THE SULLIVAN GROUP

TSG NEWSLETTER

SAVING LIVES - REDUCING RISK

From The Editor

In this issue we present a very interesting case of perispinal abscess, and review the most recent updates to the EMTALA regulations and Interpretive Guidelines (IGs).

One of my medical partners recently encountered this case of perispinal abscess. He made an outstanding diagnosis given all the facts and circumstances. We present this case because it underscores the problems inherent in making an early diagnosis of this high-risk presentation.

Not to sound like a broken record, but CMS has been at it again. There are new modifications to the August 2008 rules and changes to the Interpretive Guidelines. These are substantive changes. If you are attempting to stay current with EMTALA, this review is a must read. All changes will be incorporated into the TSG EMTALA library in the next few weeks. If you haven't updated on EMTALA in a while, now may be the time to consider it.

Case Presentation

A 60-year-old female presented from the renal dialysis unit to the emergency department (ED) with a complaint of low back pain. She had been treated as an inpatient two weeks prior to this visit for sepsis. During that admission the attending physician assumed that the sepsis was caused by the A-V shunt. Treatment was started as an inpatient and she was discharged with continuing outpatient antibiotic management.

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On arrival to the ED from the dialysis unit, the patient's low back pain was mild to moderate. She stated that she had pain in the low back for four weeks and today it had increased significantly during her dialysis treatment. The patient also complained of some frequency of urination. She was afebrile and her other vital signs were all within normal limits.

The ED physician considered the various causes of low back pain and ordered a lumbosacral film and a urinalysis. Since the patient had renal failure and recent sepsis, the physician also ordered a complete blood count and a metabolic profile. The labs revealed a UTI, a normal white blood cell count, and a normal metabolic profile for a patient with chronic renal failure. The radiograph of the lumbosacral spine revealed mild spondylolisthesis, osteoporosis, and some degenerative joint disease.

The physician initially considered three possible reasons for back pain: 1) a urinary tract infection, 2) degenerative joint disease, and 3) discomfort due to renal dialysis [for some reason patients often develop pain following renal dialysis and wind up in emergency departments]. This physician had recently read the TSG course on "failure to diagnose perispinal abscess" and at some point he considered the diagnosis in his differential. This consideration brought him back to the bedside. He spoke further with the patient about her low back pain and discovered that the onset was four weeks prior and she never had a problem with back pain before this. He then asked about the strength in her legs and her gait. She responded that her legs felt weak.

The patient's internist and urologist were both in house and came to the ED immediately following the physician's evaluation. The emergency physician suggested the possibility of a perispinal abscess and recommended a CT scan. The internist and urologist both disagreed and felt that with no elevation of the white count, no fever, and a recent normal gallium scan, perispinal abscess was unlikely. Nonetheless, they

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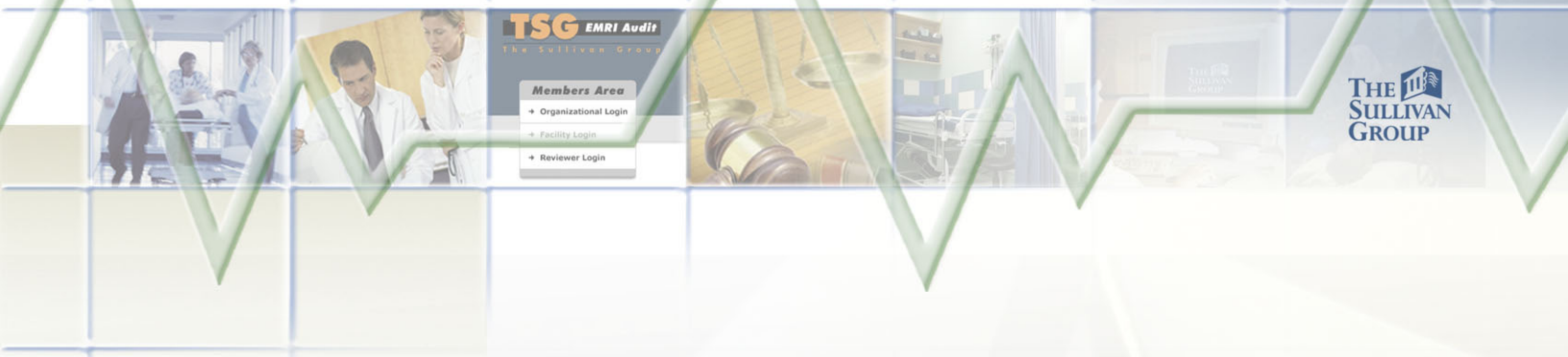

