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Details for Title: Emergency Medical Treatment and Labor Act (EMTALA) Requirements & Conflicting Payor Requirements or Collection Practices

Title	Emergency Medical Treatment and Labor Act (EMTALA) Requirements & Conflicting Payor Requirements or Collection Practices
Memo #	14-06-Hospitals /CAHs
Posting Date	2013-12-13
Fiscal Year	2014
Summary	<ul style="list-style-type: none"> • EMTALA & Payor Requirements: Some proposed or existing payment policies of third party payors of hospital services have generated confusion among providers about their EMTALA obligations. The Centers for Medicare & Medicaid Services (CMS) is clarifying for Medicare-participating hospitals and critical access hospitals (CAH) that they are required to comply with EMTALA, regardless of any conflicting requirements of third-party payors, including when those payors are State Medicaid programs. • Certain Hospital Collection Practices May Also Conflict with EMTALA: It is not acceptable for a hospital or CAH to request immediate payment, by cash or other methods, for services provided to an individual who is protected under EMTALA prior to the receipt of such services. A hospital may only request on-the-spot payment after it has conducted an appropriate medical screening examination (MSE) and, if applicable, stabilized an individual's emergency medical condition (EMC) or admitted the individual. Hospital patients are further protected under the patient's rights Condition of Participation at 42 CFR 482.13(c)(3), which protects patients from abuse or harassment. • Provisions of the Affordable Care Act May Mitigate Future Problems: The Affordable Care Act contains provisions requiring certain insurance issuers to cover emergency services, including stabilization, without preauthorization.

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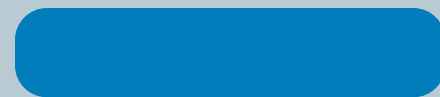


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Center for Clinical Standards and Quality /Survey & Certification Group

Ref: S&C: 14-06-Hospitals /CAHs

DATE: December 13, 2013

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Emergency Medical Treatment and Labor Act (EMTALA) Requirements &
Conflicting Payor Requirements or Collection Practices

Memorandum Summary

- ***EMTALA & Payor Requirements:*** Some proposed or existing payment policies of third party payors of hospital services have generated confusion among providers about their EMTALA obligations. The Centers for Medicare & Medicaid Services (CMS) is clarifying for Medicare-participating hospitals and critical access hospitals (CAH) that they are required to comply with EMTALA, regardless of any conflicting requirements of third-party payors, including when those payors are State Medicaid programs.
- ***Certain Hospital Collection Practices May Also Conflict with EMTALA:*** It is not acceptable for a hospital or CAH to request immediate payment, by cash or other methods, for services provided to an individual who is protected under EMTALA prior to the receipt of such services. A hospital may only request on-the-spot payment after it has conducted an appropriate medical screening examination (MSE) and, if applicable, stabilized an individual's emergency medical condition (EMC) or admitted the individual. Hospital patients are further protected under the patient's rights Condition of Participation at 42 CFR 482.13(c)(3), which protects patients from abuse or harassment.
- ***Provisions of the Affordable Care Act May Mitigate Future Problems:*** The Affordable Care Act contains provisions requiring certain insurance issuers to cover emergency services, including stabilization, without preauthorization.

Background

CMS has received questions from providers that suggest third-party health services payors may be proposing or establishing payment-related policies and procedures that could, if adhered to by Medicare-participating hospitals and CAHs, place those facilities and their physicians at risk for noncompliance with EMTALA. Providers submitting questions to CMS have expressed

confusion about whether a third party payor's policies might alter EMTALA compliance requirements, or have asked CMS to intervene where they believe a proposed Medicaid policy would create conflicts with EMTALA.

It is important for all parties to understand that, regardless of the individual's payment method and/or the ability to pay, a Medicare-participating hospital or CAH must provide the services required under EMTALA, in accordance with 42 CFR 489.20, subsections l, m, q, and r, and 42 CFR 489.24. Furthermore, in the case of Medicaid payor proposals, it is important to be aware that not every proposal under discussion in a State ends up being formally included as an amendment to its State Medicaid plan. Furthermore, CMS will only approve revisions to State Medicaid plans that adhere to applicable Federal regulations, including those governing provision of emergency services. When CMS becomes aware of existing or proposed State Medicaid policies or practices that would create conflict with Federal Medicaid or EMTALA requirements, it takes action to resolve the conflict.

