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UNDERSTANDING CMS' NEW GUIDANCE FOR HOSPITAL EMERGENCY SERVICES: PRESERVE YOUR MEDICARE PROVIDER STATUS

Part 2: Requirements for hospitals with an emergency department; best practices for compliance

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The Key To EMTALA Serenity

- "This game is impossible to officiate."
  - Rick Majerus, Basketball Coach

Coming to the Emergency Department:

The “Dedicated Emergency Department,” Off-Campus Departments, and Ambulances

"Dedicated Emergency Department:" The September 2003 Final Rules

Definition: Hospital department, whether on or off main campus, is a DED if it meets 1 of 3 tests:

1. - Licensed by the state as an ED; **or**

“Dedicated Emergency Department:” The September 2003 Final Rules

2. - “Held out to the public” as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; **or**

“Dedicated Emergency Department:” The September 2003 Final Rules

3. -“based on a representative sample of patient visits that occurred during” the previous calendar year, the department provides “at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.”

"Dedicated Emergency Department:" The September 2003 Final Rules

- CMS will decide case-by-case
- CMS: This is an "objective standard"
- "Prudent layperson" no longer standard

"Dedicated Emergency Department:" The September 2003 Final Rules

- Log and on-call list needed in all DED's
- Can transfer to unaffiliated facility

Off-Campus Departments

Will be most deeply affected by the new “dedicated emergency department” definition

History: The OPPS Debacle

- 2000 proposed rule: CMS sought to extend EMTALA to virtually all hospital departments, on-campus or off
- Very rarely enforced – unworkable
- New rule much narrower but raises many questions

Current Rule, Off-Campus

- Urgent care clearly covered
- OB and psych very likely covered
- Policies and procedures needed (now in Medicare conditions of participation: 42 CFR § 482.12(f)(3))

Current Rule, Off-Campus

- Issues arises for off-campus facility not holding self out as urgent care provider, but still providing care on urgent basis without appointment
- Hospitals must apply the “one-third” rule; will face policy decisions
- Methodology?

On-Call Panels

Always be wary when someone says to you, "I'm from Washington and I've come to help."

Call Panels: The Preamble to the Final 2003 Rule

Apply "all relevant factors" test, including:

- Number of staff physicians
- Other demands on the physicians
- Frequency with which on-call services needed by hospital's patients
- Provisions for situations where physician not available

Call Panels: The Final Rule

First:

- "Each hospital must maintain an on-call list of physicians on its medical staff in a manner that best meets the needs of the hospital's patients who are receiving services required under this section *in accordance with the resources available to the hospital, including the availability of on call physicians."*

Call Panels: The Final Rule

Second:

- (i) To respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control; *and*

Call Panels: The Final Rule

Third

- *"(ii) To provide that emergency services are available to meet the needs of patients with emergency medical conditions if [the hospital] elects to permit on-call physicians to schedule elective surgery during the time that they are on call or to permit on-call physicians to have simultaneous on-call duties."*

Call Panels: Flexibility or Illusion?

Consider:

- A patient presents needing neurosurgery services.
- Neurosurgery call panelists are not available
- The patient is transferred as a result

Is there an EMTALA violation (i.e., did the on-call physician "fail or refuse to appear within a reasonable time")?

Call Panels: Flexibility or Illusion?

The answer depends on the situation:

- A 300-bed hospital with only 2 neurosurgeons and a limited call schedule?
- A 300-bed hospital with 9 neurosurgeons who are simultaneously on call at two other hospitals?
- A large teaching hospital with plenty of neurosurgeons to provide “24-7” call?

. . . CMS Guidance Memos

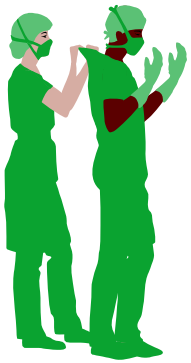
Simultaneous Call:

- CMS "is revising its policy to allow on-call physicians to provide coverage simultaneously at several hospitals to maximize patient access to care."
- But each hospital has an "independent EMTALA obligation"
- Policies and procedures required; hospitals are responsible to be aware of other hospitals' call schedules.

. . . CMS Guidance Memos

- **Cannot list physician groups on the call list.**

- **On-call surgeon may perform elective surgery; but CMS "should expect" surgeon to have "planned backup."**



Call Panels: Compliance Suggestions for Hospitals

- **Have policies and procedures for when particular specialist not available or unable to respond**
- **Back-up call panels may be necessary**
- **Transfer agreements may help**
- **Do not read "flexible" to mean optional**

When Does EMTALA End, and Does It Apply to Inpatients?

A New "Bright Line"

- **Prior law: Once a hospital stabilizes or appropriately transfers a patient, the hospital's EMTALA obligations end.**

- **New "bright line" in 2003 rules: EMTALA ends on** admission **of a patient with an unstabilized emergency condition to the hospital, *if admission "made in good faith in order to stabilize."***

When Does EMTALA Really End?

Preamble: When one of 3 things occurs:

- Screening and stabilization
- Admission
- Appropriate transfer

But Just How “Bright” A Line Is This Anyway?

- **“Good Faith” is inherently ambiguous; requires case-by-case interpretation**
- **Preamble: Bad faith = circumvention**
- **Direct admit does not trigger EMTALA**

A Bright Line?

Examples

- Initial admission in good faith, but later transfer questionable
- Acceptance of transfers still required under subsection (g)?
- Are financial delays permissible after admission?

Applicability to Hospital Inpatients

- **EMTALA generally does NOT apply to inpatients (unless admission in bad faith)**

- **EMTALA does NOT extend to admitted non-emergent inpatient if patient's condition deteriorates**

EMTALA Quick Reference Matrix

1. Did the individual "come to the Emergency Department" and request evaluation or treatment, and was each individual logged?

YES → 2.

NO → No further analysis required.

2. Did the Hospital provide an appropriate MSE by a qualified person?

YES → 3.

NO → The Hospital may be in violation of EMTALA.

3. Did the individual have an EMC?

YES →

NO → No further analysis required.

EMTALA Quick Reference Matrix (continued)

4. Did the Hospital, within its capabilities, provide stabilizing treatment of the EMC?

YES

NO → The Hospital may be in violation of EMTALA.

5. Was the MSE and stabilizing treatment provided without delay to inquire about the individual's financial status?

YES

NO → The Hospital may be in violation of EMTALA.

6. Did the Hospital refrain from *seeking* prior authorization from any payor until the Hospital completed the MSE and initiated any necessary stabilizing treatment?

YES

NO → The Hospital may be in violation of EMTALA.

7. Was the patient admitted in good faith to the Hospital as an inpatient to stabilize?

NO

YES → No further analysis required.

EMTALA Quick Reference Matrix (continued)

8. Was the patient's EMC "stabilized"?

NO

YES → No further analysis is required.

9. Did the individual make an informed request to be transferred?

NO

YES → Go to Question 11.

10. Did the physician or QMP certify that the medical benefits outweighed the risks of the transfer?

YES

NO → The Hospital may be in violation of EMTALA.

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11. Did the Hospital do ALL of the following:

- Stabilize to minimize the risks of transfer;
- Contact the receiving facility/physician and get acceptance of the transfer;
- Document the individual's request or the physician's certification in the medical charts;
- Send a copy of the medical records to the receiving faculty/physician;
- Transport by qualified personnel as determined by the ER physician?

YES

NO → The Hospital may be in violation of EMTALA.