deferred to the emergency physician's judgment. A third discussion with the patient revealed that she had recently developed some difficulty walking.

It turned out the patient was allergic to iodine so the emergency physician ordered an MRI. The patient had an anterior perispinal abscess between T12 and L5. The physician called the internist and urologist who were VERY surprised at the diagnosis. The internist recommended admission to the general inpatient unit. The emergency physician felt that given the diagnosis and the presumed related neurologic deficit, the patient needed a transfer for neurosurgical evaluation. The patient was transferred to a tertiary care hospital and had immediate surgical intervention. She did well.

Discussion

We present this case to emphasize the consideration of perispinal abscess in the appropriate clinical setting. This particular physician is an extremely adept clinician. Still, the case serves as a reminder that this high-risk entity has to be front of mind in order to make it into the differential diagno-

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sis. An informal analysis at the ACEP Medical Directors Academy indicates that emergency physicians are seeing cases of perispinal abscess more often than in the past, perhaps due to the increased incidence of MRSA in the community. The abscess in this case was caused by MRSA.

Patients often present with an onset of back pain that is not explained by any apparent mechanism of injury. In this case, the physician's consideration of the diagnosis took him back to the bedside to elicit additional history. The additional history revealed that the patient had increasing weakness in the legs and problems walking. This history caused the physician to search for a perispinal abscess.

Obviously perispinal abscess is a high-risk presentation, and any delay or failure to diagnose may result in significant morbidity or mortality. The ED physician mentioned that it would have been easy to conclude that the patient's pain was related to the UTI, osteoarthritis, or simply pain associated with renal dialysis. However, there were additional critical clues available.

Fortunately, this physician was listening, and he avoided a catastrophic outcome ■

