

Resolving Conflicts between EMTALA and Managed Care Requirements

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The Emergency Medical Treatment and Active Labor Act (EMTALA) requires a hospital to provide services to persons who come to the emergency department (ED) for emergency treatment without regard for their ability to pay. Yet some managed care plans require that the hospital obtain authorization before rendering emergency medical treatment, with the result that hospitals risk either nonpayment for services or violation of EMTALA. Hospitals can improve their payment rates for ED care by amending or challenging preauthorization requirements and insisting that plans apply a uniform standard of care to treatment of ED patients.

The Emergency Medical Treatment and Active Labor Act (EMTALA) is a Federal law that requires a hospital that offers emergency medical services to treat persons who request it at the hospital's emergency department (ED) if an emergency medical condition exists, regardless of the patient's ability to pay. Treatment must be provided to stabilize the patient at the very least, unless specified conditions authorizing the patient's transfer to another facility are met.^a Some states have similar statutes.^b

EMTALA imposes these requirements on hospitals. It does not require managed care plans to pay for

those services when they are provided to the plan's members. Indeed, EMTALA requirements conflict with some managed care contracts that require the hospital to obtain authorization to provide services to members as a condition of payment. This conflict is aggravated by the fact that EMTALA prohibits hospitals from even inquiring about a patient's ability to pay for emergency services before screening, stabilizing, or other treatment is rendered to the patient.

The conflict between what EMTALA prohibits and what managed care contracts may require was recognized, but not resolved, by a November 1999 Special Advisory Bulletin issued jointly by the HHS Office of Inspector General (OIG) and Centers for Medicare and Medicaid Services (CMS—formerly HCFA).^c In the bulletin, CMS and the OIG acknowledged the untenable position many hospitals are placed in when their managed care contracts and EMTALA requirements conflict. Although the two agencies could not solve this dilemma due to the absence of statutory authority to regulate plans, some limited assistance was offered to providers confronted with this situation.

First, CMS clarified that under EMTALA regulations, hospitals may ask whether the patient requiring emergency services is insured and what the insurance is, as long as treatment is not delayed.^d

Second, CMS modified its earlier interpretation of EMTALA to allow

hospitals, in certain instances, to seek authorization earlier in the treatment process. In the bulletin, CMS eased this restriction by permitting hospitals to seek authorization from managed care plans once stabilization treatment has been initiated.^e

Even with this change in CMS's position, hospitals still are faced with costly claim denials for emergency medical services provided prior to the beginning of stabilization treatment. Also, even though a provider may seek authorization from a managed care plan once stabilization treatment has been initiated, if that authorization is denied, the hospital must continue to provide treatment until the patient is stabilized for transfer or discharge, or until other conditions authorizing transfer are met. Hospitals need to look beyond CMS's regulatory authority to resolve conflicts between EMTALA and their managed care contracts.

Legal versus Contractual Obligations

Providers can take certain actions to resolve this conflict between their legal obligations under EMTALA and their contractual obligations under managed care contracts.

Hospitals should amend or challenge any preauthorization requirement. Hospitals should negotiate amendments to their current and

a. 42 USC § 1395dd; 42 CFR §§ 489.20, 489.24.

b. See, eg, California Health and Safety Code §§ 1317 et seq.

c. OIG/HCFA (now CMS) Special Advisory Bulletin on the Patient Anti-Dumping Statute, *Federal Register*, November 10, 1999, pp. 61353-61359.

d. *Federal Register*, November 10, 1999, p. 61358, col. 3.

e. *Federal Register*, November 10, 1999, p. 61354, cols. 3 and 61358, cols. 2 and 3.

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future contracts that eliminate all preauthorization provisions for services required to be provided under EMTALA. This is a reasonable request, because such provisions could not have been intended to require a hospital to comply with a contractual requirement that would be illegal under state or Federal law.

If the plan is not willing to eliminate the preauthorization requirement, there are other approaches to negotiating a contract amendment or obtaining payment. First, the hospital should not overlook the possibility that state law already makes it illegal for a plan to require preauthorization for emergency services.^f If the state in which the hospital is located does not have such a prohibition, it may be worthwhile for the hospital to join with the state hospital association to take up the issue with the legislature. If the state adopted such a prohibition after the hospital's current managed care contract became effective, the preauthorization requirement may be void under the general provisions present in most managed care contracts that require terms that become void during the course of the contract to be severed, or that automatically amend the contract to conform to changes in the law.