Additional Protections Under The Affordable Care Act

Section 1001 of the Affordable Care Act created a new Section 2719A in the Public Health Service Act (PHSA) that provides for fair practices of private health insurance plans and generally states that if a health insurer offers benefits with respect to emergency services, the following are required:

- There may be no requirement for preauthorization of services even if the emergency services are provided on an out-of-network basis;
- There cannot be administrative requirements or limitations imposed on emergency services provided on an out-of-network basis that are stricter than those imposed on in-network emergency services; and
- The amount of cost sharing expressed as a co-payment amount or a co-insurance rate for out-of-network emergency services cannot exceed the amounts imposed on in-network emergency services.

Thus, the Affordable Care Act adopted protections for individuals to ensure that they receive appropriate emergency care without concerns of undue payment hardship. Note that the definitions of "emergency medical condition" and "emergency services" in Section 2719A(b)(2) of the PHSA specifically reference EMTALA provisions at Section 1867 of the Act.

These Affordable Care Act requirements apply to non-grandfathered employer group health plans (both insured and self-insured) and to non-grandfathered health insurance issuers in the group and individual markets. These requirements, however, do not apply to Medicare and Medicaid fee-for-service or managed care plans.

Third Party Payor Policies or Practices Raised by Providers & Pertinent EMTALA Requirements

The following are examples of reported existing or proposed practices which, if the hospital or CAH were to adhere to them, could place them at risk of violating EMTALA. (Throughout this memo, when we use the term “hospital,” it also includes CAHs for EMTALA purposes, unless expressly stated otherwise.):

1. Payors requiring prior authorization before a hospital initiates stabilizing treatment, or initiates or accepts an appropriate transfer of an individual protected under EMTALA who has been determined, on the basis of an appropriate MSE, to have an EMC requiring stabilization.
 - 42 CFR 489.24(d)(4) prohibits a hospital from seeking, or directing an individual to seek, insurer authorization for screening or stabilization services until after the hospital has provided the MSE and initiated stabilizing treatment. In light of the Affordable Care Act provisions (see above) that require many insurance issuers to cover emergency services without prior authorization, CMS expects there to be fewer cases in which a hospital may be asked to seek prior authorization.

Further, in accordance with 42 CFR 489.24(f), a hospital with specialized capabilities required by an individual protected under EMTALA must accept an appropriate transfer of that individual, if it has the capacity to do so. Recipient hospitals may not first inquire into the individual’s ability to pay or whether a third-party payor has authorized the transfer or admission.

- It is important to note that under EMTALA the statutory definition of an individual’s EMC being “stabilized” does not necessarily equate to an individual being clinically stable. As defined in the Social Security Act (“the Act”) at §1867(e)(3)(B) (and the regulations at 42 CFR 489.24(b)), the term “stabilized” means, with respect to an EMC, “that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).”

The similarity of the terms “clinically stable” and “stabilized” appears to cause confusion among hospitals, practitioners and other hospital staff. It is not uncommon for practitioners to find that an individual has become “clinically stable,” often understood to mean the normalization of the individual’s vital signs, and then conclude that the hospital’s EMTALA obligation has ended. However, if the EMC has not been stabilized, as that term is defined above, EMTALA continues to apply. For example, a patient diagnosed with appendicitis might have relatively normal vital signs, but is still in need of surgery, and therefore continues to have an EMC that has not been stabilized.

- Furthermore, many practitioners and some third-party payors seem to assume that if an individual can withstand the risk of a transfer, then that means the individual has been stabilized and the hospital's EMTALA obligation has ended. This also is not necessarily the case. This mistaken assumption can be reflected in the commonly used term "stable for transfer." "Stable for transfer" is not a term used in EMTALA, and it is not necessarily equivalent to the term "stabilized," as defined for EMTALA purposes. Use of this term can, therefore, be very misleading.