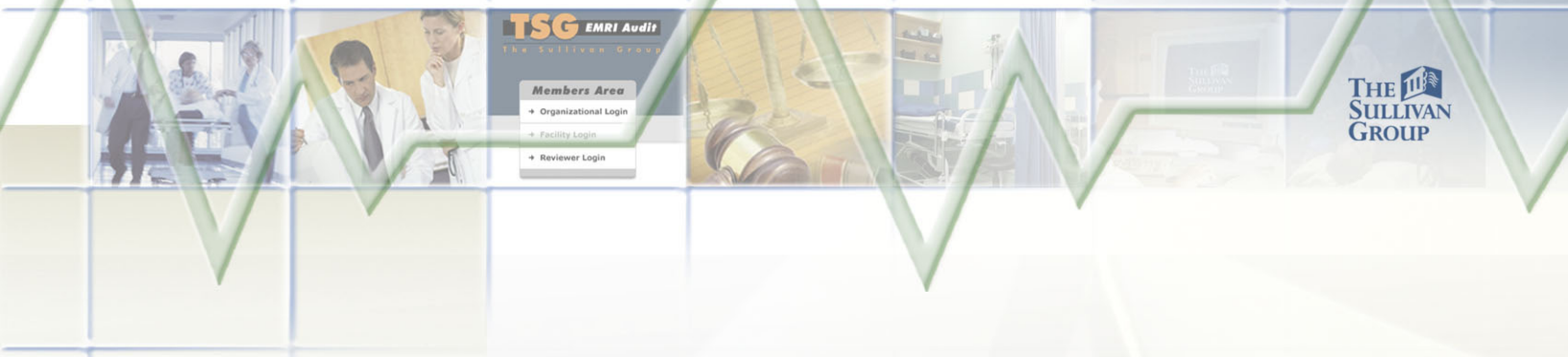
Sepsis Update

It is imperative that practitioners are aware of recent changes in the management of severe sepsis and septic shock. There are significant evidence-based recommendations for a new management paradigm that has a predictable impact on morbidity and mortality. Practitioners, emergency departments and hospital organizations should be proactive, evaluate the research, and implement Early Goal Directed Therapy (EGDT) or early aggressive management of severe sepsis and septic shock. For some hospitals this may require transfer relationships with more sophisticated medical centers.

TSG recently updated the Sepsis: Medical Error & Risk Reduction course to include an overview and recommendations related to the current understanding of this high-risk presentation.

EMTALA Update

Based on the Technical Advisory Group's (TAG) recommendations and other considerations, in April 2008 CMS published new proposed regulations in the Federal Register and final regulations in August 2008. On March 6, 2009, CMS published a set of



"Final Rule Revisions" and updated the Interpretive Guidelines. The revisions address: 1) On-Call Obligations with a focus on Community Call (CCP) Plans, 2) Emergency Waivers for national emergencies, and 3) Recipient Hospital Responsibilities for admitted patients. All of the related documents are available for your review at www.thesullivangroup.com under the "Products & Services" and "EMTALA Resources" tabs. This issue contains a brief summary of the final rule changes and updates to the Interpretive Guidelines. There is an extensive review of the 2008 final regulations in the Summer 2008 TSG Newsletter. This issue will address only the most recent revisions.

On-Call Obligations Under The Community Call Plan (CCP)

Hospitals are required to maintain an on-call list. CMS has revised the new regulations and Interpretive Guidelines so that the on-call list must now include the names of physicians participating on call through a Community Call Plan. Obviously if your hospital does not participate in a CCP, this issue is not relevant to you.

The second change to the on-call-related regulations is a deletion of language which has proven difficult to interpret and caused much confusion. The deleted language required hospitals to maintain an on-call list "in a manner that best meets the needs of the hospital's patients who are receiving services … in accordance with the resources available to the hospital, including the availability of on-call physicians."

CMS points out that this deletion does not reduce the hospital's responsibility to ensure that it is providing adequate specialty on-call coverage consistent with the resources the hospital has available.

Important: *The fact that a hospital may participate in a community call plan does not relieve it of its obligation to perform medical screening examinations and stabilizing treatment within its capability.*

The hospital must have written policies and procedures in place to respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control.

If your hospital participates in a CCP, the new regulations and Interpretive Guidelines provide a list of requirements. To review the

