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CMS PUBLISHES IPPS 2009 FINAL RULE REVISIONS TO EMTALA REGULATIONS

On March 6, 2009, CMS published a Survey & Certification Transmittal (S&C-09-26) that revised the EMTALA regulations pursuant to the Fiscal Year 2009 Inpatient Prospective Payment System (IPPS) final rule effective October 1, 2008. The following is a brief executive summary:

On-Call Obligations

Several major changes include permitting hospitals to meet their on-call obligations through participation in a Community Call Plan (CCP). These plans must be formal among the hospitals participating in the CCP, meet very specific requirements and also require each hospital to have written policies and procedures in place to respond to situations in which the on-call physician is unable to respond for any reason. The CCP does not require prior review and approval from CMS before the CCP can be implemented.

A hospital still has an obligation to maintain an on-call list of physicians who are available to provide the necessary call coverage. CMS made a significant change in the regulation that required hospitals to maintain an on-call list established in a manner that best meets the needs of the hospital's patients who are receiving services within the resources available to the hospital, including on-call physicians.

Hospitals are now required to maintain an on-call list of physicians who are on the hospital's medical staff, or who have privileges at the hospital, or who are on staff or have privileges at another hospital participating in a formal CCP, available to provide treatment necessary after the initial examination to stabilize individuals with emergency medical conditions who are receiving services in accordance with the resources available to the hospital. Thus, hospitals should ultimately try to provide adequate on-call coverage consistent with the services and the resources available at the hospital.

Hospitals with Specialized Capabilities – EMTALA Obligations

A hospital with specialized capabilities does **not** have an obligation under EMTALA to accept an appropriate transfer of that individual. The regulations state that once an individual has been admitted in good faith to the admitting hospital, the EMTALA obligation with respect to that individual has ended for the admitting hospital - even if the individual remains unstabilized. CMS notes, however, that individuals placed in observation status are still subject to the EMTALA requirements because they have not been formally admitted as inpatients.

Emergency Waivers

Sanctions for potential EMTALA violations for an inappropriate transfer during a national emergency or for the direction or relocation of an individual to receive medical screening at an alternate location pursuant to an appropriate State

emergency preparedness plan or, in the case of a public health emergency that involves a pandemic infectious disease, pursuant to State pandemic preparedness plan do not apply to a hospital, with a dedicated emergency department located in an emergency area during an emergency period, as specified in section 1135(g)(1) of the Social Security Act. A waiver of these sanctions is limited to a 72 hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect until the termination of the applicable declaration of a public health emergency, as provided for by section 1135(e)(1)(B) of the Act.

CMS has provided further clarifications in their Interpretive Guidelines (IGs) pursuant to Survey & Certification Transmittal (S&C-09-26). The IGs elaborate on the regulatory changes noted above. The IGs are not the law or regulation, but they do provide guidance that is beneficial to Medicare participating hospitals (as well as the Medicare surveyors). The following is CMS's more detailed summary of the recent EMTALA changes.

CMS Summary of EMTALA Clarifications

****This Guidance is Effective Immediately****

1. On-Call Provisions

a. Community Call Plan (CCP) Requirements

The IPPS FY 2009 final rule added a provision at 42 CFR.489.24(j)(2)(iii) that permits hospitals to participate in a formal CCP to share their on-call responsibilities. Participation by hospitals in a CCP is entirely voluntary. CMS is simply making this option available to hospitals that wish to pursue it.

The regulation establishes the minimum requirements that a hospital must include in any formal CCP:

- A clear delineation of on-call coverage responsibilities; that is, when each participating hospital is responsible for on-call coverage (for a specific time period, or for a specific service, or both);
- A description of the specific geographic area to which the plan applies;
- A signature by an appropriate representative of each hospital participating in the plan;
- Assurances that any local and regional EMS system protocol formally includes information on community on-call arrangements;
- A statement specifying that even if an individual arrives at a hospital that is not designated as the on-call hospital, that hospital still has an obligation to provide a medical screening exam and stabilizing treatment within its capability, and that hospitals participating in the community call plan must abide by the regulations governing appropriate transfers; and
- An annual assessment of the community call plan by the participating hospitals.

Ideally a CCP should be integrated into a community's pre-hospital emergency services arrangements. This would facilitate the prompt delivery of specialist stabilizing treatment to individuals whose emergency medical condition (EMC) and need for specialty care can be identified while in transit to the hospital. However, it is important to note that the regulation does not relieve any hospital participating in the CCP of its EMTALA obligations to any individual that comes to the hospital's dedicated emergency department (DED), even when that hospital is not on-call for a specific specialty service under the plan. The hospital must still conduct an appropriate medical screening examination and, if the individual is

determined to have an EMC, must provide stabilizing treatment within its capability to do so, or arrange for an appropriate transfer.

Under a formal EMTALA CCP, if an individual who comes to a hospital's DED requires the services of a specialist for stabilizing treatment, and another participating hospital pursuant to the plan has the responsibility for providing that service at that specific time, then a transfer to the hospital with the available on-call specialist would generally be appropriate, assuming all other transfer requirements are met. In most circumstances, it would be sufficient for a surveyor investigating the appropriateness of the transfer to confirm that the individual had an EMC that required the services of a specialist who was on the hospital's on-call list, but was providing the on-call services directly at another CCP hospital. A CCP does not require prior review and approval from CMS before it can be implemented. Furthermore, as with other call plan options (e.g., permitting on-call physicians to perform elective surgery or take simultaneous call at two or more facilities), each hospital must also have a back-up plan when the CCP is not operational. Surveyors who investigate an EMTALA complaint at a hospital that participates in a CCP are expected to determine whether the plan complies with all of the regulatory requirements put forth in §489.24(j)(2)(iii) - as indicated at the end of this summary.

