

restaurants or independent medical practices.

We stated that if this proposed change limiting EMTALA applicability to only those on-campus departments of the hospital became final, we believe that if an individual comes to an on-campus provider-based entity or other area or structure on the campus not applicable under the new policy and presents for emergency care, it would be appropriate for the entity to call the emergency medical service if it is incapable of treating the patient, and to furnish whatever assistance it can to the individual while awaiting the arrival of emergency medical service personnel. However, the hospital on whose campus the entity is located would not incur an EMTALA obligation with respect to the individual.

In the May 9, 2002 proposed rule, we solicited comments from providers and other interested parties on the proper or best way to organize hospital resources to react to situations on campus where an individual requires immediate medical attention.

We proposed in § 489.24(b) to revise the definition of "Comes to emergency department" (specifically, under proposed new paragraph (1)) and make conforming changes at § 413.65(g)(1).

In the August 1, 2002 final rule issued following the May 9, 2002 proposed rule (67 FR 50090), we only adopted as final the deletion of the second sentence of the existing § 413.65(g)(1) that address the nonapplicability of EMTALA to provider-based entities. We did not adopt other proposed clarifications concerning application of EMTALA to provider-based departments, on or off the campus, or any other proposals concerning EMTALA.

3. Summary of Public Comments and Departmental Responses

Comment: Several commenters expressed general approval of the proposed clarifications of the definition of "hospital property" for purposes of the EMTALA regulations and stated that the proposals will lead to more precise interpretation of the regulations.

Response: We agree, and are adopting the proposed clarifications as part of this final rule.

Comment: One commenter expressed strong opposition to the proposed clarification under which on-campus provider-based entities would not be subject to EMTALA. The commenter noted that individuals seeking emergency treatment may be severely confused or agitated, so that they would be unable to determine whether a particular area or facility is a dedicated emergency department, and that in

some cases such individuals may also be physically unable to proceed to the dedicated emergency department. The commenter also stated that provider-based departments frequently are located close to the main hospital campus, typically receive higher reimbursement from Medicare by virtue of their provider-based status, and may be indistinguishable, especially to an individual in a crisis situation, from areas at which emergency care is provided. The commenter suggested that, in view of this, it is not unreasonable to expect the provider-based entity to assume responsibility for ensuring that individuals who present with emergency care needs receive screening and stabilization. Therefore, the commenter recommended that we require that provider-based entities either ensure that transfer to a dedicated emergency department occurs safely, or provide screening and stabilization at the entity if it is able safely to do so.

Response: We understand and share the commenter's concern for individuals seeking emergency services who come to provider-based entities for assistance, but note that the legislative provision under which EMTALA responsibilities apply (section 1867 of the Act) is specific to hospitals, and does not extend to nonhospital entities (such as rural health clinics or physician offices), even where those entities may be located adjacent to hospital facilities and owned or operated by hospitals, or both. Therefore, we are not making a revision in this final rule based on this comment.

4. Provisions of the Final Rule

We are adopting, as final with minor editorial changes as explained earlier in this preamble, the proposed revision of "come to the emergency department" and "hospital property" in which hospital property is, in part, defined as "the entire main hospital campus as defined at § 413.65(b) of this chapter, including the parking lot, sidewalk, and driveway, but excluding other areas or structures of the hospital's main building that are not part of the hospital, such as physician offices, RHCs, SNFs, or other entities that participate separately in Medicare, or restaurants, shops, or other nonmedical facilities." This will clarify that on-campus provider-based entities would not be subject to EMTALA.

We are also adopting as final without modification the proposed clarifying change to § 413.65(g)(1).

XI. EMTALA and On-Call Requirements (§ 489.24(j))

A. Background

We have frequently received inquiries concerning the statutory requirement that hospitals maintain an "on-call" list of physicians to provide services to patients who seek care in hospital emergency departments. We believe there are a number of misconceptions in the provider industry concerning these on-call requirements. Therefore, as in the May 9, 2002 proposed rule (67 FR 31478), we are including a section that clarifies what kinds of obligations physicians and hospitals have to provide on-call coverage under EMTALA.

Section 1866(a)(1)(I)(iii) of the Act states, as a requirement for participation in the Medicare program, that hospitals must maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition. If a physician on the list is called by a hospital to provide emergency screening or treatment and either fails or refuses to appear within a reasonable period of time, the hospital and that physician may be in violation of EMTALA as provided for under section 1867(d)(1)(C) of the Act.

The CMS State Operations Manual (SOM) further clarifies a hospital's responsibility for the on-call physician. The SOM (Appendix V, page V-15, Tag A404) states:

- Each hospital has the discretion to maintain the on-call list in a manner to best meet the needs of its patients.
- Physicians, including specialists and subspecialists (for example, neurologists), are not required to be on call at all times. The hospital must have policies and procedures to be followed when a particular specialty is not available or the on-call physician cannot respond because of situations beyond his or her control.

Thus, hospitals are required to maintain a list of physicians on call at any one time, and physicians or hospitals, or both, may be responsible under the EMTALA statute to provide emergency care if a physician who is on the on-call list fails to or refuses to appear within a reasonable period of time. However, Medicare does not set requirements on how frequently a hospital's staff of on-call physicians are expected to be available to provide on-call coverage; that is a determination to be made between the hospital and the physicians on its on-call roster. We are aware that practice demands in treating other patients, conferences, vacations,