HOOPER LUNDY & BOOKMAN, INC.
HEALTH LAW PERSPECTIVES

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CMS Releases Final EMTALA Regulations

The Center for Medicare & Medicaid Services (CMS) has published and made final new regulations for the Emergency Medical Treatment and Active Labor Act (EMTALA) which will become effective November 10, 2003. Response to the new regulations has been mixed. Consumer groups and emergency medicine professionals are concerned that the new regulations will result in delayed access to specialists in emergency cases, and overcrowding at those emergency rooms that regularly offer specialty care. On the other hand, many hospital and physician groups believe the new regulations bring clarification and realistic limits to an otherwise ambiguous law.

Highlights of the new regulations include:

- **Individuals who present to a "Dedicated Emergency Department."** EMTALA obligations apply when a person comes to a "dedicated emergency department" of a hospital and requests examination or treatment for a medical condition. "Dedicated emergency department" means any department or facility of the hospital, whether located on or off campus, that meets at least one of the following requirements: (a) it is licensed to provide emergency services, or (b) it is held out to the public as a place that provides care for emergency medical conditions on an urgent basis without an appointment, or (c) during the preceding calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without appointment. CMS notes that labor and delivery units, psychiatric units, and urgent care centers (even if located off campus) are all likely to fall within one of these categories.
- **Individuals who present elsewhere on "Hospital Property."** EMTALA also applies when individuals present on "hospital property" other than at the dedicated emergency department if a request for emergency medical service is made, or if a prudent layperson observer would believe that the individual needs emergency care.
- **Definition of "Hospital Property" Narrowed.** The 250 yard rule will continue to apply, but now excludes areas or structures of the hospital's main building that are not part of the hospital, such as physician offices, rural health centers, skilled nursing facilities, or other entities that participate separately under Medicare, or restaurants, shops, or other nonmedical facilities.
- **Inpatients**. Once a patient is admitted, EMTALA obligations cease, but CMS will carefully re-

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view the propriety of admissions to determine if patients are being admitted to avoid EMTALA obligations and facilitate a transfer.

- **Non-Emergency Outpatient Services**. EMTALA does not apply to patients that come to a hospital department (other than a dedicated emergency department) for nonemergency services (e.g. imaging) then develop an emergency medical condition. Such circumstances will be covered by the Medicare conditions of participation.

- **Physician On-Call Requirements.** Hospitals need only "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 EMTALA covered services. There is no requirement that particular specialists always be in call, but the hospital must have written policies and procedures to address situations where a particular specialty is not available. Similarly, hospitals must have written policies and procedures to provide for emergency services if the hospital allows its on-call physicians to schedule elective surgeries when they are on call, or allows doctors to take simultaneous call at two or more hospitals.

- **Off-Campus** Departments. EMTALA only applies to off-campus departments that qualify as a "dedicated emergency department." However, hospitals must, as a condition of participation, maintain policies and procedures for the handling of emergencies at off-campus departments.

- **Application to Ambulances.** EMTALA does not apply to hospital-owned air or ground ambulance if (a) the ambulance is operated under community-wide EMS protocols that direct it to transport the individual to a hospital other than the hospital that owns the ambulance, or (b) the ambulance is operated at the direction of a physician who is not employed or otherwise affiliated with the hospital that owns the ambulance.

- **Prior Authorization from Health Insurance.** Hospitals, physicians, and nonphysician practitioners are prohibited from seeking insurance company prior authorization for screening or stabilization services until after the screening has been completed and stabilization treatment has been initiated; however, there can be no delay on stabilization treatment while authorization is sought. This rule does not prohibit a treating physician from seeking information regarding the patient's medical history and needs. Hospitals can ask insurance questions as part of a reasonable registration process so long as the questions do not delay screening and stabilization or "unduly discourage individuals from remaining for further evaluation."

HLB is preparing further analysis and information to assist our affected clients in preparing to comply with the new regulations. Please contact Robert Valencia at (310) 551-8167 or rvalencia@health-law.com if you have any questions.

Sanctioned Provider May Sue DHS for Civil Rights Violations

Hooper, Lundy & Bookman continues to forge new law in the area of provider civil rights with a current case involving a Medi-Cal provider who was the subject of a DHS investigation, withholds and suspension of his Medi-Cal provider privileges (*Maynard v Bonta*, USDC Cent. Calif., No. CV 02-06539, Sept. 3, 2002).

The case involves a physician whose offices were the subject of an unannounced search without warrant by a DHS investigator. The physician was subsequently charged with fraud for allegedly authorizing unnecessary ultrasounds of Medi-Cal patients. During the course of his appeals process, the physician was forced to sell his practice and faced financial ruin.

