THE SULLIVAN GROUP

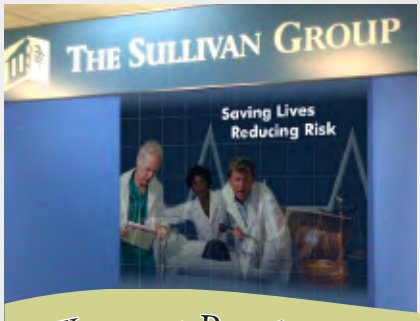
TSG NEWSLETTER

SAVING LIVES - REDUCING RISK

From The Editor

CMS has been very busy on the EMTALA front. There is much to report with recent changes in both the Interpretive Guidelines and the Federal Regulations. This newsletter provides a summary of the recent changes. In general, TSG has attempted to shorten the Quarterly Newsletter. However, in this case it is important for readers to be aware of all the EMTALA changes so it is a bit long.

If you have not taken a TSG EMTALA course in a while, it may be time for a refresher. We built a two-hour EMTALA Basics course specifically for that purpose.



Finally, if you plan on attending the ACEP Scientific Assembly please stop by and see us.

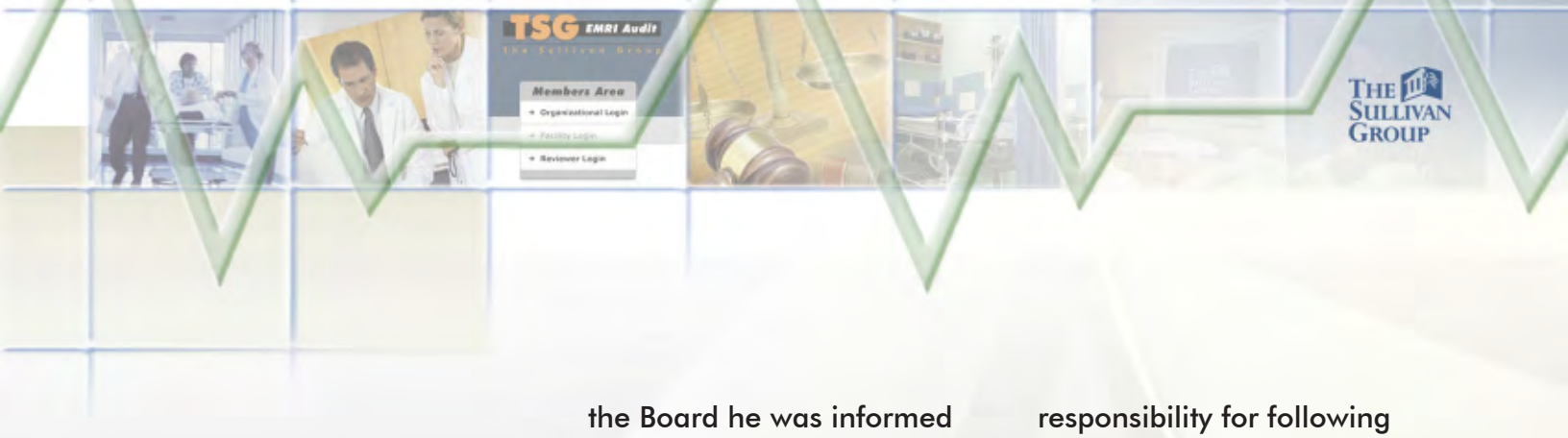
We are at Booth # 620. See you there!

In This Issue...

ED Discharge Instructions Save The Day

TSG recently received a call from a Texas emergency physician with a story demonstrating the impact that a well-written discharge instruction can have in the course of a malpractice or administrative review. This case was referred to and reviewed by the Texas Medical Board. The Board dismissed the case and specifically referred to the content and quality of the discharge instructions as a primary reason.

A 32 year-old female presented to a Texas emergency department with chest pain. She was well-known to the ED staff as a drug seeker. Dr. Smith saw the patient, who requested narcotics for her pain. Dr. Smith recognized that the patient had signs of thyrotoxicosis. She was tachycardic and tachypneic and had other signs



suggesting a thyroid disorder. He ruled out a cardiac etiology for the pain.

Dr. Smith treated the patient with Toradol for pain and a beta-blocker for the thyrotoxicosis. Her vitals were stable and the patient was discharged in good condition. She was not happy with the discharge as she had not received a narcotic as requested. The patient registered a formal complaint with the Texas Medical Board alleging that Dr. Smith had not provided an adequate examination, nor did he provide adequate treatment.

