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CMS releases revisions to EMTALA

The Centers for Medicare & Medicaid Services (CMS), on September 9, formally issued a final rule modifying the Emergency Medical Treatment and Labor Act (EMTALA), frequently referred to as the “patient anti-dumping statute.” EMTALA requires hospitals to provide medical screening, treatment, and stabilization for patients who present to a hospital emergency department seeking treatment for an emergency medical condition.

The final rule, effective November 10, 2003, reflects most of the changes previously proposed by the College and clarifies the obligations for physician and hospital on-call coverage. Major provisions include the following:

- A hospital must maintain its on-call list in a manner that best meets the needs of patients who are receiving services required under EMTALA in accordance with the capability of the hospital. This revision explicitly acknowledges the limits on availability of on-call staff in many specialties and geographic areas.

- Medicare does not set requirements on how frequently a hospital’s on-call physician staff are expected to be available to provide coverage. Such determinations are to be made by the hospital and the physicians on its on-call roster.

- There is no predetermined “ratio” used to identify how many days a hospital must provide medical staff for a particular specialty. In particular, EMTALA does not require that a hospital provide 24/7/365 coverage whenever there are at least three physicians in a specialty.

- A hospital may permit simultaneous on-call services at different hospitals and the scheduling of elective surgery by on-call physicians, but must have policies in place to follow when a specialist is unavailable.

Other provisions of the final rule that may interest surgeons include:

- A patient who requests treatment, without specifying that the condition is not an emergency, need only receive the appropriate screening to determine whether he or she has an urgent condition.

- Prior authorization may be sought from an insurance company, as long as the process does not delay screening and stabilization services.

- EMTALA does not extend to a patient who has been admitted as an inpatient subsequent to being seen in the emergency room or who has begun to receive outpatient services as a part of another nonemergency encounter.

- A dedicated emergency department is defined as any department on or off the main hospital campus that is licensed by the state, is presented to the public as providing emergency care, or had provided at least one-third of its outpatient treatment on an urgent basis during the previous year.

A copy of the final EMTALA rule may be found at <http://www.cms.gov/physicians/default.asp>, and the text of the rule can be obtained at <http://a257.g.akamaitech.net/7/257/2422/14mar20010800/ed>.

Medicare announces 2004 fee schedule proposals

In early August, CMS announced proposed changes in the Medicare physician fee schedule. Days later, the agency provided comprehensive proposals for modifying the payment of drugs administered in a physician's office. Although drugs are not covered by the fee schedule, some of the provisions in the drug proposal would affect it. The proposed rules provided no new information on the annual physician payment update factor, estimated in March 2003 to be -4.2 percent.

Major proposed changes in the fee schedule include:

- Adoption of all the recommendations made by the Practice Expense Advisory Committee (PEAC) in the practice expense portion of the fee schedule. Approximately 650 surgical procedures were reviewed by the PEAC, and the practice expense inputs suggested will produce relative value units that are generally lower than the old charge-based practice expense values.

- Revision of the malpractice geographic practice cost index (GPCI) this year and the remaining GPCIs (for work and practice expense) next year. GPCIs are applied to the national relative values to bring payments in line with the local cost of practice. The malpractice GPCIs, which are of special interest to surgeons, will be recalculated later this summer when new malpractice data are available.

- Use of more recent data for the consumer price index-urban in the computation of the Medicare Economic Index.

- Revision of the payments for removing benign and malignant skin lesions so the same payment is made for benign and malignant skin lesions of the same size and anatomic location.

- A survey taken by the American Society of Clinical Oncology (ASCO) showed that drug administration practice expenses were undervalued. If a drug pricing proposal (see below) is adopted, CMS proposes to use the ASCO survey data instead of the data from the American Medical Association's Socioeconomic Monitoring System (SMS) in the calculation of practice expense. In the past, CMS had used data from a survey done by the Society of Thoracic Surgeons but had blended it with the SMS data. They are now proposing to remove the blend from the data, giving the thoracic surgeons a small, unexpected increase in practice expenses.

Medicare currently pays 95 percent of the average wholesale price (AWP) for drugs administered in a physician's office, but physicians are able to obtain drugs at prices substantially lower than the AWP. CMS is seeking comments on four alternative methods of paying for drugs: (1) paying the same amount for drugs that carriers pay in their private business; (2) applying a discount from the inflated AWP for 2004 and establishing more reasonable updates in the future; (3) using existing and new sources of market-based prices; and (4) creating a competitive bidding process for drugs.

The College will submit comments on the fee schedule, which are due on October 7, and on the drug provisions on October 14. The notices may be accessed at <http://www.cms.hhs.gov>.