CMS Clarifies Applicability of EMTALA in Recent Revisions to Hospital Inpatient Prospective Payment System

EMTALA Obligations Extend to Hospitals Without A Dedicated Emergency Department

On August 18, 2006, the Centers for Medicare and Medicaid Services (“CMS”) issued its final rule revising the hospital inpatient prospective payment system (“IPPS Final Rule”). As part of the changes to the IPPS Final Rule, CMS implemented several changes affecting the Emergency Medical Treatment and Labor Act of 1986 (“EMTALA”). Specifically, CMS clarified that certain EMTALA transfer obligations are applicable to hospitals with specialized capabilities, even if such hospitals lack a Dedicated Emergency Department. CMS also expanded the scope of who can certify false labor to include certified nurse midwives and other qualified medical persons. Finally, CMS clarified the definition of the term “regional referral centers.”

Generally speaking, EMTALA requires Medicare-participating hospitals with Dedicated Emergency Departments to provide a screening examination to all patients who present to the hospital’s Dedicated Emergency Department and request examination or treatment for a medical condition. For purposes of EMTALA, a hospital’s labor and delivery unit is considered a Dedicated Emergency Department. If the screening examination reveals the patient has an emergency medical condition, EMTALA obligates a hospital to provide stabilizing treatment or transfer the patient to an appropriate facility.

I. Accepting Transfers and Specialized Capabilities

The IPPS Final Rule clarifies that all Medicare-participating hospitals have an obligation to accept an appropriate transfer, regardless of whether the hospital has a Dedicated Emergency Department, if the hospital has specialized capabilities and capacity to treat the patient. By emphasizing the applicability of EMTALA transfer obligations to hospitals with specialized capabilities, CMS is making clear that the analysis of whether an EMTALA obligation exists extends beyond just the threshold inquiry of whether or not the hospital has a Dedicated Emergency Department. The IPPS Final Rule specifically extends the EMTALA transfer obligation to physician-owned specialty hospitals that participate in Medicare. In its discussion concerning physician-owned specialty hospitals, CMS declined to impose any new call coverage or transfer requirements on such specialty hospitals. CMS notes that Medicare Conditions of Participation already impose an obligation on all participating hospitals, including physician-owned limited service facilities, to have a physician on duty or on call at all times and to provide adequate physician services for hospital patients.
CMS affirmatively stated in the IPPS Final Rule that the EMTALA transfer obligations of hospitals with specialized capabilities do not require such hospitals to open a Dedicated Emergency Department if they do not have one. Nor does the IPPS Final Rule impose any additional EMTALA obligations on those hospitals without Dedicated Emergency Departments with respect to walk-in patients who initially go to such hospitals seeking examination or treatment for a medical condition.

With a new emphasis on hospitals having “specialized capabilities,” hospitals will need clarification on what that term actually means. Existing EMTALA regulations at 42 C.F.R. § 489.24(f) have a partial list of facilities CMS considers as having specialized capabilities. This list includes facilities with burn units, shock trauma units and neonatal intensive care units. Despite several requests for clarification on the definition of specialized capabilities from commenters to the proposed version of this rule, the IPPS Final Rule expressly declines to provide any additional regulatory guidance. CMS cited its own decision not to propose any changes to the existing definition and the fact that the EMTALA Technical Advisory Group (EMTALA TAG) is currently considering revising the definition as reasons for not providing any new guidance.

II. CMS Expands the List of Medical Personnel Who May Certify False Labor

The second major change to the existing EMTALA regulation is the decision by CMS to amend the definition of “labor” to allow certified nurse midwives and other qualified medical personnel to certify false labor. The EMTALA statute defines “emergency medical condition” to include a pregnant woman having contractions where the absence of immediate medical attention seriously jeopardizes the health of the woman and her unborn child. CMS then promulgated regulations defining both “emergency medical condition” and “labor.” The definition of “labor” in the regulations required a physician to certify that the woman is in false labor after reasonable observation. False labor is not considered an emergency medical condition, however, the definition meant hospitals could not fully discharge their EMTALA obligation without physician certification.

After hearing from physicians and non-physicians regarding the competence of non-physician practitioners to determine whether a woman is in false labor, the EMTALA TAG recommended that CMS amend the definition to include certified nurse midwives and other qualified medical personnel. CMS accepted the EMTALA TAG’s recommendation and the IPPS Final Rule amends the definition accordingly. It is important to note that the certified nurse midwives and the other qualified medical personnel must be acting within the scope of practice under state law and as defined in the hospital’s medical staff bylaws.

III. CMS Clarifies Definition of Regional Referral Center

CMS made one final and minor change to the existing EMTALA regulation by clarifying its reference to “regional referral centers” in the definition of recipient hospital responsibilities. This term is not found anywhere else in the Medicare regulations and, therefore, CMS wanted to clarify that the term is intended to mean “Referral Centers” as defined in
42 C.F.R. 412.96. Generally, referral centers are defined as hospitals in rural areas with 275+ beds where at least 50 percent of the Medicare patients are referred from other hospitals or by physicians who are not on staff at the hospital and where at least 60 percent of the Medicare patients live more than 25 miles away from the hospital.

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