The Board communicated with Dr. Smith, asking him to send in all the relevant patient records, and told him the review would take about six months. Dr. Smith told TSG that he was out of town for two weeks and upon his return he found the case against him had been dismissed. When he contacted the Board he was informed that the Board had dismissed the case based on all the facts and circumstances but, in particular, based on the documentation in the discharge instructions. The outcome saved Dr. Smith a good deal of time, money, and aggravation.

Dr. Smith's ED utilizes an electronic discharge program from Exitcare LLC. The Texas Medical Board found that the discharge instruction on thyrotoxicosis provides an overview and summary of the disorder, clearly indicates that management of this disorder occurs on an outpatient basis, invites the patient to return for any change in condition, designates a time frame for follow-up, and contains a signed agreement of understanding with the patient regarding responsibility for following the instructions. TSG and Exitcare LLC entered a strategic relationship approximately eighteen months ago for two reasons: 1) to keep emergency department patients safe; and 2) to keep our practitioners out of harm's way.

The discharge process is a critical "risk" moment in the patient experience. Properly managed it can have a significant impact on patients' health outcomes and can have a major impact on litigation or administrative actions. TSG reviewed over 500 Exitcare documents, adding additional risk management and patient safety documentation into the Exitcare discharge instruction library. It appears it is having the intended impact!

We appreciate the positive outcome and the feedback from Dr. Smith. Thanks to Dr. Smith and Exitcare LLC for their permission to publish this story ■

EMTALA – What's New?

CMS created a Technical Advisory Group (TAG) in 2003 for the following purpose: 1) to review the EMTALA regulations; 2) to provide advice and recommendations to the Secretary (of CMS) concerning these regulations and their application to hospitals and physicians; 3) to solicit comments from physicians, hospitals and the public regarding the implementation of the regulations; and 4) to disseminate information about the regulations to all interested groups. The TAG met 7 times over a 30-month term that ended in September 2007.

Based on the TAG recommendations and other considerations, in April 2008 CMS published new proposed regulations in the Federal Register and final regulations in August 2008. Both documents are available at www.thesullivangroup.com under the "Products & Services" and "EMTALA Resources" tabs.

After 25 years of EMTALA, most hospitals and physicians understand the medical screening examination and stabilizing treatment issues. Although hospitals continue to violate these provisions periodically, the recent major issue under EMTALA is the transfer of patients to hospitals with specialized capabilities. TSG has special expertise in EMTALA and we provide web-based training and periodically on-site assistance as part of CMS corrective actions. One of our client hospitals recently had to self-report 12 cases of failure to accept transfers in a three-month time frame. The hospital had specialized capabilities but the on-call specialists were refusing transfers. This is a common scenario around the country. Most current EMTALA administrative actions involve transfer issues.

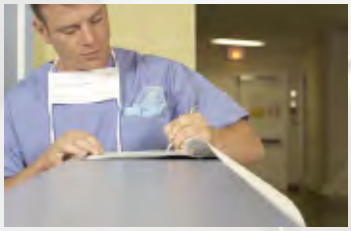
The EMTALA Nondiscrimination Requirement

The relevant section of the EMTALA statute, regulations, and interpretive guidelines is the "Nondiscrimination" provision.

"NONDISCRIMINATION – A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual."

This provision has been interpreted broadly by CMS. The receiving hospital does not need a special unit or service; it simply needs to have more specialized capability than the transferring hospital. For example, if Hospital A does not have a surgeon on call on a particu-

lar day, and Hospital B does, then Hospital B has a specialized capability that is unavailable at Hospital A.



If a patient with right lower quadrant pain presents to Hospital A, and the emergency physician believes the patient may have appendicitis and requires admission and probable surgery, without a surgeon on the on-call schedule, the patient requires transfer. Hospital A may call Hospital B and request a transfer. Under the Nondiscrimination provision Hospital B must accept that patient since it has the specialized capability of a surgeon on call.

As on-call physicians continue to drop off the on-call schedules around the country, the number of transfers to hospitals with specialized capabilities has increased dramatically. This has become a major problem as hospitals with "specialized capabilities" are often inundated with transfer requests from other hospitals. Assuming the receiving hospital has the specialized capability and has the capacity to accept the patient, it must do so under EMTALA.