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1. **Patient Safety and Risk Reduction: A New Paradigm**
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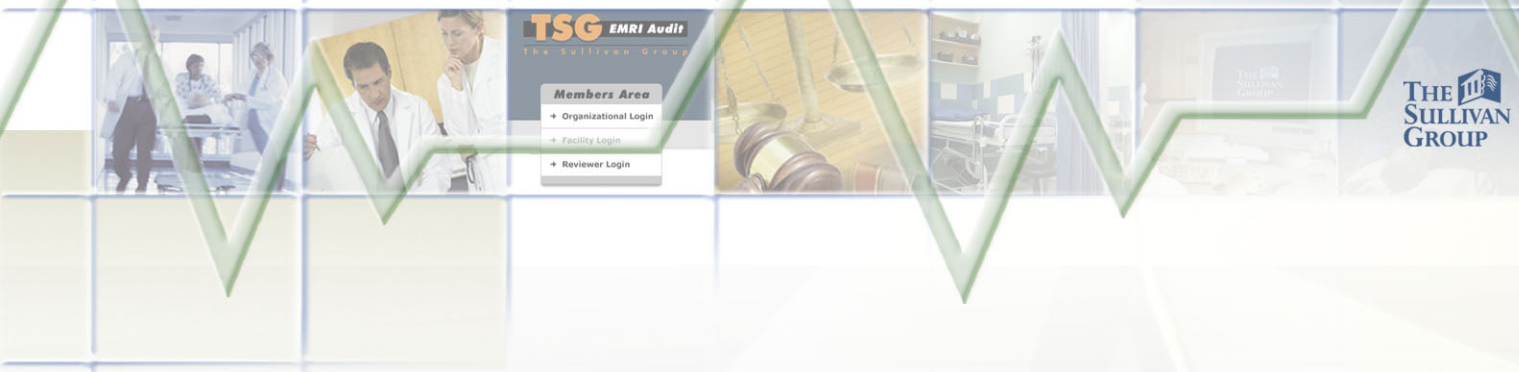
1. **The Good, the Bad and the Ugly**
   Tues., Oct. 6 @ 8:00 am
2. **Taking the Stand - Real Medical Malpractice Cases**
   Tues., Oct. 6 @ 12:30 p.m.
3. **The James D. Mills, Jr. Memorial Lecture - How Physicians Think: The Cognitive Autopsy**
   Weds., Oct. 7 @ 12:30 p.m.
4. **Keeping Yourself Out of Hot Water**
   Weds., Oct. 7 @ 5:00 p.m.

ASHRM Conference

1. **Medical Malpractice Moot Court**
   Fri., Oct. 23 @ 1:15 p.m.

Physicians' Reciprocal Insurers Annual Risk Mgmt. Conference

1. **Patient Safety and Risk Reduction: A New Paradigm**
   Tues., Nov. 17



full list, go to the TSG web site and review the CMS documents under EMTALA Resources or review the Summer 2008 Newsletter.

CCP example from CMS: "If an individual who comes to a hospital's dedicated ED requires the services of a specialist for stabilizing treatment, and another participating hospital pursuant to the plan has the responsibility for providing that service at that specific time, then a transfer to the hospital with the available on-call specialist would generally be appropriate, assuming all other transfer requirements are met. In most circumstances, it would be sufficient for a surveyor investigating the appropriateness of the transfer to confirm that the individual had a CEMC that required the services of a specialist who was on the hospital's on-call list, but was providing the on-call services directly at another CCP hospital."

Emergency Waiver Regulation Technical Changes

In prior rule making, CMS addressed the need for hospitals to follow community plans during local or national emergencies. There are now some additional technical requirements for EMTALA waivers. Hospital administrators should be familiar with these changes. Clinicians should be aware that EMTALA screening and stabilization requirements may be waived based on local and state disaster or emergency protocols. The EMTALA rule revisions address waivers based on national emergencies.

EMTALA Obligations For Hospitals With Specialized Capabilities

There is a final rule clarification for hospitals with specialized capabilities:

"The provisions of this paragraph (f) do not apply to an individual who has been admitted to a referring hospital under the provisions of paragraph (d)(2)(i) of this section."

Interpretation: Once an individual is admitted in good faith to the admitting hospital, the admitting hospital has satisfied its EMTALA obligation with respect to that individual, even if the individual remains unstabilized, and a hospital with specialized capabilities does NOT have an obligation to accept an appropriate transfer of that individual.

However, it is important to note that this rule does not apply to individuals who are protected under EMTALA and placed in observation status rather than admitted as inpatients. These individuals are outpatients.

Updated Interpretive Guidelines

The March 6th CMS communication includes updates to the Interpretive Guidelines consistent with the changes to the three sections described above. These changes should be read together with the Advanced Copy of the Interpretive Guidelines which can be found on the TSG web site.