For example, an "appropriate transfer," as discussed at Section 1867(c) of the Act and in the regulations at 42 CFR 489.24(e), assumes that the:

- Individual has an EMC that has not been stabilized;
- Hospital lacks the capability or capacity to provide stabilizing treatment; and
- Benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks resulting from effecting the transfer.

In such a case, although the individual may be "stable for transfer," he/she nevertheless has an unstabilized EMC, and remains protected under EMTALA before, during and after the transfer. Therefore, it would not be appropriate for a hospital to seek prior authorization for the transfer from a payor before initiating or agreeing to accept the transfer.

2. Payors requiring secondary evaluation and approval of individuals with EMCs by insurer/payor-designated personnel as a condition for inpatient admission or transfer, including designation of transfer destination. 42 CFR 489.24(a)(1) requires that the MSE be performed by individuals determined qualified by hospital bylaws and regulations. If physician specialists are required to complete the MSE or provide stabilizing treatment for an EMC, 42 CFR 489.20(r) requires hospitals to maintain a list of on-call physicians who are on the hospital's medical staff or have privileges. If the hospital lacks the capability or capacity to stabilize an EMC, it must make an appropriate transfer in accordance with 42 CFR 489.24(e).

Anecdotally we have become aware of some third-party payors with policies or proposed policies that seem to assume, incorrectly, that any individual for whom a transfer is being planned has been "stabilized," and thus is no longer protected under EMTALA. As indicated above, this is incorrect, and procedures for a third-party payor to intervene in the transfer decisions regarding an individual protected under EMTALA could, if adhered to by hospitals, place them at risk of violating EMTALA.

In addition to the above practices, there are other payor payment policies that have been under discussion in some States and which appear to have caused confusion among providers about their interaction with EMTALA requirements. Examples include the following:

1. Payor refusal to pay for emergency department (ED) services because the payor views the diagnosis codes on the hospital's bill to the payor as representing conditions that are "non-emergent". In States where such payor practices have been under discussion, some hospitals and physicians have asked if a payor adopts such a policy, would the hospital's and physicians' EMTALA obligations also necessarily change. CMS has advised them that the EMTALA obligations would not change.

In accordance with 42 CFR 489.24(a), the hospital must provide an appropriate MSE for any individual who "comes to the ED." If the individual is determined through the MSE to have an EMC, the hospital must provide stabilizing treatment or an appropriate transfer. The fact that the individual's third-party payor may subsequently deny payment to the hospital or to the physicians involved, does not change the hospital's or physicians' EMTALA obligations.

Further, hospitals must assure that the EMTALA definition is used to determine whether the individual has an EMC. In accordance with the regulations at 42 CFR 489.24(a) (implementing Section 1867(e)(1) of the Act), an EMC is defined as:

"(1) A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in—

- (i) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- (ii) Serious impairment to bodily functions; or
- (iii) Serious dysfunction of any bodily organ or part; or

(2) With respect to a pregnant woman who is having contractions—

- (i) That there is inadequate time to effect a safe transfer to another hospital before delivery; or
- (ii) That transfer may pose a threat to the health or safety of the woman or the unborn child."

2. Payors restricting the number of consults that will be paid for during a hospital encounter/stay, including the use of consults for completing an MSE or providing stabilizing treatment of EMCs. Hospitals must not assume that such a coverage limitation by one or more payors would allow them to limit the services they are required to provide under EMTALA in accordance with 42 CFR 489.24(a).
3. Payors limiting the number of annual visits to the emergency department by a covered individual. Hospitals must not assume that such a coverage limitation means that they can limit the number of times they will provide an individual with an MSE and, if applicable, stabilizing treatment.

Hospital Debt Collection Practices

CMS has learned of instances where hospitals request immediate payment, by cash, check, or credit card, from individuals who are in the ED. Payment demands have been made for the current emergency services being offered to the individual, even though their ED encounter is still in progress, as well as for past hospital services.