There is relative clarity around this EMTALA requirement transfer issue if a patient is in Hospital A's emergency department and Hospital B has a specialized capability. But what about patients who have been admitted to a hospital and then need a specialized capability that is not available? CMS had not weighed in on this issue until April of this year in their proposed regulations published in the Federal Register.

CMS Reverses Its Position on Applying The Nondiscrimination Patient Transfer Provision to Inpatients!

In April 2008, CMS proposed to amend Sec. 489.24(f) to add a provision that when an individual covered by EMTALA is admitted as an inpatient and remains unstabilized with an emergency medical condition, a receiving hospital with specialized capabilities has an EMTALA obligation to accept that individual, assuming that the transfer of the individual is an appropriate transfer and the participating hospital with specialized capabilities has the capacity to treat the individual. Although this was only a proposed rule, CMS characterized it as a "clarification."

This was a surprise since in 2003 CMS published an EMTALA final rule that established

that EMTALA did not apply to inpatients! This "clarification" generated a flurry of comments from various groups around the country. This was clearly more than a "clarification." It was a major policy change.

The final rule on this issue was published on August 19, 2008 in the Federal Register Volume 73, No. 161, pages 48654-48668. You can review the language on the TSG web site under EMTALA resources "Final Regulations August 2008." The comments and response are very interesting.

The bottom line is that CMS has reversed its position on this "clarification." The Nondiscrimination provision will not apply to inpatients. The relevant language from the final rule follows.

"Finally, as stated previously, due to the concerns that commenters raised, we are not finalizing the proposed policy. Rather, we are finalizing a policy that a hospital with specialized capabilities is not required under EMTALA to accept the transfer of a hospital inpatient. Although we believe that the language of section 1867(g) of the Act can be interpreted as either applying or not applying to inpatients, after reviewing the comments raised by many commenters, we have serious concerns about the impact the proposed policy would have had on patient care and the possibility that it may overburden many hospitals that are currently having difficulties providing sufficient emergency care."

"As stated previously, in this final rule, rather than adopting the proposed regulation language, we are clarifying the EMTALA regulations at § 489.24(f) with respect to hospital inpatients by stating that once an individual is admitted in good faith by 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 EMTALA obligation to accept an appropriate transfer of that individual. We encourage the public to make CMS aware if this interpretation of section 1867(g) of the Act should result in harmful refusals by hospitals with specialized capabilities to accept the transfer of inpatients whose emergency medical condition remains unstabilized, or any other unintended consequences."

Proposed Changes to the EMTALA Physician On-Call Requirements

The EMTALA TAG dedicated a significant portion of its discussion to a hospital's physician on-call obligations under EMTALA and made several recommendations to the Secretary regarding physician on-call requirements.

physician on-call obligations followed by an explanation of their "community call plan" proposal.

The EMTALA Statute and regulations require that a hospital must keep 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 stabilizing 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. Thus, hospitals are required to maintain a list of on-call physicians, and physicians or hospitals, or both, may be held responsible under the EMTALA statute if a physician who is on call fails or refuses to appear within a reasonable period of time. Below is the TAG's analysis of hospitals'

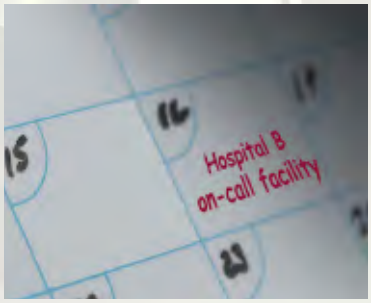
"In the May 9, 2002 proposed rule (67 FR 31471), we (the TAG) stated that we were aware of hospitals' increasing concerns regarding their physician on-call requirements. Specifically, we noted that we were aware of reports of physicians, particularly specialty physicians, severing their relationships with hospitals because of on-call obligations, especially when those physicians belong to more than one hospital medical staff. We further noted that physician attrition from these medical staffs could result in hospitals having no specialty physician service coverage for their patients. In the September 9, 2003 final rule, we clarified the regulations at Sec. 489.24(j) to permit on-call physicians to schedule elective surgery during the time that they are on call and to permit on-call physicians to have simultaneous on-call duties. We also specified that physicians, including specialists and subspecialists, are not required to be on call at all times, and that 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."