The following points contain a summary of the relevant changes and some important reminders regarding what surveyors will be looking for when they show up at your hospital to assess your facility's compliance with EMTALA.

On-Call-Related Issues

1. Your on-call list must be up-to-date, and accurately reflect the current privileges of the physicians on call. Physician group names are not acceptable for identifying the on-call physician. Individual physician names are to be identified on the list with their accurate contact information.
2. "It is crucial … that hospitals are aware of their responsibility to ensure that they are providing sufficient on-call services to meet the needs of their community."
3. In a CCP, on-call physicians do not have to travel to the hospital requiring their services. Patients may be transferred to the hospital providing the services under the plan.

4. The IGs take the explanation a step further. "For example, if an individual requires the services of a neurologist on a date when the neurologist on-call pursuant to the CCP is based at hospital B, and that neurologist is part of hospital A's (the transferring hospital) on-call list, then a transfer to hospital B to obtain the services of the neurologist on-call would be in order, assuming all other transfer requirements have been met." The physician could go to hospital A if he or she chose, but would not be obligated to go to hospital A.
5. The new CCP provisions do not relieve hospitals from accepting appropriate transfers under the "Non-Discrimination" provisions of the statute and regulations.

6. Hospitals must be able to demonstrate back-up procedures when allowing on-call physicians to take "simultaneous call" or allowing surgeons to perform elective surgery when on the on-call schedule.
7. If an emergency physician determines that an on-call physician must be present in the emergency department, the on-call physician is required to respond in person in a reasonable time frame. The IGs recommend that hospitals establish a maximum number of minutes for an on-call physician to respond in person.

EMTALA Obligations Waived

A hospital may transfer or relocate individuals to alternate locations for medical screening pursuant to an appropriate state emergency preparedness plan or, in the case of a public health emergency that involves a pandemic infectious disease, pursuant to state pandemic preparedness plans. EMTALA sanctions will not apply during the emergency period. The waiver of these sanctions is limited to a 72-hour period unless continued due to an ongoing pandemic infectious disease.

Appropriate Transfers

1. If a hospital participates in a CCP, the transferring hospital is required to provide stabilizing treatment within its on-site capability and capacity. In addition, all other typical EMTALA transfer requirements must be met.
2. A Medicare-participating hospital that has specialized capabilities or facilities may not refuse to accept an appropriate transfer from another hospital of an individual with an unstabilized emergency medical condition who is protected under EMTALA and requires such specialized capabilities or facilities.
3. This assumes that the recipient hospital has the capacity to treat the individual, and the referring hospital lacks that capability or capacity.

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4. This requirement to accept an appropriate transfer applies even if the receiving hospital does not have a dedicated emergency department.
5. The recipient hospital's EMTALA obligations do not extend to individuals who are inpatients of another hospital. Thus, a hospital may not be cited for violating EMTALA if it refuses to accept the transfer of an inpatient from the referring hospital.
6. Inpatient means an individual admitted for bed occupancy for purposes of receiving inpatient hospital services, and that he or she will remain at least overnight. This does not include patients in observation status even if they remain in a bed overnight. CMS considers these individuals to be outpatients.
7. Important new Interpretive Guideline. Hospitals that request transfers must recognize that the appropriate transfer of individuals with unstabilized emergency medical conditions who require specialized services should not routinely be made over great distances, bypassing closer hospitals with the needed capability and capacity.

Editor's Note: This is a major issue with many "receiving hospitals" who complain that transferring hospitals are bypassing several "closer hospitals" with similar specialized services. This statement regarding bypassing closer hospitals is included only in the Interpretive Guidelines, not in the regulations. Therefore, interpretation and enforcement will be up to local state agencies and several CMS regions. This does provide some basis for "receiving hospitals" working under the strain of large numbers of transfers to raise this important issue to protect themselves from inappropriate patient dumping. If this is relevant to your situation, work with local counsel to address this critical issue ■

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