSON PRESENTS TO ANY OTHER DEPARTMENT OF THE HOSPITAL FOR A CONDITION THAT MAY BE AN EMERGENCY:** The Final Rule clarifies that EMTALA’s requirements apply when an individual comes to the “dedicated emergency department” for any medical condition, regardless of whether the individual expressly requests treatment for an emergency condition. At the same time, EMTALA is also triggered when an individual presents to an on-campus area of the hospital that is not a “dedicated emergency department” seeking examination or treatment for what may be an emergency medical condition. EMTALA will also apply if a prudent layperson observer would believe the individual needs emergency examination or treatment.

**EMTALA DOES NOT APPLY TO OUTPATIENTS:** Under the Final Rule, EMTALA obligations do not apply to an individual who has begun to receive outpatient services as part of an encounter other than an encounter that triggers the EMTALA obligations, i.e., if the patient develops an emergency condition during the outpatient encounter.

**EMTALA DOES NOT APPLY TO INPATIENTS:** The Final Rule clarifies that hospitals are not required to continue providing stabilizing treatment, as understood for EMTALA purposes, once an individual is admitted (in good faith) to the hospital as an inpatient. The Medicare Hospital Manual definition of “in patient” is adopted in the final rule.

**EXCEPTION FOR HOSPITAL OWNED & OPERATED AMBULANCES:** The Final Rule creates an exception to the old definition of “comes to the emergency department” for certain patients in hospital-owned and operated ambulances. Under this exception, if the hospital-owned ambulance delivers the patient to a different hospital due to community-wide EMS protocols, the patient will not be considered to have come to the parent hospital.

**HOSPITAL SCREENING IS FIRST PRIORITY:** The Final Rule prohibits a hospital from seeking prior authorization for screening or stabilization services until after the hospital has provided the medical screening and initiated further examination and treatment that may be required to stabilize the emergency medical condition. However, this Final Rule does not prohibit a hospital from seeking advice on the patient’s medical history and needs, so long as the consultation does not inappropriately delay required emergency services. The Final Rule also allows hospitals to follow reasonable registration processes for emergency patients, including asking for insurance status and information so long as the inquiry does not delay the medical screening or treatment.
EMTALA DOES NOT APPLY TO “PREVENTIVE CARE SERVICES:” EMTALA does not apply to “preventive care services” or other services that are unrelated to an examination or treatment for a medical condition.

EMTALA DOES APPLY TO “PHARMACEUTICAL SERVICES:” “Pharmaceutical services” requested in a dedicated emergency department are subject to EMTALA.

...... FOCUS ON FINAL RULE’S ON-CALL PROVISIONS ......

Like the existing EMTALA regulations that require hospitals to maintain on-call rosters – but which do not describe specific obligations for on-call coverage – the Final Rule generally provides that hospitals must maintain on-call rosters “in a manner that best meets the needs of the hospital’s patients who are receiving services required under [EMTALA],” but they may recognize the potential limits of hospital resources, specifically, the availability of on-call staff in many areas.

The following tables break down the Final Rule’s on-call provisions into two distinct categories: (1) Rules Regarding On-Call Rosters & Hospital Policies and (2) Rules Regarding On-Call Coverage.

**Rules Regarding On-Call Rosters & Hospital Policies**

Factors to be considered in determining whether an on-call roster best meets the needs of a hospital’s patients: 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.

Hospitals must have written policies and procedures to provide for emergency services and respond to situations when: (a) a particular specialty is not available; (b) on-call physician cannot respond due to circumstances beyond his/her control; (c) on-call physician cannot respond because s/he has scheduled elective surgery while on call (if permitted by the hospital) or (d) the physician cannot respond because s/he has simultaneous on-call duties for two or more hospitals (if permitted by the hospital to do so).

Hospitals that do not maintain a dedicated emergency department are not required to maintain an on-call roster.

The practice of refusing to be listed on the on-call roster, but taking calls selectively, e.g., based on the ability to pay, violates EMTALA.
Rules Regarding On-Call Coverage

Each hospital has the discretion to maintain the required on-call list in a manner to best meet the needs of its patients who are receiving services required under EMTALA in accordance with the capability of the hospital, including the availability of on-call physicians. This list is required under section 1866(a)(1)(l)(iii) of the Social Security Act. A hospital would not be required to maintain on-call physician coverage for types of services it does not routinely offer.

No requirement for full-time on-call coverage by a specialty, or any predetermined “ratio” used to identify how many days a hospital must provide on-call coverage based on the number of physicians on staff for that particular specialty; i.e., hospital is not required to have 24-hour coverage in all specialties if it cannot reasonably do so.

Some coverage may be provided by means other than the specialist coming to the emergency room, e.g., transfer to another facility may be appropriate for hospitals with limited specialty coverage. If after screening no emergency condition exists referral to a physician’s office for further treatment may be appropriate.

CMS also recognizes there may be circumstances in which a physician assistant may be the appropriate practitioner to respond to a call from an emergency department or other hospital department that is providing screening or stabilization mandated by EMTALA. Such decision should be made by the on-call physician, according to CMS.

Physicians whose clinical privileges are more expansive than their actual scope of practice can be on-call physicians, i.e., “a physician who is in a narrow subspecialty may, in fact, be medically competent in his or her general specialty, and in particular may be able to promptly contribute to the individual’s care by bringing skills and expertise that are not available to the emergency physician . . . .”

CMS recognizes that when an EMTALA violation involving on-call coverage is found to have occurred, surveyors and CMS regional office staff will review all facts of the situation carefully to ensure that hospitals that have acted in good faith to ensure on-call coverage are not unfairly penalized for failure by individual physicians to fulfill their obligations.

No minimum level of on-call coverage is mandated by the rule. CMS stated it is not feasible for it to do so because of the variation in the size, staffing, and capabilities of the different institutions that participate in Medicare as hospitals.

Physicians who come to the hospital to see their own patients should not necessarily be considered to be “on call.”