"We expected these clarifications would help to improve access to physician services for all hospital patients by permitting hospitals flexibility to determine how best to maximize their available physician resources. Furthermore, we expected that these clarifications would permit hospitals to continue to attract physicians to serve on their medical staffs, thereby continuing to provide services to all patients, including those individuals who are covered by EMTALA."

As part of its recommendations concerning physician on-call requirements, the EMTALA TAG suggested that hospitals be permitted to participate in "community call." Specifically, the language of the recommendation states: "The TAG recommends that CMS clarify its position regarding shared or community call: that such community call arrangements are acceptable if the hospitals involved have formal agreements recognized in their policies and procedures, as well as backup plans. It should also be clarified that a community call arrangement does not remove a hospital's obligation to perform an MSE."

The TAG also recommended that "a hospital may satisfy its on-call coverage obligation by participation in an approved community/ regional call coverage program (CMS to determine appropriate approval process)."

"We (the TAG) believe that community call (as described below) would afford additional flexibility to hospitals providing on-call services and improve access to specialty physician services for individuals in an emergency department. Therefore, we are proposing to amend our regulations at Sec. 489.24(j) to provide that hospitals may comply with the on-call list re-quirement specified at Sec. 489.20(r)(2) (under our proposed revision), by participating in a formal community call plan so long as the plan meets the elements outlined below. We are further proposing to revise the regulations to state that, notwithstanding participation in a community call plan, hospitals are still required to perform medical screening examinations on individuals who present seeking treatment and to provide for an appropriate transfer when appropriate."



"We propose 'community call,'' to be a formal on-call plan that permits a specific hospital in a region to be designated as the on-call facility for a specific time period, or for a specific service, or both. For example, if there are two hospitals that choose to participate in community call, Hospital A could be designated as the on-call facility for the first 15 days of each month and Hospital B could be designated as the on-call facility for the rest of each month."

"Alternatively, Hospital A could be designated as on-call for cases requiring specialized interventional cardiac care, while Hospital B could be designated as on-call for neurosurgical cases. We anticipate that hospitals and their communities would have the flexibility to develop a plan that reflects their local resources and needs. Such a community on-call plan will allow various physicians in a certain specialty in the aggregate to be on continuous call (24 hours a day, 7 days a week), without putting a continuous call

obligation on any one physician. We note that generally if an individual arrives at a hospital other than the designated on-call facility, is determined to have an unstabilized emergency medical condition, and requires the services of an on-call specialist, the individual would be transferred to the designated on-call facility in accordance with the community call plan."

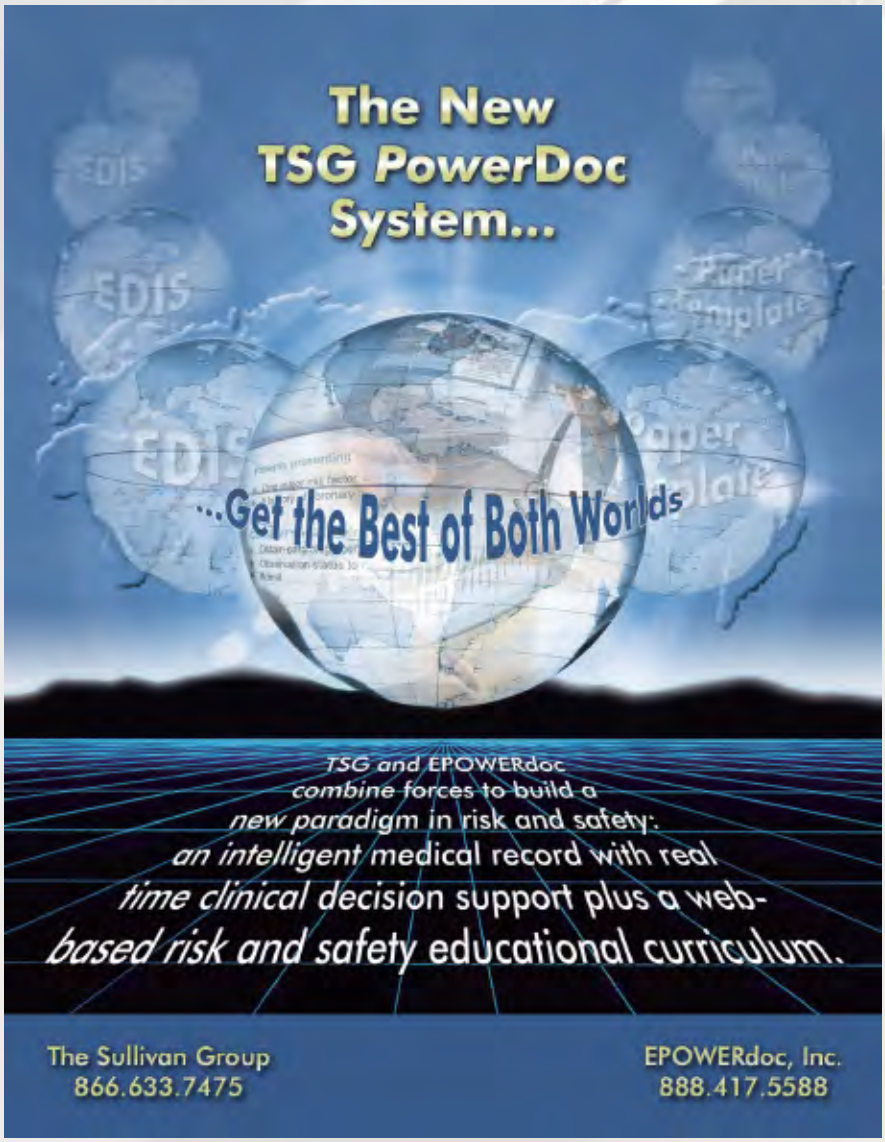
"As noted above, we are proposing that a community call plan must be a formal plan among the participating hospitals. While we do not believe it is necessary for the formal community call plan to be subject to pre-approval by CMS, if an EMTALA complaint investigation is initiated, the plan will be subject to review and enforcement by CMS. We are proposing that, at a minimum, hospitals must include the following elements when devising a formal community call plan:

1. The community call plan would include a clear delineation of on-call coverage responsibilities, that is, when each hospital participating in the plan is responsible for on-call coverage.
2. The community call plan would define the specific geographic area to which the plan applies.
3. The community call plan would be signed by an appropriate representative of each hospital participating in the plan.
4. The community call plan would ensure that any local and regional EMS system protocol formally includes information on community on-call arrangements.
5. Hospitals participating in the community call plan would engage in an analysis of the specialty on-call needs of the community for which the plan is effective.
6. The community call plan would include a statement specifying that even if an individual arrives at the hospital that is not designated as the on-call hospital, that hospital still has an EMTALA obligation to provide a medical screening examination and stabilizing treatment within its capability, and hospitals participating in community call must abide by the EMTALA regulations governing appropriate transfers.
7. There would be an annual reassessment of the community call plan by the participating hospitals."

CMS is still taking public comments on the proposed elements of the formal community call plan. It is also soliciting public comments on whether individuals believe it is important that, in situations where there is a governing

State or local agency that would have authority over the development of a formal community call plan, the plan be approved by that agency.

Introducing a New & Safe Way to Practice



"In summary, we are proposing that, as part of the obligation to have an on-call list, hospitals may choose to participate in community call, provided that the formal community call plan includes, at a minimum, the elements noted in bullets above. Additionally, each hospital participating in the community call plan must have written policies and procedures in place to respond to situations in which the on-call physician is unable to respond due to situations beyond his or her control. We are further proposing that a hospital would still be responsible for performing medical screening examinations on individuals who present to the hospital seeking treatment and conducting appropriate transfers, regardless of which hospital has on-call responsibilities on a particular day."

Other TAG Recommendations

The TAG made over 55 recommendations. Only a few have been implemented by CMS.

Screening Examination and Certification for Women in "False Labor"

The EMTALA TAG, after receiving public comments from representatives of the American College of Nurse-Midwives and the American College of Obstetricians and Gynecologists, recommended that the CMS amend the EMTALA regulations that allowed only physicians to certify that a pregnant woman experiencing contractions is in false labor.

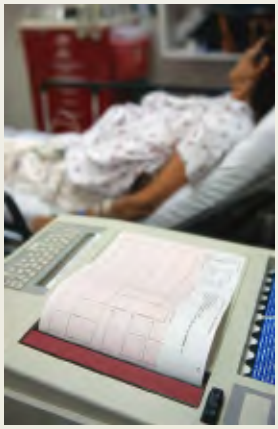
According to the TAG, the regulation precluded certified nurse midwives or other qualified medical personnel (QMP) from performing a task for which they are well trained and competent to perform. Under the prior regulations if a QMP other than a physician (e.g., a Registered Nurse, Physician Assistant etc.) determined that a woman was in false labor, a physician had to certify the diagnosis. CMS has now changed the regulations through a redefinition of labor.