b. Relocation of On-Call List Regulatory Provisions

Previously the requirement for hospitals to maintain an on-call list was located in two separate sections of the regulations: 42 CFR 489.20(r)(2), which articulates Medicare provider agreement requirements, and in 42 CFR 489.24(j)(1), which is specific to EMTALA. However, the statutory requirement for a hospital to maintain an on-call list is found at section 1866 of the Social Security Act (SSA), which governs the Medicare provider agreement, not in section 1867 of the SSA, where the EMTALA provisions are located. Thus, in order to make the regulatory framework consistent with the statutory framework, the requirement at 42 CFR 489.24(j)(1) has been revised to delete language establishing an on-call list requirement and instead cross-reference the requirement at 42 CFR 489.20(r)(2). In addition, the regulation at 42 CFR 489.20(r)(2) has been revised to reflect the addition of a community call plan option and now reads as follows:

An on-call list of physicians who are on the hospital's medical staff, or who have privileges at the hospital, or who are on staff or have privileges at another hospital participating in a formal community call plan in accordance with §489.24(j)(2)(iii), available to provide treatment necessary after the initial examination to stabilize individuals with emergency medical conditions who are receiving services required under §489.24 in accordance with the resources available to the hospital;

This revised regulation contains two notable changes. The first revision is the addition that the on-call list includes physicians who are members of the hospital's medical staff, or who have privileges at the hospital, or who are on the medical staff or have privileges at another hospital participating in a formal community call plan. Thus, if a hospital chooses to participate in a formal EMTALA CCP, CMS expects that the hospital's on-call list will also include physicians at other hospitals participating in the plan who are, pursuant to the plan, on-call to provide specialist services for stabilizing treatment to individuals who present to the initial hospital with emergency medical conditions.

The second change to the relocated regulation replaces previous wording that required hospitals to maintain an on-call list "...in a manner that best meets the needs of the hospital's patients who are receiving services ...[under EMTALA] in accordance with the resources available to the hospital, including the availability of on-call physicians." The deleted language has proven difficult to interpret and

has caused confusion as to its meaning. The revised language more closely tracks the statutory language. Hospitals should not perceive the change in regulatory text as reducing their responsibility to ensure that they are providing adequate specialty on-call coverage consistent with the resources the hospital has available.

2. Emergency Waiver Regulation Technical Changes

The FY 2008 IPPS final rules published in the Federal Register on August 22, 2007 inadvertently omitted regulatory language that was consistent with the statutory language found in section 1135. The FY 2009 IPPS final rules include the corrected regulatory text. However, S&C-08-05, issued December 4, 2007 (and revised December 14, 2007), which discussed circumstances under which EMTALA waivers could be granted during national emergencies, conformed to the statutory requirements pursuant to amendments to section 1135(b) of the Social Security Act. Thus, that guidance is consistent with the FY 2009 rule change.

In light of experience gained in several weather-related disasters in FY 2008, CMS has refined procedures that hospitals must follow when utilizing an EMTALA waiver authorized in accordance with Section 1135. Hospitals must notify their State Agency when activating their disaster plan and utilizing waivers via the process described in the S&C-08-05. The purpose of this notification is to allow CMS to track the numbers and locations of hospitals that utilize the waivers.

3. EMTALA Obligations for Hospitals with Specialized Capabilities

The FY 2009 IPPS Final Rule clarified EMTALA obligations for hospitals with specialized capabilities with the addition of the following language at §489.24(f)(2):

The provisions of this paragraph (f) do not apply to an individual who has been admitted to a referring hospital under the provisions of paragraph (d)(2)(i) of this section.

Thus, once an individual is admitted in good faith to the admitting hospital, the admitting hospital has satisfied its EMTALA obligation with respect to that individual, even if the individual remains unstabilized, **and** a hospital with specialized capabilities does **NOT** have an EMTALA obligation to accept an appropriate transfer of that individual. However, it is important to note that this rule does not apply to individuals who are protected under EMTALA and placed in observation status rather than admitted as inpatients. These individuals are outpatients.

42 CFR §489.24(j)(2)(iii) specifically states the following:

(j) *Availability of on-call physicians.* In accordance with the on-call list requirements specified in §489.20(r)(2), a hospital must have written policies and procedures in place—

(1) 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

(2) To provide that emergency services are available to meet the needs of individuals with emergency medical conditions if a hospital elects to—

(i) Permit on-call physicians to schedule elective surgery during the time that they are on call;

(ii) Permit on-call physicians to have simultaneous on-call duties; and

(iii) Participate in a formal community call plan. Notwithstanding participation in a community call plan, hospitals are still required to perform medical screening examinations on individuals who present seeking treatment and to conduct appropriate transfers. The formal community plan must include the following elements:

(A) A clear delineation of on-call coverage responsibilities; that is, when each hospital participating in the plan is responsible for on-call coverage.

(B) A description of the specific geographic area to which the plan applies.

(C) A signature by an appropriate representative of each hospital participating in the plan.

(D) Assurances that any local and regional EMS system protocol formally includes information on community on-call arrangements.

(E) A statement specifying that even if an individual arrives at a hospital that is not designated as the on-call hospital, that hospital still has an obligation under §489.24 to provide a medical screening examination and stabilizing treatment within its capability, and that hospitals participating in the community call plan must abide by the regulations under §489.24 governing appropriate transfers.

(F) An annual assessment of the community call plan by the participating hospitals.

If you have any questions, please do not hesitate to contact Cliff Beyler at 317-977-1441 or cbeyler@hallrender.com.

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