

commenter believed that allowing such concurrent authorization serves no useful purpose and leaves the hospital open to charges that the steps taken to obtain concurrent authorization actually delay stabilization services. This commenter also recommended that the regulations not allow the concurrent authorization of stabilizing treatment and the furnishing of actual stabilizing treatment.

*Response:* We recognize that the distinction between screening services and stabilizing treatment may be difficult to define outside the context of a specific case. However, we believe clinicians will be able, when dealing with a particular patient or case, to identify clearly when the assessment of an individual has concluded and they have begun stabilizing the patient with an emergency medical condition. We expect that these clinical judgments will be the basis for determining when contact will be appropriate, and that surveyors will use their own clinical training and experience in evaluating clinicians' actions.

Regarding the comment that authorization serves no useful purpose, we note that the regulation merely permits, but does not require, hospitals to seek concurrent authorization with the furnishing of stabilizing treatment. We do not believe it is appropriate to prohibit the practice in all cases and, therefore, are not making any revision to the proposed language, which we are adopting in this final rule, based on this comment.

We would like to clarify again that hospitals that choose to seek concurrent authorization while administering stabilizing treatment must not delay such treatment in order to obtain authorization. Even if the approving insurer or physician denies authorization for the stabilizing treatment, the hospital is *obligated* under EMTALA to provide the necessary stabilizing treatment (if the hospital has such capabilities).

*Comment:* Some commenters stated that restrictions on contact with a patient's insurer are not appropriate because a hospital's administrative staff might not be fully aware of the status of an individual's treatment (that is, whether a screening has occurred and stabilizing treatment has been initiated) and that a hospital might, therefore, violate this requirement inadvertently by requesting authorization prematurely, even though no delay in the screening or stabilization actually occurs.

*Response:* We recognize the possibility pointed out by the commenter, but believe that hospitals

will be able to develop procedures to alert administrative staff as to when contact may be initiated.

### 3. Authorization Requests by Nonphysician Practitioners

*Comment:* Five commenters recommended that we state more specifically that CMS' policies on prior authorization apply to authorization for both hospital and physician (and nonphysician practitioner) services. In addition, the commenters recommended that the regulations be revised to clarify whether EMTALA policies also apply to emergency medical or stabilizing services furnished by nonphysician practitioners.

A number of commenters recommended that the regulations be revised to state that nurse practitioners and all other medical or hospital personnel involved in the individual's treatment, and not just emergency physicians, are permitted to contact the patient's physician for information and advice relevant to the patient's medical history and needs, as long as screening services or stabilizing treatment are not inappropriately delayed.

Another commenter recommended a change in the wording of proposed § 489.24(d)(4)(iii) regarding contacts between emergency physicians and individuals' personal physicians. The commenter believed that the regulations should also allow such contacts with the individual's physician to be initiated by a qualified medical person other than a physician, such as a physician assistant or nurse practitioner.

*Response:* We agree with the commenters that the prior authorization policies apply equally to hospital services, physician services, and nonphysician practitioner services, and are revising § 489.24(d)(4)(ii) to clarify this point. We also agree that qualified medical personnel other than physicians, such as nonphysician practitioners (physician assistants and nurse practitioners), should be permitted to initiate such contacts, and are revising § 489.24(d)(4)(iii) in this final rule accordingly.

*Comment:* A number of commenters recommended that the final rule be revised to state that concurrent contact with an individual's insurer (that is, contact undertaken by administrative staff not involved in patient screening or treatment that occurs while clinical staff continue to screen the individual) is not a violation of EMTALA as long as it does not delay screening or stabilization.

*Response:* We recognize that section 1867(h) of the Act states only that a

hospital may not delay an EMTALA screening or stabilization in order to inquire about the individual's method of payment or insurance status, and does not specifically address the issue of when it is appropriate for contact with the individual's insurer to be made. Hospitals have in the past expressed a need for further guidance on the agency's policy in this area and the Special Advisory Bulletin cited earlier was developed to provide guidance on this and other issues. We do not wish to be overly prescriptive on this issue, but do believe that hospitals should have a clear statement of the agency's policy and that the policy should strike a reasonable balance between the need to avoid creating circumstances in which screening or stabilization will be likely to be delayed and the equally important need to protect the individual from avoidable liability for the costs of emergency health care services. We believe the policy in the Special Advisory Bulletin and reiterated in proposed rule strikes that balance. Therefore, we are not adopting the commenters' suggestion.

Further, we note that many insurers now provide a "window" of at least 24 hours following emergency department treatment during which authorization can be obtained. In addition, many States have enacted revisions to their insurance statutes over the past several years that explicitly contemplate the existence of the Federal EMTALA statute. As a practical matter, we believe this feature of private insurance contracts, as well as State laws governing health insurance contracts, will allow screening and stabilization to go forward without compromising the individual's rights to have care covered under his or her health plan.

### 4. Medical Staff Communications

*Comment:* Two commenters objected to the proposed language under which contact by an emergency physician with the individual's physician is not prohibited as long as the consultation does not inappropriately delay EMTALA-mandated screening or stabilization. One commenter stated that it is never appropriate for regulations to restrict physicians' communications with one another. The other commenter stated that section 1867(h) of the Act governs only contacts for the purpose of insurance information and does not relate in any way to contact with the individual's physician. The commenter believed the proposed language at § 489.24(d)(4)(iii) should be deleted because, in the commenter's view, it implies that some contacts with individuals' physicians might be