"§489.24 (b) Labor means the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman experiencing contractions is in true labor unless a physician, certified nurse-midwife, or other qualified medical person acting within his or her scope of practice as defined in hospital medical staff bylaws and State law, certifies that, after a reasonable time of observation, the woman is in false labor."

TSG Comment: This is a welcome change to the regulations and interpretive guidelines. The prior physician certification requirement was onerous and almost impossible to adhere to.

Specialty Hospitals Without Emergency Departments

CMS clarified that hospitals with specialized capabilities (as defined in the EMTALA regulations) that do not have a dedicated emergency department are bound by the same responsibilities under EMTALA as hospitals with specialized capabilities that do have a dedicated emergency department. CMS added language at § 489.24(f) that makes explicit the current policy that all Medicare participating providers with specialized capabilities are required to accept an appropriate transfer if they have the capacity to treat the individual.



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Moving Patients From EMS Gurneys to ED Stretchers

The EMTALA TAG also requested that CMS issue a clarification of the guidance concerning "parking" of individuals transported by emergency medical services (EMS) to hospitals. The memorandum was intended to address the specific concern that some hospital Emergency Department staff may deliberately delay the transfer of individuals from the EMS provider's stretcher to an ED bed under the mistaken impression that the ED staff is thereby relieved of their EMTALA obligation.

However, it was reported to the TAG by hospital representatives that some EMS organizations have cited this memorandum as requiring hospitals to take instant custody of all individuals presenting via EMS transport at the hospital's dedicated emergency department.

The memorandum was intended to reinforce that the EMTALA responsibility of a hospital with a dedicated ED begins when an individual arrives on hospital property (ambulance arrival) and not when the hospital "accepts" the individual from the gurney. An individual is considered to have "presented" to a hospital when he/she arrives at the hospital's dedicated ED or on hospital property and a request is made by the individual or on his/her behalf for examination or treatment of an emergency medical condition.

The following language has become EMTALA regulation and has been incorporated into the Interpretive Guidelines.

"Hospitals that deliberately delay moving an individual from an EMS stretcher to an emergency department bed do not thereby delay the point in time at which their EMTALA obligation begins. Furthermore, such a practice of "parking" patients arriving via EMS, refusing to release EMS equipment or personnel, jeopardizes patient health and adversely impacts the ability of the EMS personnel to provide emergency response services to the rest of the community. Hospitals that "park" patients may also find themselves in violation of 42 CFR 482.55, the Hospital Condition of Participation for Emergency Services, which requires that hospitals meet the emergency needs of patients in accordance with acceptable standards of practice."

"On the other hand, this does not mean that a hospital will necessarily have violated EMTALA and/or the hospital CoPs if it does not, in every instance, immediately assume from the EMS provider all responsibility for the individual, regardless of any other circumstances in the ED. For example, there may be situations when a hospital does not have the capacity or capability at the time of the individual's

presentation to provide an immediate medical screening examination (MSE) and, if needed, stabilizing treatment or an appropriate transfer. So, if the EMS provider brought an individual to the dedicated ED at a time when ED staff was occupied dealing with multiple major trauma cases, it could under those circumstances be reasonable for the hospital to ask the EMS provider to stay with the individual until such time as there were ED staff available to provide care to that individual. However, even if a hospital cannot immediately complete an appropriate MSE, it must still assess the individual's condition upon arrival to ensure that the individual is appropriately prioritized, based on his/her presenting signs and symptoms, to be seen by a physician or other QMP for completion of the MSE. The hospital should also assess whether the EMS provider can appropriately monitor the individual's condition. Hospitals may not condition their acceptance of an Emergency Medical Treatment and Labor Act (EMTALA)- related transfer upon the sending hospital's agreement to use a specific transport service designated by the receiving hospital. S&C-06-21 should not be interpreted to mean that a hospital cannot ever ask Emergency Medical Services (EMS) staff to stay with an individual transported by EMS to the hospital when the hospital does not have capacity or capability to immediately assume full responsibility for the individual."

