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EMTALA Update 2009

TELNET 2550 January 21, 2010 10-11:30 am EST

Emergency Medical Treatment and Labor Act Part 3

Sue Dill Calloway RN, MSN, JD



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Speaker

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Special Responsibilities 2406

- What must the hospital that has an ED do when a person “Comes to the ED”?
- An appropriate MSE to determine if EMC exists (heart attack, stroke, dissecting aneurysm)
 - Done within the capability of the hospital’s ED
 - Includes ancillary services routinely available to the ED
- Exam must be done by a qualified individual
 - Determined by MS R&R and bylaws
 - Called qualified medical personnel or QMP

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Comes to the ED Means

- The individual has presented at a hospital's dedicated Emergency Department (DED) and requests examination or treatment for a medical condition, or has such a request made on his or her behalf (paramedic, family)
- Based on the individual’s appearance that they need an examination or treatment (a prudent layperson observer would conclude they need help such as patient is not breathing)

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Comes to the ED Means (continued)

- Presents on hospital property, other than the dedicated ED, in an attempt to gain access to the hospital for emergency care
- Requests examination or treatment for what may be an emergency medical condition, or has such a request made on his or her behalf

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Comes to the ED Means (continued)

- Is in an ambulance, owned (ground or air) and operated by the hospital, for presentation for examination and treatment for a medical condition at a hospital's dedicated ED
 - Even if the ambulance is not on hospital grounds
- Does not apply if part of community-wide EMS protocol that direct transports to another hospital

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Comes to the ED Means (continued)

- Is in a non-hospital-owned (air or ground) ambulance on hospital property for presentation for examination and treatment for a medical condition at a hospital's DED
- If the ambulance is not on property, can refuse, even if squad contacts staff by phone or telemetry, if in diversionary status

Comes to the ED Means (continued)

- If you are on diversion, squad can still disregard denial and if they show up, EMTALA obligations attach to the patient
- Read the definitions in the EMTALA law because they mean things you may not realize from a common understanding¹

¹ <http://ecfr.gpoaccess.gov> 42 CFR 489.24

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Electronic Code of Federal Regulations.
e-CFR
 TM

e-CFR Data is current as of July 9, 2009

Title 42: Public Health
[PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL](#)
[Subpart B—Essentials of Provider Agreements](#)

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§ 489.24 Special responsibilities of Medicare hospitals in emergency cases.

(a) *Applicability of provisions of this section.* (1) In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) "comes to the emergency department", as defined in paragraph (b) of this section, the hospital must—

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Hospital Property Means

- Entire main hospital campus and includes:
 - Parking lot
 - Hospital campus (which includes the 250 yard rule)
 - Sidewalk and driveway
- DOES NOT INCLUDE areas of the hospital's main building that are not part of the hospital
 - Physician offices, skilled nursing facilities, shops, restaurants

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Hospital Campus 250 Yard Rule

- The physical area immediately adjacent to the providers main building
- Other structures that are not strictly contiguous to the main building, but are located within 250 yards of the main building
- Other areas that are determined on an individual case basis by CMS Regional Office (RO)

EMTALA and Outpatients 2406

- If an individual is registered as an outpatient and presents on hospital property, other than to the DED
- The hospital does not have an obligation to provide a MSE even if patient suffers EMC
- This is if the patient has begun to receive a course of treatment for outpatient care
- This patient is protected in the hospital CoPs to protect patient's health and safety

Capacity Means

- Capacity means the ability of the hospital to accommodate the individual requesting examination or treatment of the transferred individual
- Capacity encompasses such things as numbers and availability of qualified staff, beds, and equipment
- The hospital's past practices of accommodating additional patients in excess of its occupancy limits

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Capacity Means (continued)

- Redefined by CMS in November 2001 memo
- The test:
 - **Is not** if the hospital has ever done it before
 - **Is** whatever a hospital customarily does to accommodate patients in excess of its occupancy limits
- This is a lower standard of care

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Medical Screening Examination Definition

- An MSE means a physical (and mental when necessary) health evaluation
 - Used to determine if they have an emergency medical condition (EMC)
- EMC could include seizure, life threatening injury, pain, extensive bone or soft injury, vascular or nerve damage, psychiatric disturbance, or symptoms of substance abuse
- If an EMC does not exist then EMTALA does not apply

