Recent regulatory and statutory changes have clarified the responsibilities of Medicare-participating hospitals in treating individuals with emergency medical conditions. On November 10, 2003, new Emergency Medical Treatment and Labor Act (EMTALA) regulations took effect, easing many prior concerns about EMTALA’s reach. In addition, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (“Medicare Modernization Act”) includes a number of changes related to EMTALA. This Advisory highlights key aspects of the final regulations and summarizes the provisions of the Medicare Modernization Act pertaining to EMTALA.

In 1986, Congress enacted EMTALA, which requires hospitals to provide a medical screening examination when a patient comes to the emergency department and requests examination or treatment for a medical condition. If an emergency medical condition is determined to exist, the hospital must provide either stabilizing treatment or an appropriate transfer. Regulations implementing EMTALA were first promulgated in 1994 and have been amended several times since then to add additional requirements for hospitals and physicians. Failure to comply with EMTALA requirements can result in termination from the Medicare program, civil monetary penalties, and/or a private lawsuit seeking damages.

In response to industry concerns that the EMTALA regulations did not reflect practical and clinical realities, the recent final regulations clarify the following four areas:

1. The extent to which EMTALA applies to individuals who are on-campus and to individuals who present at off-campus departments or clinics of a hospital.
2. The applicability of EMTALA to inpatients and outpatients.
3. Physician on-call requirements.
4. Responsibilities of hospital-owned ambulances under EMTALA.

1. Where in the hospital does EMTALA apply?

The new regulations limit the scope of EMTALA’s application by redefining the instances when a Medicare-participating hospital must satisfy the EMTALA requirements, as summarized below.

a. Off-campus departments/clinics and provider-based entities and on-campus locations other than the emergency department

EMTALA no longer applies to an individual who comes to an off-site clinic or department of the hospital or a provider-based entity unless the location meets the definition of a “dedicated emergency department.”

A “dedicated emergency department” means any clinic or department of the facility, regardless of whether it is on or off the main hospital campus, that meets at least one of the three following criteria:
• It is licensed by the state in which it is located as an emergency room or emergency department;
• It holds itself out to the public (e.g., by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent, non-appointment basis, such as an urgent care center; or
• During the preceding calendar year, it provided at least one-third of its outpatient visits for the treatment of emergency medical conditions.

The new regulations also clarify that EMTALA applies when an individual comes to an area on the hospital’s property other than a dedicated emergency department if the individual requests (or has a request made on his or her behalf for) examination or treatment of an emergency medical condition. In the absence of such a request, EMTALA applies if a "prudent layperson" would believe that the individual needs an emergency examination or emergency treatment. The new regulations further provide that the "hospital’s property" excludes entities that participate separately under Medicare (such as physicians’ offices, rural health centers, or skilled nursing facilities) and restaurants, shops or other nonmedical facilities that are not owned or operated by the hospital.

b. Applicability of EMTALA to inpatients and outpatients

The regulations further clarify that a hospital’s obligations under EMTALA end at the time that the hospital, in good faith, admits an individual for hospital inpatient care, regardless of whether the individual is experiencing an emergency medical condition. Transfer and stability issues for that individual are then governed by Medicare hospital conditions of participation, state laws, and professional considerations, and are not governed by EMTALA.

In addition, hospitals do not have an EMTALA obligation towards an individual who has begun to receive services as part of a scheduled outpatient encounter and subsequently experiences an emergency medical condition, even if the individual is transported to the hospital’s dedicated emergency department. As is the case with inpatients, transfer and stability issues for that individual are governed by Medicare hospital conditions of participation, state laws, and professional considerations.

2. Physician on-call requirements under EMTALA

The new regulations attempt to recognize on-call staff limitations by clarifying that hospitals must maintain an on-call list of physicians that "best meets the needs of the hospital’s patients who are receiving services required under [EMTALA] in accordance with the capability of the hospital, including the availability of on-call physicians." However, the new regulations provide little additional guidance to help manage the on-call challenges hospitals face.

The regulations do incorporate statements in program memoranda issued
4. EMTALA provisions in the Medicare Modernization Act

Effective January 1, 2004, the Medicare Modernization Act provides that Medicare must pay for EMTALA-required services based on the patient’s presenting symptoms, and not on the patient’s ultimate diagnosis. Also, in response to concerns that hospitals and physicians were often unaware when an EMTALA investigation had closed, the Medicare Modernization Act requires the Department of Health and Human Services (“HHS”) to establish a procedure for notifying hospitals and physicians when an investigation is closed. In addition, the Act requires HHS to establish a Technical Advisory Group, comprised of 19 members, to review EMTALA implementation issues. Finally, the Act requires that CMS request prior review by a Quality Improvement Organization (“QIO”) of EMTALA cases before making a determination concerning termination of a hospital’s participation in Medicare. Previously QIO review was required only in cases where the OIG imposed a civil monetary penalty.

Recommended Action

- Review other materials, such as corporate compliance codes of conduct, that might describe the hospital’s EMTALA obligations to ensure that they are consistent with revised hospital policies and procedures.
- Review medical staff bylaws to ensure on-call obligations are addressed.
- Ensure policies and procedures are in place to address whether the hospital will permit physicians to be on call at more than one institution simultaneously or will permit the physician to schedule elective surgery when on call. If so, ensure there is a back-up plan to address instances when the physician is unable to respond. This may include working out communication and transfer protocols with other institutions.
- Ensure that appropriate staff are aware of the hospital’s EMTALA obligations and any policy changes.

For further information about the EMTALA final rule and the new statutory changes, please contact Michelle DeBarge at 860.297.3702 / mdebarge@wiggin.com or Melinda Agsten at 203.498.4326 / magsten@wiggin.com.