

CMS ANNOUNCES FINAL EMTALA RULE

The Centers for Medicare and Medicaid Services (“CMS”) recently issued final regulations clarifying obligations to patients under the Emergency Medical Treatment and Active Labor Act, known as EMTALA. EMTALA, originally passed in 1986, was intended to discourage hospitals from turning away patients based on their ability to pay. While EMTALA mainly applies to hospitals, widening interpretation of EMTALA has created risk management concerns for physicians who provide ER call coverage.

EMTALA Requirements

EMTALA requires hospitals to provide an appropriate medical screening examination to any person who goes to a hospital’s emergency department and requests treatment or an examination for a medical condition. If the examination reveals an emergency condition, the hospital must provide either stabilizing treatment or an appropriate transfer to another medical facility. EMTALA applies to all hospitals that offer emergency services and participate in the Medicare program, and covers all patients, not just Medicare patients, treated at those hospitals. The new regulations attempt to clarify many areas of ambiguity. Some of the more intriguing provisions are discussed below.

Clarification on the Status of Inpatients

The new regulations clarify that EMTALA does not apply after a patient has been seen, screened, and admitted for inpatient hospital services. This rule applies even if the inpatient was admitted through the emergency department, and even if the patient has been boarded in the emergency department as long as there is an expectation that the patient will remain overnight and occupy a bed in the hospital. An exception to this rule arises, however, if the patient has been admitted in bad faith to avoid the EMTALA requirements.

Regulations Expand Definition of “Emergency Department”

The new regulations expand the definition of “emergency department” to mean any department or facility of the hospital, whether or not it is situated on the main hospital campus, that is licensed by the state as an emergency room or emergency department, is held out to the public as providing care for emergency medical conditions, or during its previous calendar year has provided at least one third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis. This definition arguably broadens the scope of EMTALA by including certain sites that may not be located on the main campus of a hospital. However, it is clear from the comments to the regulations that urgent care facilities that do not meet the above definition would not be subject to EMTALA.

On-Call Coverage Addressed

The regulations also address the requirement that hospitals maintain a roster of on-call physicians, and debunked what was believed to be an unwritten rule requiring hospitals to have 24/7 coverage in a particular subspecialty if three or more subspecialists were practicing at the hospital. Further, CMS, through its comments on the final regulations, reiterated that under current law, there are penalties for physicians who negligently violate a requirement of EMTALA, including physicians who refuse to appear when called while they are on call.

Under the new regulations, hospitals will have the discretion to develop their on-call lists in a way that best meets the needs of their communities. Physicians will be permitted to be on call simultaneously at more than one hospital and to schedule elective surgery and other medical procedures while they are on call. CMS, however, refused to adopt any bright line rules with respect to hours or days per week that a physician is required to be on call.

On-Call Obligations for Sub-Specialists

CMS also addressed sub-specialists who might be disadvantaged by agreeing to be on call. The comment to the regulations uses as an example an orthopedic surgeon who sub-specializes in pediatric cases. The question posed was whether the orthopedic-pediatric surgeon would be required to assist in non-pediatric, orthopedic

cases while on call. CMS indicated that a physician who has a narrow subspecialty may, in fact, be competent in his or her general specialty and may be able to contribute to an individual's care by bringing to bear skills and expertise that are not available to the emergency physician. While the emergency physician and the on-call sub-specialist may need to discuss the best way to meet the patient's medical needs, CMS indicated that any disagreement between the two regarding the need for an on-call physician to come to the hospital and examine the patient must be resolved by deference to the judgment of the emergency physician.

What Happens if You Don't?

Violators of EMTALA may have the Medicare participation terminated and may be subject to civil monetary penalties of up to \$50,000 per violation. Additionally, patients who have suffered harm and hospitals to which a patient has been improperly transferred may also have a private right of action under EMTALA.