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Moving Patient to Another Department

- If patient is screened in the ED, when can the patient be moved to another department for further screening or stabilization without it being a transfer?
 - All patients with same medical condition are moved, regardless of their ability to pay
 - Need a bona fide reason to move the patient
 - Appropriate personnel accompany the patient

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Moving Patient to Another Department (continued)

- Example—patient with eye injury needs the special equipment in the eye clinic
- Movement is not considered a transfer, since moved to another hospital-owned-facility or department
- Cannot move patients to a location off campus for their MSE, such as a satellite clinic or urgent care center

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Patient Shows Up at Off-Campus Location

What if the hospital owns an off-campus department (like a physical therapy department) and a patient shows up at the wrong location?

- The off-campus location does not have an ED and does not meet definition of DED
- Sending the patient to the main campus (main hospital ED) is not a transfer
- If a request is made for emergency services, the staff should use whatever they have in place and call 911

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Off Campus

- The off-campus facility must have P&P in place so staff know what to do
- In a true emergency, staff may want to send to the closest ED
- The P&P should state that the facility will provide initial treatment within its capability and capacity
- If all the off-campus Physical Therapy Department has is a cart, blanket, and oxygen, then they need to use them when indicated
- Orient new employees regarding P&P

MSE 2406

- MSE is an ongoing process
- Triage is not generally considered to be an MSE
 - It is a system of prioritizing when the patient will be seen by the physician or QMP (PA, NP)
- MSE will be different, depending on signs and symptoms
- Patient with chest pain, difficulty breathing, and diaphoresis is assessed differently than the patient who was bitten by her bird

Medical Screening Examination

- The MSE must be adequate and appropriate
 - MSE will vary, based on the patient's condition, complaints, and history
 - MSE will not vary for pregnant women
- This means the same screening exam as all others with similar symptoms presenting to the ED (same standard of care)
- Request for MSE or treatment can be made by anyone
 - Family member, squad, police, or bystander

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Medical Screening Examination (continued)

- Includes ancillary services routinely available to the ED
 - Example—may include CT scans and ultrasound
- “MSE is the most complex and far-reaching of the EMTALA mandates”

Source: Bitterman, Robert, pg. 23, Providing Emergency Care Under Federal Law; EMTALA, Published by ACEP, 1 800 798-1822

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MSE of Pregnant Patients

- For pregnant women having contractions, MSE includes at a minimum:
 - Ongoing evaluation of FHTs
 - Observation and recordation of the regularity and duration of uterine contractions
 - Fetal position and station
 - Cervical dilation, status of membranes (leaking, intact, ruptured)

ACOG PRACTICE BULLETIN



CLINICAL MANAGEMENT GUIDELINES FOR OBSTETRICIAN—GYNECOLOGISTS

NUMBER 106, JULY 2009

Replaces Practice Bulletin Number 70, December 2005

Intrapartum Fetal Heart Rate Monitoring: Nomenclature, Interpretation, and General Management Principles

This Practice Bulletin was developed by the ACOG Committee on Practice Bulletins with the assistance of George A. Macones, MD. The information is designed to aid practitioners in making decisions about appropriate obstetric and gynecologic care. These guidelines should not be construed as dictating

In the most recent year for which data are available, approximately 3.4 million fetuses (85% of approximately 4 million live births) in the United States were assessed with electronic fetal monitoring (EFM), making it the most common obstetric procedure (1). Despite its widespread use, there is controversy about the efficacy of EFM, interobserver and intraobserver variability, nomenclature, systems for interpretation, and management algorithms. Moreover, there is evidence that the use of EFM increases the rate of cesarean deliveries and operative vaginal deliveries. The purpose of this document is to review nomenclature for fetal heart rate assessment, review the data on the efficacy of EFM, delin-

MSE for Pregnant Patients

- Most ED's direct women over 20 weeks gestation with pregnancy related complaints to LD
- If any doubt about the nature of the complaint, then can have ED nurse triage
 - This approach is acceptable to CMS
- If pregnant trauma patient, OB nurse should go to the ED to evaluate the patient
- Hospital must have P&P and all staff in the ED and OB must know the policy