Receiving Hospital Refusal Based on Method of Transport - Unacceptable

The EMTALA TAG received testimony indicating that instances have occurred where a hospital has refused to accept an appropriate transfer of an individual with an emergency medical condition unless the sending hospital used an air medical service owned by the receiving hospital for the transfer. The TAG recommended that CMS issue guidance on this matter. CMS regulations now include a provision that it is a violation of the EMTALA requirements for a receiving hospital to condition its acceptance of an appropriate transfer of an individual with an emergency medical condition upon the sending hospital's use of a particular transport service to accomplish the transfer. Specifically, 42 CFR 489.24 (f) reads in pertinent part as follows:

"Recipient hospital responsibilities. A participating hospital that has specialized capabilities… may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual."

"If in the course of an EMTALA investigation there is evidence that a hospital with specialized capabilities or facilities and the necessary capacity to treat an individual with an emergency medical condition conditioned, or attempted to condition, its acceptance of an appropriate transfer of the individual on the use by the sending hospital of a particular transport service instead of the transport arrangements made by the attending physician at the sending hospital, then the receiving hospital is to be cited for violation of EMTALA Tag A411."

TSG Comment: Bad facts make bad law. The receiving hospitals that demanded that sending hospitals use their helicopters caused this issue to be regulated. Thanks a lot to the hospital control freaks. This regulation, while it may be necessary to keep bad actors in line, will give rise to a host of questions regarding legitimate requests for certain types of transport from hospitals that truly have the patients' safety in mind. Irrespective of this regulation, when in doubt about requesting a higher level of transport vs. complying with this regulation, do the right thing from a medical perspective, and deal with the EMTALA consequences later.

On-Call Physician and Telemedicine / Telehealth

It has been brought to the attention of CMS that the interpretative guidelines for 42 CFR 489.20(r) and §489.24(j), concerning hospital/Critical Access Hospital (CAH) on- call physician requirements under - EMTALA, are being interpreted by some parties as prohibiting emergency department physicians from utilizing modern telecommunications to facilitate consultation with specialists who are not present in the hospital/CAH. There is no such prohibition under EMTALA.

It is necessary to distinguish among:

- a hospital's/CAH's obligation under EMTALA to maintain an on-call list of physicians on its medical staff in a manner that best meets the needs of its patients;
- the obligation of an on-call physician to make an in-person appearance when requested to do so by the physician who is treating an individual who has come to the emergency department of the hospital/CAH; and
- remote consultation on the individual's case by the treating physician with another physician, who may or may not be on the hospital's/CAH's on-call list.

The EMTALA statute and regulations establish requirements regarding hospital/CAH on-call lists and the obligations of on-call physicians to make

in-person appearances. These provisions require hospitals/CAHs to "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." Each hospital/CAH must maintain its on-call list in a manner that best meets the needs of the hospital's patients who receive services required under EMTALA. The resources available to a hospital/CAH, including the availability of on-call physicians, are taken into account when assessing the adequacy of its on-call list.

There is no EMTALA prohibition against the treating physician consulting on a case with another physician, who may or may not be on the hospital's or CAH's on-call list, by telephone, video conferencing, transmission of test results, or any other means of communication. CMS is aware that it is increasingly common for hospitals/CAHs to use telecommunications to exchange imaging studies, laboratory results, EKG's, real-time audio and video images of patients, and/or other clinical information with a consulting physician not on the hospital/CAH premises. Such practices may contribute to improved patient safety and efficiency of care. In some cases it may be understood by the hospitals/CAHs and physicians who establish such remote consulting arrangements that the physician consultant is not available for an in-person assessment of the individual at the treating physician's hospital/CAH.

However, if a physician:

- is on a hospital's or CAH's on-call list; and
- has been requested by the treating physician to appear at the hospital; and
- fails or refuses to appear within a reasonable period of time,

then the on-call physician may be subject to sanctions for violation of the EMTALA statutory requirements. It is only when the treating physician requests an in-person appearance by the on-call physician that a failure by the latter to appear in person may constitute an EMTALA violation.

In summary CMS strikes the language in the Interpretive Guidelines (CMS State Operations Manual, Appendix V) that addresses telehealth/telemedicine (relating to the regulations at §489.24(j)(1)) and replaces it with language that clarifies that the treating physician ultimately determines whether an on-call

physician should come to the emergency department and that the treating physician may use a variety of methods to communicate with the on-call physician. A potential violation occurs only if the treating physician requests that the on-call physician come to the emergency department and the on-call physician refuses.

