

outside the dedicated emergency department, that action is within the hospital's discretion. CMS would look to see what type of capabilities the hospital has in responding to such emergency cases and whether the hospital responded appropriately.

Comment: One commenter believed that having different EMTALA policies based on which door of the hospital the individual enters is fundamentally flawed and exacerbates the confusion about when the EMTALA duty has been met. The commenter requested that we simplify the issue by delineating that EMTALA applies in any case of any individual who comes to the dedicated emergency department and for whom a request for emergency care is made, until that individual is stabilized or admitted.

Another commenter found it confusing to have a separate definition of dedicated emergency department. The commenter stated that it is already well-established and accepted that any individual who arrives anywhere on hospital property, whether it is the emergency department or a sidewalk within 250 yards of the main building and requests care for a emergency medical condition triggers EMTALA obligations for the hospital. Therefore, the commenter added, it is immaterial whether or not an individual presents to a "dedicated emergency department," since arrival anywhere on a hospital campus automatically triggers EMTALA.

Response: As we explain in the discussion above regarding clarification of the definition of "dedicated emergency department," and also in the proposed rule, there has been much confusion on the applicability of EMTALA to individuals who present for emergency care, but do not make it to a hospital's emergency department. We have stated previously that an individual may not be denied emergency services simply because a person failed to actually enter a hospital's emergency department. That is, under certain conditions, an individual does not need to present at a hospital's emergency department in order to be protected by EMTALA.

Thus, in clarifying our policy, it is necessary to address *where* and under what conditions the individual is presenting in order to determine whether EMTALA is triggered. EMTALA is not triggered by a request for physical therapy (that is, for a *medical condition*) at the hospital's on-campus physical therapy department. However, EMTALA would be triggered by that same request inside a hospital's dedicated emergency department, since

the statute clearly states that requests for examination or treatment of "medical conditions" at emergency departments trigger EMTALA. By the same token, request for treatment of a gunshot wound at the on-campus radiology department would also trigger EMTALA, since a gunshot wound is clearly an "emergency medical condition."

We believe that, in making our clarification of "dedicated emergency department," we are assisting in clarifying a hospital's responsibilities under EMTALA to screen and provide necessary stabilizing treatment to an individual who comes to a hospital, presenting either at its dedicated emergency department or elsewhere on hospital property; that is, we are clarifying at what point EMTALA is triggered. The "which door" concept is integral to this analysis. An individual can "come to the emergency department" under the statute creating an EMTALA obligation on the part of the hospital, in one of two ways: The individual can present at a hospital's dedicated emergency department and request examination or treatment for a *medical condition*; or the individual can present elsewhere on hospital property (that is, at a location that is on hospital property but is not part of a dedicated emergency department), and request examination or treatment for an *emergency medical condition*.

D. Provisions of the Final Rule

In summary, in consideration of the comments discussed under this section, in this final rule, we are—

- Adopting as final the proposed definition of hospital property under § 489.24(b) with one clarifying editorial change concerning the language in the proposed definition about excluding other areas or structures that are located within 250 yards of the hospital's main building." We are removing the proposed phrase "located within 250 yards of the hospital's main building" because the phrase is duplicative of the language in the definition of "us" at § 413.65(b). "Campus" includes the 250 yards concept in its definition; therefore, by referencing § 413.65(b) in the definition of "hospital property" under EMTALA, we are already including the concept of 250 yards.

- Adopting as final the proposed definition of patient under § 489.24(b), with a modification to reflect the nonapplicability of EMTALA to an individual who has begun to receive outpatient services at an encounter at the hospital other than an encounter that the hospital is obligated by EMTALA to provide.

IX. Scope of EMTALA Applicability to Hospital Inpatients (§ 489.24(d)(2))

A. Background and Provisions of the Proposed Rule

While most issues regarding EMTALA arise in connection with ambulatory patients, questions have occasionally been raised about whether EMTALA applies to inpatients. In late 1998, the United States Supreme Court considered a case (*Roberts v. Galen of Virginia*, 525 U.S. 249 (1999)) that involved, in part, the question of whether EMTALA applies to inpatients in a hospital. In the context of that case, the United States Solicitor General advised the Supreme Court that the Department of Health and Human Services (DHHS) would develop a regulation clarifying its position on that issue. After reviewing the issue in the light of the EMTALA statute, in the May 9, 2002 proposed rule (67 FR 31475), we proposed that EMTALA would apply to admitted emergency patients until they have been stabilized.

As we noted in the proposed rule, once a hospital has incurred an EMTALA obligation with respect to an individual, that obligation continues while the individual remains at the hospital, so that any transfer to another medical facility or discharge of the individual must be in compliance with the rules restricting transfer until the individual is stabilized under existing § 489.24(d). In these cases, we stated that the hospital continues to be obligated under section 1867 of the Act, irrespective of the inpatient admission, and that an individual's emergency medical condition will be considered to have been stabilized only when the criteria in § 489.24(b) are met. That is, the individual's condition must be such that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during a transfer of the individual from the facility or, if the patient is a pregnant woman who is having contractions, that the woman has delivered the child and the placenta. We believed that such a policy would provide protections under the statute to those patient populations that are most vulnerable—individuals who are experiencing emergency medical conditions (including women in labor who are admitted to the hospital).

In addition, we proposed to clarify in the proposed rule that an individual who goes in and out of apparent stability with sufficient rapidity or frequency would not be considered "stabilized" within the meaning of § 489.24; transient stability of such an individual does not relieve the hospital