

# LEGAL ALERT

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## HEALTH CARE LAW UPDATE

### EMERGENCY MEDICAL SERVICE OBLIGATION CLARIFIED IN EMTALA FINAL RULE

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On August 29, 2003, the Centers for Medicare & Medicaid Services (CMS) issued a final rule clarifying Medicare-participating hospitals' obligations to patients who request treatment for emergency medical conditions under the Emergency Medical Treatment and Labor Act, known better as EMTALA or the "anti-dumping" law.

EMTALA requires hospitals to provide appropriate medical screening examinations to all persons who come to the hospital's dedicated emergency department requesting examination or treatment of a medical condition. If the screening examination reveals the person has an emergency medical condition, the hospital must provide stabilizing treatment and/or appropriately transfer the person to another medical facility. EMTALA applies to all hospitals that participate in the Medicare program and offer emergency services and covers all patients treated at those hospitals.

Hospitals that violate EMTALA can suffer a myriad of consequences, including loss of their Medicare participating agreement, civil money penalties of up to \$50,000 per violation, and possible civil liability to private parties. Public relations, reputation, licensure and accreditation may also be adversely affected.

This new final rule is intended to provide clear, common sense guidelines for responding to requests for treatment of an emergency condition. CMS believes it has designed a rule that will ensure that patients receive appropriate screening and emergency treatment, regardless of their ability to pay, while removing barriers to the efficient operation of hospital emergency departments. In general, the new final rule reduces the EMTALA burden on both hospitals and physicians.

#### *Summary of Key Provisions of the Final Rule*

- The new rule expands the term "dedicated emergency department" to mean any hospital, facility, or department, whether situated on or off the main hospital campus, that: (1) is licensed by the state as an emergency room or emergency department; (2) is known to the public as providing care for emergency medical conditions without requiring an appointment; or (3) during its previous calendar year, has provided at least one-third of all its outpatient visits for the treatment of emergency medical conditions on an urgent basis.

CMS also advises that the term "dedicated emergency department" may include hospital obstetrical/gynecological and psychiatric units

that provide services to persons who present as unscheduled ambulatory patients, but are routinely admitted for evaluation and treatment. However, CMS noted that the dedicated emergency department to which an individual presents does not necessarily have to be the one to do EMTALA screening and stabilization. For example, if a man were to seek emergency treatment for a medical condition in the obstetrics and gynecology department rather than the general emergency department, this presentation would create an EMTALA obligation for the hospital, but the hospital would not be prohibited from transporting the individual to its general emergency department for screening and stabilization if such action were medically indicated.

- The rule clarifies when physicians, particularly specialists, must serve on hospital medical staff “on-call” lists. Given the limited availability of on-call physicians in many specialties and geographic areas, hospitals are given discretion to develop their on-call rosters to best meet their patients’ needs. Also, in keeping with traditional practices of “community call,” physicians are permitted to be on call simultaneously at more than one hospital, and to schedule elective surgery or other medical procedures during on-call time; provided hospitals have written policies and procedures in place to ensure appropriate emergency services are available.

Additionally, the rule clarifies that Medicare does not set requirements for how frequently a hospital’s staff of on-call physicians are expected to be available to provide on-call coverage; that determination is to be made between the hospital and the physicians on its on-call roster. The preamble to the rules states there is no predetermined “ratio” that CMS uses to identify how many days a hospital must provide on-call medical staff coverage. Rather, 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.

- The rule clarifies that hospital-owned ambulances may comply with citywide and local community protocols for responding to medical emergencies and thus be used more efficiently. For example, if an ambulance operating under a community-wide emergency medical service protocol it to transport a person to a facility other than the hospital that owns the ambulance, EMTALA does not apply to the ambulance-owning hospital.
- The rule clarifies the extent to which EMTALA applies to inpatients and outpatients. According to CMS, EMTALA does not apply to patients who begin receiving scheduled, non-emergency outpatient hospital services before they present for examination or treatment for an emergency medical condition, even if they are later transferred to the hospital’s dedicated emergency department. Moreover, EMTALA ceases to apply after a patient has been seen, screened, and admitted for inpatient hospital services, unless the admission was made in bad faith to avoid the EMTALA requirements.
- The rule allows hospitals to follow a reasonable registration process, which may include asking whether persons are insured, and if so, by what insurer, provided the inquiry does not delay services or discourage persons from remaining. Hospitals do not have to wait until a medical screening exam has been completed to collect such information from a patient.
- The rule specifically fails to exempt “Urgent Care Centers” as “dedicated emergency departments” for EMTALA purposes. In the preamble to the rule CMS states that if a department or facility is held out to the public, by name, posted signs, advertising, or other means, as a place that provides care for emergency medical conditions, it would meet

the definition of “dedicated emergency department.”

- The rule also specifies that emergency physicians and others involved in emergency treatment may consult a person’s physician at any time about the patient’s medical history, provided the consultation does not unreasonably delay services.

The final rule was published in the September 9, 2003, Federal Register, and will be effective November 10, 2003. Although the final rule provides significant guidance, some compliance issues remain. CMS noted in the preamble to the final rule that it will be developing interpretive guidelines and training materials for EMTALA surveyors as well as EMTALA-related patient information and educational material.

Of course, while the new regulations are crucial in determining what measures are necessary for federal regulatory compliance, they have no effect on previously decided case law interpreting the act. For example, the new regulations interpret the act so that it does not apply to patients who have been admitted as inpatients to the hospital. However, current case law enforcing EMTALA in the Sixth Circuit, which includes Michigan, holds the exact opposite that: “once a patient is found to suffer

from an emergency medical condition in the emergency room, she cannot be discharged until the condition is stabilized, regardless of whether the patient stays in the emergency room.” *Thornton v Southwest Detroit Hosp.*, 895 F2d 1131, 1134 (CA6, 1990). In fact, a federal court owes no deference to the administrative rules if it concludes that the Congressional intent of the statute is clear. *St. Anthony Hosp. v United States Dep't of Health & Human Services*, 309 F3d 680, 691 (CA10 2002).

Thus, a key to determining the effect of the new rules is whether the new rules contradict established legal precedent. Where there is no such precedent or where the new rule is consistent with legal precedent, the new rules can guide hospital policy; however, where there is clear legal precedent which contradicts the new rule, hospitals may be unwise to change policy based solely on this most recent interpretation of EMTALA by CMS.

*For more information on the EMTALA Final Rule, links to CMS, and other relevant web sites and a complete library of our Legal Alerts, please visit the SHRR web site at [www.shrr.com](http://www.shrr.com). For other questions or to receive assistance in evaluating your practice or facility’s EMTALA compliance, please contact any member of the Health Care Law Department at Smith Haughey Rice & Roegge.*

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