Note also that Medicare and Medicaid managed care plans are prohibited from requiring preauthorization for emergency services, including those that "are needed to evaluate or stabilize an emergency medical

condition," under the Balanced Budget Act of 1997.^g

Even in the absence of a specific legal prohibition, other parts of the state's regulatory structure may implicitly prohibit preauthorization requirements for emergency services. For example, California Health and Safety Code section 1367(h) requires that all contracts between plans and providers "shall be fair, reasonable, and consistent with the objectives of this chapter." This type of general provision might persuade a plan that a preauthorization requirement violates state law because it is unfair and unreasonable. Such a provision also could be used by the state enforcement agency to issue a cease-and-desist order against plans that persist in requiring preauthorization for emergency services. Several states are taking a more active approach to regulating plans. Such general state statutes also might be emphasized during arbitration or litigation to obtain payment for emergency services for which a plan has denied payment on the basis that no preauthorization was requested.

One rule of contract interpretation is that the language of the contract will not be interpreted to result in an absurdity.^h A contract provision that expressly requires preauthorization for services in general could be interpreted as not applying to emergency services in particular because applying the preauthorization requirement to emergency services would have the absurd result of a hospital not being paid for medically necessary services it legally was required to render to the plan's

member. A state's statutory rule of contract interpretation that contracts be reasonable supports this view.

Where the hospital is successful in excluding emergency medical services from preauthorization requirements, the hospital must be careful to articulate clearly the scope of the exclusion. For reasons that have nothing to do with EMTALA, managed care contracts often define the term "emergency services" more narrowly than does EMTALA, which requires the provision of screening, treatment, and stabilization services. If the contract's exclusion of preauthorization requirements for emergency services is not carefully drafted, it may exclude from these requirements a class of services that is narrower than that which a hospital must provide to comply with EMTALA. To protect the hospital, "emergency services" should be defined to include all services required under EMTALA. Alternatively, the exclusion from the preauthorization requirement should define "emergency services" for the purposes of that exclusion to include the services required under EMTALA.

Hospitals should clarify that a uniform standard of care applies to the emergency department. Another conflict between EMTALA and managed care, which is distinct from the issue of preauthorization, is a plan's concurrent or retrospective review of the medical necessity of the emergency services provided or the duration of the emergency status. The bulletin touched upon this issue by addressing dual-staffing arrangements, in which the plan supplies its own medical staff in the ED to manage the emergency cases of its members.

The basic point the bulletin made was that, although dual staffing was not illegal per se under EMTALA, a dual-staffing arrangement could not

f. For example, California Health and Safety Code §1371.4(b) provides "As long as Federal or state law requires that emergency services and care be provided without first questioning the patient's ability to pay, a healthcare service plan shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition."

g. 42 USC §§1395w-22(d) covers emergency services and prior authorization for Medicare enrollees. 42 USC §§1396u-2 covers the same for Medicaid enrollees.

h. See, eg, *Pacific Tel. & Tel. Co. v. City of Lodi*, 58 Cal. App. 2d 888 (1943).

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result in a lesser level of care being given to plan members than to those treated by the hospital's staff.¹ One can infer from this conclusion that the OIG also would disapprove of hospitals applying different standards of care to plan members in an effort to comply with a plan's utilization guidelines for emergency care.

Ironically, this issue is potentially aggravated by the bulletin's change of policy to permit hospitals to seek authorization from plans once stabilization treatment has been initiated. A plan has a legitimate need to be made aware as soon as possible of services that are being provided to

its members, particularly expensive ones such as emergency services. However, CMS's new policy presents an earlier opportunity for the plan to assert its medical management over the patient and increases the risk that a hospital either may violate EMTALA by providing a lower level of care to a plan member or risk nonpayment by applying the hospital's higher standard.

Hospitals should attempt to include contract provisions that identify the hospital and the treating ED physicians as the presumptive determiners of medical necessity and of the length of the emergency condition for services that fall within the scope of EMTALA. The contract should recite the hospital's obligation under Federal

law to provide the same level of emergency care to all patients who request emergency services. It also should provide that claims for all emergency services required to be provided under EMTALA will be paid. ■

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i. *Federal Register*, November 10, 1999, p. 61357, col. 1.

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