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Labor Defined 2406

- Labor is the process of childbirth beginning with the latent or early phases of labor and continuing through the delivery of the placenta
- A woman experiencing contractions is in true labor:
 - Unless, after a reasonable time of observation, a physician, certified nurse-midwife, or other QMP, acting within his or her scope of practice as defined in the hospital MS bylaws and State law, certifies that the woman is in false labor

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Certification of False Labor

- Physician or QMP must examine patient to determine if EMC exists
- True labor is an EMC (never defined in original statute as an EMC)
- CMS requires the certification of false labor

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Certification of False Labor (continued)

- If woman is in false labor, the MD, QMP or nurse-midwife is required to certify diagnosis before discharge
- One of these individuals must complete the certification of false labor
- Can use stamp, sticker, or form
- Can use CMS Memos to draft form (Sept 26, 2006 Memo, S&C-06-32 and earlier memo January 16, 2002 S&C-02-14)

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Certification of False Labor Sample Form (continued)

I hereby state that the patient has been examined for a reasonable time of observation and certify that the patient is in false labor.

Name and Title _____

Date _____ Time _____

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Born Alive Law

- Born-Alive Infants Protection Act of 2002
 - CMS added to EMTALA interpretive guidelines
 - Under Tag 2406
- CMS Issued a letter on April 22, 2005,
 - Reference S&C-05-26,
 - Bulletin advises state survey agencies that violations of this Act should be investigated as potential EMTALA violations¹

¹ <http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter05-26.pdf>

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-05-26

DATE: April 22, 2005
TO: State Survey Agency Directors
FROM: Director
Survey and Certification Group
SUBJECT: Interaction of the Emergency Medical Treatment and Labor Act (EMTALA) and
the Born-Alive Infants Protection Act of 2002

Letter Summary

- The Born-Alive Infants Protection Act of 2002 (Pub. L. 107-207) adds to the United States Code a definition of the term "individual" to include every infant who is born alive, at any stage of development; it also adds a definition of the term "born alive."

Born Alive Law

- Infant born alive, hospital would have to resuscitate if request made for MSE on infant's behalf
- Infant is deemed an individual
- ED and L&D meet the definition of DED so EMTALA applies
- If born elsewhere on campus use the lay person standard that infant had EMC¹

¹ <http://pediatrics.aappublications.org/cgi/content/full/116/4/e576>

Born Alive Law (continued)

- Complaint manual has section updated 03-17-06, page 48
- Tells surveyor how to handle a complaint
- Definition of person and individual under 1 USC 8(a) makes it clear that EMTALA is applicable to infants born alive
- If request was made on infant's behalf or based on infant's appearance that infant needed examination and treatment¹

<http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/itemdetail.asp?filterType=dual,%20date&filterValue=2|yyyy&filterByDID=3&sortByDID=4&sortOrder=ascending&itemID=CMS060362&intNumPerPage=10>

Minor Child 2406

- Federal EMTALA law preempts state law on informed consent
- A minor child can request an examination or treatment for an EMC
- Hospitals are required to conduct an MSE on infants to determine if they have an EMC
- Hospitals should not delay by waiting for parental consent
- If no EMC exists after the MSE, staff can wait for parental consent before proceeding

MSE On-Campus Provider Based Entity

- Hospitals with off-campus departments, such as rural health clinics or physician offices, cannot move patients for MSE when on campus
- Hospitals should know if they are freestanding entities or provider based entities
 - Many small hospitals can meet the definition of provider based entities
 - Billing is different based on your status
- CMS issues transmittal A-30-030 to help explain this and to describe the criteria and procedure to determine if you are a provider based entity

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Provider Based Entity

- Published April 7, 2000, rule sets out criteria (65 FR 18504)
- Aug 1, 2002 (67 FR 50078) revised the Oct 1, 2002 regulations for those not grandfathered in
- See 42 CFR & 413.65
- Contains sample attestation form you can use

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Program Memorandum Intermediaries

Transmittal A-03-030

Department of Health &
Human Services (DHHS)
Centers for Medicare &
Medicaid Services (CMS)

Date: APRIL 18, 2003

CHANGE REQUEST 2411

SUBJECT: Provider-based Status On or After October 1, 2002

Regulations in 42 CFR §413.65 describe the criteria and procedures for determining whether a facility or organization is provider-based. The Medicare Hospital Inpatient Prospective Payment System final rule published on August 1, 2002 (67 FR 50078) revised those regulations effective on October 1, 2002, for facilities or organizations that are not grandfathered as provider-based as described below and, in the case of grandfathered facilities, effective for main provider cost reporting periods beginning on or after July 1, 2003. This Program Memorandum (PM) provides information on the background of the provider-based regulations and notifies you of the actions you are to take to implement the revised regulations.