The EMTALA regulations at 42 CFR 489.24(a)(1) explicitly require a hospital to provide any individual who comes to the ED a medical screening examination and, if applicable, stabilizing treatment, regardless of the individual's ability to pay. Further, 42 CFR 489.24(d)(4)(i) explicitly prohibits a hospital from delaying examination or treatment in order to inquire about an individual's method of payment or insurance status. However, in the interest of allowing hospitals to continue to engage in reasonable administrative practices that support efficient operations without violating the spirit of EMTALA, the provisions at 42 CFR 489.24(d)(4)(ii) and (iv) also describe permitted exceptions to the general prohibition on inquiring about method of payment or insurance status.

A request to an individual to make immediate payment for services required under EMTALA while such required services are being provided does **not** fall under either of the permitted exceptions, since it is neither a request for insurer authorization of screening and stabilizing treatment that has already been initiated (42 CFR 489.24(d)(4)(ii)), nor is it a component of a reasonable patient registration practice (42 CFR 489.24(d)(4)(iv)).

- Generally, beyond furnishing an insurance card or other evidence of insurance, the individual is not involved in the processing of a request for insurance authorization, nor is the individual's stabilizing treatment disrupted when the hospital makes such a request to the insurer. Further, a request for insurer authorization is not a demand for immediate payment by the insurer. Accordingly, the regulation at 42 CFR 489.24(d)(4)(ii) permits such requests for insurer authorization to be made, but only after stabilizing treatment has been initiated, in order to assure that the request does not delay the screening examination and diagnosis of the individual's condition.
- Likewise, hospitals, in accordance with 42 CFR 489.24(d)(4)(iv), are permitted to employ reasonable registration practices that neither delay screening or treatment, nor unduly discourage individuals from remaining for further evaluation. Asking an individual for basic identifying information, emergency contact information, whether he or she is insured and if so by whom, are permitted practices, so long as there is no delay in screening or treatment.
- Under Section 1867(h) of the Act and the regulation at 42 CFR 489.24(d)(4), a hospital is prohibited from delaying appropriate screening or stabilizing treatment to inquire about an individual's method of payment. A request by the hospital for immediate payment by an individual who is protected under EMTALA goes well beyond a mere inquiry about payment method. Furthermore, a request for immediate payment risks creating the appearance that the

hospital is linking provision of services required under EMTALA to the individual's ability to pay, contrary to the requirement at 42 CFR 489.24(a)(1).

- The issue has been raised whether a request for the individual to make a payment is equivalent to a request for insurance authorization, making it therefore permissible under the regulation for a hospital to request payment, so long as the request is timed to occur after stabilizing treatment has been initiated. We see no basis for assuming these requests are equivalent, and thus a hospital's request to an individual for payment is not covered by the regulation governing insurance authorization requests. Moreover, a request for payment could readily be interpreted by an individual protected under EMTALA as conditioning provision of care, or linking the extent of care offered, upon ability to pay, contrary to the requirement at 42 CFR 489.24(a)(1), regardless of the manner in which such request is made and regardless of whether the request is made after stabilizing treatment has been initiated.
- A request for payment carries a very high risk of unduly discouraging individuals, particularly those who lack the ability to pay, from remaining for further evaluation, and thus does not satisfy the reasonable registration process requirements of 42 CFR 489.24(d)(4)(iv).

Once a hospital's EMTALA obligations to an individual have ended, i.e., the individual has been screened and determined not to have an EMC, or the individual's EMC has been stabilized, or the individual with an unstabilized EMC has been admitted in good faith as an inpatient for stabilizing treatment, hospitals may make payment requests. In the case of a hospital (but not a CAH), the manner of the payment request must be consistent with the patient's right under the hospital Conditions of Participation at 42 CFR §482.13(c)(3) to be free from all forms of abuse or harassment.

Detailed guidance regarding EMTALA requirements can be found in Appendix V of the CMS State Operations Manual (SOM) at the following location: http://cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

Questions regarding this memo should be sent to: hospitalscg@cms.hhs.gov

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators within 30 days of this memorandum.

/s/

Thomas E. Hamilton

cc: Survey and Certification Regional Office Management