Recent Changes to the Interpretive Guidelines

There is an advance copy of the new Interpretive Guidelines available on the TSG web site. We provide a summary here but strongly recommend that you download and read the entire document. Although approximately 40 pages long, it is an outstanding resource and overview of the current EMTALA requirements.

1. **Availability of On-Call Physicians.** Section 489.24(j). This change is essentially the On-Call Physician and Telemedicine discussed above. CMS is emphasizing that whether the on-call physician needs to make an appearance in the emergency department is at the discretion of the emergency physician. The section also clarifies that it is fine to utilize modern means of communication such as telemedicine. However, these modern means of communications do not take the place of the on-call physician's presence in the department when required by the emergency physician.

2. **Clarification of Medical Screening Examination, Triage, and EMTALA Required Documentation.** Section 489.24(a). CMS found it necessary to provide further guidance on these issues.
   a. Regarding the MSE, CMS points out that it is not an isolated event. "It is an ongoing process that begins, but typically does not end, with triage." Regarding the MSE, CMS further points out that the MSE can involve a wide spectrum of actions which include the history and physical, but may include lab, imaging, etc.
   b. Regarding triage, CMS points out the obvious, that triage is a clinical assessment of the individual's presenting signs and symptoms at the time of arrival at the hospital, in order to prioritize when the individual will be seen by a physician or other qualified medical personnel (QMP).
   c. Finally CMS requires that the medical record reflect continued monitoring according to the individual's needs until it is determined

whether or not the individual has an EMC.

3. **Definition of Labor.** This has been addressed in the new regulations discussion above. The same new definition has been incorporated into the interpretive guidelines.

4. **EMTALA Applies to Newborns.** The interpretive guidelines contain an important new provision with regard to newborns. There has been some confusion about whether a newborn is a person and if he or she has "come to the hospital" and is thus covered by EMTALA. The IGs indicate that an infant that is born alive is a "person" and an "individual" and the EMTALA medical screening requirement applies. If a request is made for screening on the infant's behalf, or a prudent layperson would conclude that the infant needed examination or treatment for a medical condition, the hospital would violate EMTALA for failure to provide such a medical screening examination. This includes newborns in the emergency department and labor and delivery and there is a provision for newborns elsewhere on the hospital campus. However note that the IGs specifically state "If the hospital admits the infant, its obligation under EMTALA ends." We encourage readers to review this new language in IG section 489.24(a).

5. **Delay Moving Patient from EMS Gurney to Stretcher Space.** The addition to the regulations discussed above has been incorporated into the IGs in section 489.24(a) and section 489.24(e).

6. **EMTALA Waiver.** In section 489(a)(2) the IGs provide for an EMTALA waiver in certain emergency circumstances. Specifically CMS will waive sanctions if patients are relocated before the medical screening examination pursuant to an appropriate State emergency preparedness plan or state pandemic preparedness plan. We strongly encourage a review of this specific language in the new IGs. There are multiple requirements for the waiver to apply, and it applies up to 72 hours "in most cases."

7. **Receiving Hospital Refusal Based on Method of Transport – Unacceptable.** This is the new provision from the regulations discussed above, found in the IGs at section 489.23.

8. **Lateral Transfers.** The IGs contain some new language regarding lateral transfers. A lateral transfer is a transfer from a facility that has a certain resource to another hospital with the same resource. For example Hospital A has a patient with right lower quadrant abdominal pain and a general surgeon on the on-call schedule. Hospital B has a general surgeon on the on-call schedule. The transfer of the patient from Hospital A to Hospital B is deemed a lateral transfer.

In the current IGs, CMS states that such a transfer is not mandated "except where the sending hospital has a serious capacity problem, a mechanical failure of equipment, or similar situations" in section 489.24(e) ■

Summary

If you read this entire newsletter, great staying power!

That was a lot of information. It is important for emergency providers and hospital administration to stay on top of the EMTALA regulations and interpretive guidelines. As always an

ounce of prevention can stop years of litigation and avoid huge legal bills. Time should be spent on patient care, not on defending allegations of wrongdoing under EMTALA. All of these changes will be built into the TSG EMTALA course library. It may be time to get your practitioners up to speed on the new changes. If there is interest in accessing the EMTALA library or any of the TSG Risk and Safety courses call **866-MEDRISK or 630-268-1188.**

Thank you ■

Comments and feedback are always welcome!

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