NOTE: This PM supersedes program instructions concerning provider-based status in §2446 of the Provider Reimbursement Manual, Part I (PRM-I) and §2004 of the State Operations Manual (SOM) that apply to any facility for periods before the regulations at 42 CFR §413.65 become applicable to it.

A. Background

1. Current Regulations

Since the beginning of the Medicare program, some providers, which we refer to as "main providers," have functioned as single entities while owning and operating multiple provider-based departments, locations, and facilities that were treated as part of the main provider for Medicare purposes. Having clear criteria for provider-based status is important because this designation can result in additional Medicare payments for services furnished at the provider-based facility, and may also increase the coinsurance liability of Medicare beneficiaries for those services.

In the April 7, 2000, *Federal Register* (65 FR 18504), we published a final rule specifying the criteria that must be met for a determination regarding provider-based status. The regulations at existing 42 CFR §413.65(b)(2) apply the same criteria to facilities on the main provider campus as to off-campus facilities, and state that before a main provider may

Ambulance

- If patient is not on hospital property, then EMTALA does not apply and not deemed to have come to the ED
- If patient in an ambulance owned by the hospital, then the patient is deemed to have come to the ED and EMTALA applies, even if ambulance is five miles out
- If patient in non-hospital owned ambulance and is on the property of the hospital, then EMTALA applies (too late to divert)

Telemetry 2406

- If patient is in non-owned ambulance and hospital contacted by telemetry, patient is not deemed to have come to the ED
 - Unless the ambulance is on the hospital's property already
- Hospitals contacted by telephone or telemetry communication can still divert if on diversionary status
- Hospital owned ambulance may only divert if pursuant to community-wide EMS protocol
 - Need level 1 trauma center

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Diversionary Status

- A hospital can be in diversionary status
 - It does not have staff or beds to accept additional patients
 - Includes ED beds and critical care beds
 - Can divert critical care patients if no critical care beds
- If the ambulance disregards the hospital's instructions and brings the patient on to hospital grounds, hospital cannot deny access

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Diversiónary Status (continued)

- Don't direct the ambulance to another facility unless on diversion for one of these two reasons (remember Arrington v. Wong problem, US District Ct of Appeals)
- On June 29, 2009, IG, CMS said a hospital that is not in diversionary status cannot fail to accept a telephone or radio request for transfer or admission

Diversiónary Status (continued)

- The refusal could represent a violation of other federal or state laws like Hill-Burton
- Many states have state EMTALA laws
- Hill Burton Act is also called the Hospital Survey and Construction Act which was passed in 1946 to provide grants and loans to improve physical plants of hospitals

Parking of Patients 2406

- CMS issued a memo to Region IV Hospitals on the “Parking of EMS Patients in Hospitals” on December 12, 2005; a second memo was issued April 27, 2007, and CMS included section in Tag number 2406
- States CMS has learned several hospitals prevent EMS staff from transferring patients from their stretchers to ED cart
- Some staff believe that unless hospital takes responsibility for them, hospital is not obligated to provide care

Parking of Patients (continued)

- Hospitals cannot deliberately delay moving a patient from the EMS stretcher to the bed to delay the point where their EMTALA obligations begin
- Patient is presented when arrives on hospital grounds and within 250 yards of the main hospital building
- Cannot delay MSE by not allowing EMS to leave the patient

Parking of Patients (continued)

- This does not mean that in every instance they must immediately resume all responsibility
- There might be some situations where the hospital does not have the capacity or capability
- Example is when squad brings in a patient while occupied with major trauma case
- Still need to assess patient's condition upon arrival to determine priority and if physician or QMP need to see right away

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Parking of Patients 2406 (continued)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop 52-12-23
Baltimore, Maryland 21244-1830



Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-07-20

Date: April 27, 2007
TO: State Survey Agency Directors
FROM: Director
Survey and Certification Group
SUBJECT: EMTALA Issues Related to Emergency Transport Services