Finding that DHS lacked sufficient evidence for its sanctions a state court eventually ruled that DHS had not had the grounds to withhold the physician's Medi-Cal payments or suspend his Medi-Cal provider number. Following the court decision, the physician sued DHS in federal district court for violation of his constitutional right to procedural due process, alleging damage to his medical practice and reputation.

After hearing two motions filed by DHS to dismiss the case, a federal district court recently again affirmed the physician's right to sue for deprivation of due process.

"The court's ruling in this case is very important because it sets forth in great detail the constitutional and other legal issues sur-

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Will You Get Paid in October?

A very important deadline is approaching. On October 16, 2003, most providers will be required to bill Medicare electronically *and* all electronic billing will need to use the new transaction codes issued as part of the Health Insurance Portability and Accountability Act (HIPAA) regulations.

The So-Called "Train-Wreck"

The October 16th deadline should not come as a surprise to providers, but what may be surprising is the slow-down in payables that many commentators are predicting. Even if your organization is completely prepared, has implemented the new codes or contracted with an outside service, has tested its electronic billing with all of its payors and has memorized the companion guides issued by private payors, you may still experience a significant lag time between submitting your bills and getting paid. Some predictions are to expect 20% of accounts receivable to go from 30 days aging to 90 days aging. This is what many industry groups are calling an oncoming "train-wreck."

The reasons for the possible delay in payment are two-fold. First, many providers may not be ready for the deadline and may revert to billing in paper format. An informal survey conducted by Blue Cross and Blue Shield Association (BC/BS) in Chicago found that 20%-30% of institutional providers and 30%-40% of professional providers will not be ready. These numbers are significantly lower than the June 2003 Government Accounting Office study that found that 97% of Part B providers expected to be prepared for the transition to electronic billing by October.

Therefore, in order to comply with the law, the providers who do not have the capability to bill in electronic format will have to move to paper. Second, many payors likely are not equipped to handle large volumes of paper claims. Most payors are highly automated and depend on electronic transactions to speed the payment process. Although some states, including California, have "prompt pay" laws that require payors to pay on "clean" claims within a certain number of days, the question remains whether payors will be able to meet these payment deadlines.

What You Can Do

In the face of these problems, there are still some steps that you can take to protect your organization.

- Consider establishing a line of credit now that you can draw on if cash flow becomes a problem.
- Consider hiring a clearinghouse or billing company to conduct the electronic billing for you. Note, however, that you will need to have this contract carefully examined. A few of the many potential pitfalls to look out for are: (a) will the clearinghouse/billing company ensure the transactions are HIPAA compliant?; (b) will the clearinghouse/billing company be responsible for clarifying different interpretations between the payor companion guides and the transaction codes?; and (c) will the clearinghouse/billing company indemnify you for any delays in payment due to its incorrect application of the transaction codes? It is best to contract with a clearinghouse/billing company that has received a "Level 6" certification from a HIPAA certifying agency, such as Edifax or Claredi.
- If you already have a contract with a clearinghouse/billing company, carefully review this contract for the issues mentioned above. It is imperative that this contract protect you from delays in payment that are not your fault.
- Communicate with your payors to determine what their contingency plans are if they are flooded with paper claims.
- Ask your payors for their companion guides, which should describe how to code for services that were previously billed using the local codes that have been eliminated by HIPAA.
- Review your Trading Partner Agreements to determine whether you will have any contractual recourse for payment delays. Consider revising these agreements.

Medicare Exceptions

Your organization may find some relief from the Medicare electronic billing requirements if you fit into one of the very narrow exceptions CMS has created. (Note, though, that if you bill private payors electronically, you will still need to comply with the HIPAA transaction code requirements.)

After October 16, 2003, Medicare is no longer allowed to pay any claims that are submitted in paper, except for the following:

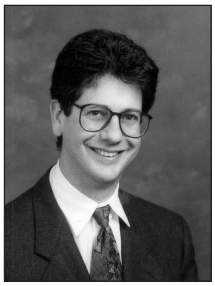
- Claims submitted by a "small" provider of services or small supplier – which means a provider of services with fewer than 25 full-time equivalent employees or a physician, practitioner, facility or supplier (other than a provider of services) with fewer than 10 full-time equivalent employees. The term "provider of services" generally includes hospitals, nursing facilities and other institutional providers that are paid through Medicare fiscal intermediaries.
- Claims submitted where CMS has determined there is no method available for the submission of an electronic claim. CMS has determined that only the following types of claims meet this exception: (a) claims by beneficiaries, (b) claims for roster billing of vaccinations, (c) claims for payment under Medicare demonstration projects, and (d) claims where more than one plan is responsible for payment prior to Medicare.
- Claims submitted where there are "unusual" or "extraordinary" circumstances precluding submission of an electronic claim. CMS has determined that only the following circumstances meet this exception: (a) dental claims and (b) where there is a service interruption in the mode of submitting the electronic claim that is outside the control of the entity submitting the claim, for the period of the interruption.

