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New EMTALA Regulations Recently Proposed by CMS

Within days of issuing new site review guidelines, the Centers for Medicare and Medicaid Services (CMS) proposed new regulations pertinent to the Emergency Medical Treatment and Labor Act of 1986 (EMTALA), a frequent topic of past Health Industry Online articles. This issue of HIO will address both of these recent developments in EMTALA.

The recently issued EMTALA regulations were in part recommendations of the EMTALA Technical Advisory Group (TAG), a committee that ceased to exist last year. The changes were proposed in the April 30, 2008 *Federal Register* and are scheduled to go into effect in October 2008. Highlights of the new regulations are as follows:

Physician Call: Currently, under EMTALA, a hospital is required to maintain an "on call" list of physicians on the medical staff that is in accordance with patient needs and resources of the hospital. The new proposal would allow a hospital to meet its on-call obligation by participating in a formal community-wide, on-call system. This would allow hospitals within a given region to create a "community call plan" where a specific hospital is assigned as the "on-call" facility for a set time period, or for a specific service, or both. However, a patient presenting to the "wrong" hospital, i.e., one not on-call for that specialty or that time period, would still be subject to EMTALA requirements and could not be moved to the "on-call hospital" without full EMTALA compliance.

Inpatient applicability of EMTALA: A hospital is considered to have met its EMTALA obligations once an unstable patient has been admitted. However, in certain situations where the level of "specialized" care needs cannot be met at a hospital, the new regulations attempt to clarify that hospitals with specialized capabilities or facilities (such as burn units, shock- trauma units, or neonatal intensive

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care units) have EMTALA obligations to accept the transfer of a patient with an emergency medical condition that remains unstabilized, i.e., they must accept the transfer if the receiving hospital has the capability and the capacity to treat the individual. The new regulations do not address whether patients who are admitted for elective diagnosis or treatment and subsequently become unstable are to be treated similarly, but based upon recommendations of the TAG, it is unlikely that EMTALA would apply to this universe of inpatients.

The new site review guidelines that became effective on March 21, 2008, are updates to the Interpretative Guidelines (IG) originally issued in 2003 and the various updates on the IGs through 2007. Highlights of some of the new site review guidelines are as follows:

Defining MSE: Under IG 489.24(a), the new guidelines specifically define a medical screening examination (MSE). "An MSE is the process required to reach, with reasonable clinical confidence, the point at which it can be determined whether an individual has an EMC [emergency medical condition] or not. An MSE is not an isolated event. It is an ongoing process that begins, but typically does not end, with triage." Importantly, the new guidelines indicate that if a hospital applies a screening process in a nondiscriminatory manner (i.e., a different level of care must not exist based on payment status, race, national origin, etc.) that is reasonably calculated to determine whether an EMC exists, it has met its obligations under EMTALA.

Newborn subject to EMTALA: Also under IG 489.24(a), the new guidelines indicate that an infant who is born alive is a "person" and "individual" under 1 U.S.C. 8(a) and the EMTALA screening requirement applies to "any individual" who comes to the emergency department. Therefore, with respect to any infant born in a dedicated emergency department, *or basically anywhere on the hospital's campus*, who appears to need a screening for an EMC, the hospital and attending physician may be liable for violating EMTALA if they fail to provide such an MSE. If a medical screening examination reveals that the infant is suffering from an emergency medical condition, the hospital has an obligation under EMTALA to provide stabilizing treatment or an appropriate transfer. If the hospital admits the infant, its obligation under EMTALA is satisfied.

"Parking" EMS Patients: The last significant revision to IG 489.24(a), addresses hospitals "parking" emergency medical services (EMS) patients by postponing the transfer

of a patient from an EMS stretcher to an emergency department bed to delay the point in time at which its EMTALA obligations begin. Such a practice of "parking" EMS patients and refusing to release EMS equipment or personnel, will not delay the EMTALA obligations of a hospital and adversely impacts the ability of EMS personnel to provide emergency response services to the rest of the community. However, there may be situations when a hospital does not have the capacity or capability to provide an immediate medical screening examination at the time of presentation and, if needed, stabilizing treatment or an appropriate transfer. In such a case, it may be appropriate to ask the EMS staff to stay with the individual until the emergency department staff is available to provide care. Although not addressed in the most recent update to the IGs, the recent case of *Morales v. Sociedad Espanola de Auxilio Mutuo Y Beneficencia*, 524 F.3d 54 (1st Cir. 2008), found that an individual who was in a **non-affiliated** ambulance en route to a hospital but who was diverted to a different hospital did "come to" the first hospital for purposes of EMTALA.

For further information regarding the newly proposed regulations, a copy of the new site review guidelines, or case law updates, please contact Joe Turano or Carol Williamson.

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