Memorandum Summary

- 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

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Helipad 2406

- Helicopters and ambulances that enter the hospital grounds just to access the helipad to tertiary hospitals do not trigger an EMTALA obligation
- If medical crew or ground crew requests medical assistance, then EMTALA obligation occurs
- The exception is if the hospital owns the air transport, the patient is deemed to have come to the ED

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Helipad 2406 (continued)

- If hospital is sending a patient, then they must have conducted a MSE prior to transporting the patient to the helipad
- Sending hospital must still implement stabilizing treatment if sending a patient to the helipad
- Hospital with helipad is not required to perform MSE when helipad is used as point of entry by the squad or other hospitals

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State Plans 2406

- State plans cannot preempt the federal EMTALA law
- State plans for indigent, psychiatric, or obstetrical patients can not disregard EMTALA
- Example—a state cannot tell the ED to send the suicidal patient off campus to have their MSE done
- Hospitals cannot discharge a patient who has not been screened

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MSE Cases

- Perception of the MD at the time of the MSE governs the scope of the MSE
- In Summers v. Baptist Medical Center, 1996
 - Patient fell out of tree while deer hunting
 - Complained of back and chest pain
 - No CXR, but thoracic and LSS x-rays
 - Discharged
 - Two days later found to have fractured sternum, rib, and vertebra
 - MD did not perceive chest symptoms sufficient to warrant x-rays

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MSE Cases (continued)

- Failure to follow your own policies and procedures (rules) will be an EMTALA violation
- PA dismissed nine month old child with fever without involvement of ED MD
 - Violation since protocol required consult with MD on all children under one

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MSE Cases (continued)

- In 1998 Bohannon case
 - Patient involved in motorcycle accident
 - C-spine films ordered
 - Patient discharged before films reviewed by ED MD
 - Hospital violated its own policy

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Who is Qualified to be a QMP 2406

- MSE must be conducted by a QMP
- Must be qualified by hospital bylaws and R&E
- Must meet the requirements of 482.55 which is the CoP for emergency services
- Board should approve the document about QMPs
- ED must be supervised by qualified member of the medical staff

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QMP

- It may be prudent for hospitals to require an MD to conduct the screening exam if one is on the premises
- CMS notes there may not always be an MD present in the hospital especially in rural areas
- QMP should be someone who is qualified by education and training such as a PA and NP
- Must be capable of ordering any necessary diagnostic procedures without exceeding the scope of their professional license

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QMPs (continued)

- This person must have access to all the hospital's resources, including ancillary services
- RNs without advance training or resources generally do not meet this criteria
- Exception:
 - In some hospitals experienced OB nurses have been deemed QMPs
 - ED nurses designated QMP for non-emergencies like BP checks or giving flu shots

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OB Nurses as QMPs

- If hospital uses RNs to conduct limited MSE (i.e., obstetrical nurses), then specific P&P should be adopted, addressing the education and training under which an RN must consult with a physician
- Note that only an MD can make a transfer decision or determine whether a pregnant woman having contractions is in false labor

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Inpatients

- CMS says the EMTALA obligations end when
 - The patient has been admitted for inpatient hospital services
 - Even if the patient has not been stabilized (although you still want to stabilize to best of your ability)
- CMS says EMTALA does not apply to hospital inpatients

Definition of Inpatient

- Inpatient is an individual who is admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital care
- Expectation that he will remain at least overnight and occupy a bed
 - The situation may later develop that the patient can be discharged or transferred
 - The patient does not actually use the bed overnight
- Cannot be a sham and must be in good faith

Inpatient 2406

- Observation patients are not inpatients and EMTALA still applies to them (2411)
 - If the case ends up in the court room the result might be different
- The case of *Moses v. Providence Hospital and Medical Centers, Inc.* held that the liability of EMTALA did not end when the patient was admitted

The Moses Case

- The Sixth Circuit stuck to its interpretation that EMTALA imposes an obligation on a hospital beyond simply admitting a patient with an EMC to an inpatient care unit
- The Court noted that the statute requires “such treatment as may be required to stabilize the medical condition,” and forbids the patient’s release unless the patient’s emergency condition has “been stabilized”

Source: *Moses v. Providence Hospital and Medical Centers, Inc.*, No. 07-2111 (6th Cir. April 2009)

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RECOMMENDED FOR FULL-TEXT PUBLICATION
Pursuant to Sixth Circuit Rule 205
File Name: 09a0137p.06

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

JOHNELLA RICHMOND MOSES, Personal
Representative of the Estate of MARIE MOSES
IRONS, deceased,
Plaintiff-Appellant,

v.