Unless your organization meets one of these exceptions, you will be required to bill Medicare electronically as of October 16th and the bills will need to comply with the HIPAA transaction code sets.

Note, as this publication went to press, Medicare announced that it has drafted a contingency plan to deal with providers who send non-compliant claims to Medicare. Medicare's contingency plan is to continue to accept and process transactions that are submitted in legacy formats while providers work through issues related to implementing the HIPAA transaction code standards. Thought it had drafted the contingency plan, it had not determined by press time whether it will deploy this contingency plan.

For more information, please contact Elspeth Delaney at (310) 551-8138 or *edelaney@health-law.com.*

Bookman Named Outstanding Hospital Lawyer



HLB founding partner Lloyd Bookman has been recognized as one of 12 Outstanding Hospital Lawyers in the nation by *Nightingale's Healthcare News*.

Mr. Bookman was chosen for his representation of numerous hospitals and healthcare systems. Practicing since 1979, he has handled more than 1,000 Medicare and Medi-Cal payment disputes. His accomplishments include:

- He served as lead counsel in the recently settled case, Orthopaedic Hospital v. Belshe, 103 F.3d 1491 (9th Cir. 1997), a decade-long case which resulted in the single largest Medicaid payout to Medicaid providers.
- He currently serves as lead counsel in the representation of more than 1,300 hospitals across the country in a group of national "outlier" Medicare appeal cases currently before the Ninth Circuit and the Medicare Provider Reimbursement Review Board .
- He served as lead counsel in Alvarado Community Hospital v. Shalala, 155 F.3d 1115 (9th. Cir. 1998) and County of Los Angeles v. Shalala, 192 F.2d 1005 (D.C. Cir. 1999) in which the Ninth and D.C. Circuits held that Medicare outlier payments under the Medicare prospective payment system were unlawfully set in cases involving 320 hospitals.
- He was instrumental in the formation of the Private Essential Access Community Hospital group (PEACH), which represents private disproportionate share hospitals (DSH) and served as general counsel for the group.
- He was recently awarded a Certificate of Distinction by the California Healthcare Association in recognition of his leadership, dedicated service and exceptional contributions to health care.

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rounding the investigation and imposition of sanctions in a typical Medi-Cal sanction case," said Patric Hooper, who represents the physician in this matter.

Mr. Hooper has a similar civil rights case pending in the 9th Circuit, which will likely be argued later this year.

"Our focus on civil rights issues related to Medi-Cal investigations will benefit not only the parties to these existing suits but also other health care providers, since the lawsuits should slow down overzealous enforcement activities and make investigators think twice before treading on providers' constitutional rights," he said.

For more information or to receive a copy of the complaint, please contact Mr. Hooper at (310) 551-8165 or phooper@health-law.com.

Bratcher Named to Commission

HLB Attorney Stacy Bratcher has been appointed to the Los Angeles County Commission on Hospitals and Health Care Delivery Systems. She was appointed to the commission by the Los Angeles County Board of Supervisors following her nomination by Supervisor Zev Yaroslavsky. The mission of the commission is to focus on improving the County hospital and health care delivery system.

Strategies For Success: Hospital Financing and Construction

Hooper, Lundy & Bookman is pleased to present a seminar exploring the latest developments and trends in Hospital Capital Financing.

Attorneys from the firm will be joined by recognized consultants and other professionals in the field to cover key issues in the half-day seminar, including:

- Key state and federal legislative developments
- Investor and Interest rate market trends
- Capital access issues for hospitals
- FHA/HUD 242 Hospital Mortgage Insurance Program
- Recent developments in construction contract models
- Innovative structured finance transactions

The seminar will be held October 14, 2003 at the Ritz Carlton in San Francisco and on October 16 at the Century Plaza Hotel in Los Angeles. Seminar registration begins at 8 a.m. The program will run from 8:30 a.m. to 12:30 p.m. at each location. There is a nominal charge of $50 per participant. To register, please indicate your location preference and mail your check to Strategies for Success Seminar, Hooper, Lundy & Bookman, Inc., 1875 Century Park East, Suite 1600, Los Angeles, CA 90067; or fax your request to Sharon Lee at (310) 551-8181 and follow with a check in the mail. For registration or other information, please contact Ms. Lee at (310) 551-8109 or *slee@health-law.com.*

CALENDAR

October 9 HLB Attorney John Hellow is Distinguished Speaker at St.Louis University, speaking on *Health Care Compliance, Fraud and Abuse*.

November TBA HLB Attorney Elspeth Delaney will speak on *HIPAA Hurdles: Law Practice Management Issues* for the Los Angeles County Bar Association.

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