PROVIDENCE HOSPITAL AND MEDICAL
CENTERS, INC. and PAUL LESSEM,
Defendants-Appellees,

CHRISTOPHER WALTER HOWARD,
Third-Party Defendant.

No. 07-2111

Appeal from the United States District Court
for the Eastern District of Michigan at Detroit.
No. 04-74889—Anna Diggs Taylor, District Judge.

Argued: December 5, 2008
Decided and Filed: April 6, 2009

Before: CLAY and GIBBONS, Circuit Judges; STAMP, District Judge.*

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The Moses Case (continued)

- The court overruled CMS’s regulation that EMTALA ended when the hospital admitted the patient in good faith
- The Court stated that the rule was contrary to EMTALA’s plain language
- This language requires a hospital to “provide . . . for such further medical examination *and such treatment* as may be required to stabilize the medical condition.”

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The Moses Case (continued)

Can a non-patient have standing to sue under EMTALA?

- EMTALA's civil liability provision reads as follows:
 - “Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located ...”

The Moses Case (continued)

- Court allowed non-patient (family member) to sue the hospital, but not the physician
- This case creates an enormous expansion of hospital liability under the federal law, especially if this interpretation is accepted in other district courts
- All inpatient ‘premature discharge’ claims would become federal ‘failure to stabilize before transfer’ claims under EMTALA
- The hospital would be directly liable for any negligence of the admitting/discharging physician

Inpatient Admission and EMTALA

- Admission does not end EMTALA requirements
- Hospital still liable for discharging an unstable patient, even after he has been admitted to the hospital
- Discharge home from the ED is defined by EMTALA as a transfer
 - All discharged patients should be stable when they leave
- Inpatients admitted for elective services are not covered by EMTALA, but by hospital CoPs

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Waiver of Sanctions 2406

- Sanctions can be waived for inappropriate transfers during a national emergency
- Sanctions waived for MSE at an alternate location
- On 9-11, when 400 people came to the closest hospital in New York, there was no way to triage and do an MSE on all these individuals
- Waiver applies if a pandemic occurs
- Waiver is limited to 72 hours during the emergency period

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Non-Emergencies in the ED 2406

- If person comes to the ED and request is made for exam or treatment
- The nature of the request makes it clear that it is not an emergency
- Hospital is only required to do such screening as appropriate
- It could be a request to have a blood alcohol test, sexual assault exam, or a blood pressure checked

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Request for Medications

- If a patient comes to the ED and requests medications, the hospital has an EMTALA obligation
- Surveyors are instructed to ask probing questions
- Was it likely by the request that the patient had an EMC?

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Request for Medications (continued)

- Hospitals are not required to provide medications because a patient who does not have an EMC is unable to pay or does not wish to get them from a retail pharmacy

Blood Alcohol Tests (BATs) 2406

- It is important to determine from the patient's condition if an MSE is needed when there is request for a BAT
- If patient only requests a BAT, then an MSE may not be necessary
- If patient is intoxicated and a prudent lay person observer would not believe the individual needed an exam, no MSE is required
- If person is involved in a MVA and may have sustained injuries, an MSE would be indicated

Blood Alcohol Tests (BATs) 2406 (continued)

- Surveyors will evaluate each case on the merits
- Make sure patient is competent to make a decision
- Many hospitals personally offer an MSE, even if patient came for a BAT
- Hypoglycemia, cerebral hypoxia, strokes, head injury, metabolic abnormalities, and ingestions of toxins can mimic alcohol intoxications

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EMC and Stabilization 2407

- If a person has an emergency medical condition (EMC), the hospital must provide further exam and treatment to stabilize the medical condition
- Example—Patient arrives with chest pain, radiating down left arm, and difficulty breathing
 - A diagnosis of an MI is made
 - This is considered an EMC
 - Hospital stabilizes with IV, oxygen, monitor, CCU admission, thrombolytics, aspirin, etc.

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Definition of EMC

- A medical condition, manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbance, symptoms of substance abuse), such that the absence of immediate medical attention could be reasonably expected to result in:
 - Placing the health of the individual in serious jeopardy (or to the mother and infant for a pregnant woman)
 - Serious impairment to bodily functions
 - Serious dysfunction of any organ

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EMC of Pregnant Women

- EMC exists with respect to pregnant women with contractions when there is inadequate time to effect a safe transfer to another hospital before delivery
- That transfer may pose a threat to the health or safety of the woman or the unborn child

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OB Patients

- Should have P&P for screening pregnant patients
- Elements of exam should be completed in all cases
 - Parity
 - Gestational age
 - Nature, frequency, duration, and intensity of contractions
 - FHT
 - Station, dilation, presentation, VS, etc.

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Necessary Stabilization Treatment 2407

- When patients come to the ED and they have an EMC, further medical exam and treatment must be provided
- Such treatment must be given as necessary to stabilize the medical condition within the capabilities and capacity
- Capabilities means that there is physical space, equipment, supplies, and specialized services
 - Surgery, obstetrics, psychiatry, pediatrics, trauma care, or intensive care

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Stabilization 2407

- Capabilities of the staff mean the level of care the hospital can provide within the training and scope of their professional license
- All individuals with similar conditions must be treated consistently, regardless of whether the patient is in a managed care plan
- If the patient refuses care, they must be informed of the risks and benefits, as discussed in the earlier section on AMA

Stabilization 2407 (continued)

- When lack capability requires a transfer of the patient, the facility must follow transfer rules
 - Must stabilize the patient before discharge or transfer
- Capacity includes what the hospital does to accommodate a patient in excess of occupancy limits
 - Examples—moving patients to other units, calling in additional staff, or borrowing equipment

Definition of Stabilization of EMC

- No material deterioration of the condition is likely to occur
 - Within reasonable medical probability
 - To result from or during the transfer, or with respect to an EMC
 - Until the woman has delivered the child and placenta

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Stabilization

- After the MSE is done, the MD should document the absence or presence of an EMC
- Document when the patient is stable
- Stabilization and transfer only kick in if the patient has an EMC
- When stable, EMTALA obligation is over

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Stabilization (continued)

- The hospital must have actual knowledge that an EMC exists, which is a subjective standard
- The definition of stabilized is an objective standard, whether the MD knew or should have known
- If the patient actually deteriorates, this issue will come up

Discharge Home with Follow Up Instructions

- Individual is considered stable and ready for discharge
 - Within reasonable clinical confidence
- It is determined that the patient has reached the point where his care and treatment could be performed later as an inpatient or on an outpatient basis
- EMC that caused the problem must be resolved

Stabilization Case Law

- Much litigation in the area of allegations of failure to stabilize
- Child with diagnosis of ear infection and dies from meningitis
 - Malpractice case, not an EMTALA violation
 - MD did not know about the meningitis
- No legal duty to stabilize the child

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Stabilization Case Law (continued)

- Federal courts also uniformly agree that the MD or hospital must have actual knowledge that the EMC existed before liability for failure to stabilize, (Vickers v. Nash General Hospital, Inc. 78 F.3d 139 (4th Vir. 1996))

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Definition of Transfer

- Transfer means the movement (including discharge)
 - Of a patient outside a hospital's facilities
 - At the direction of any person employed by (or affiliated or associated, directly or indirectly) with the hospital
- Does not include
 - Person declared dead (DOA) or
 - Person who leaves the facility without permission (AMA)

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Transfer General Rule 2409

- The general rule is, if a patient has an EMC, the patient may not be transferred
- There are exceptions to the rule on when a transfer is appropriate
- A hospital may not transfer an unstable patient unless:
 - The patient is informed of the hospital's obligations under this law
 - The risks of the transfer are provided in writing (use the transfer form)

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Transfer General Rule (continued)

- A hospital may not transfer an unstable patient unless:
(continued)
 - The physician signs a certification that the benefits, reasonably expected, outweigh the risks to the individual or unborn child, or
 - If a physician is not present in the ED at the time of transfer, a QMP can sign the certification after consultation with the physician
- Request the patient to consent in writing to the transfer

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Transfer General Rule (continued)

- The physician must later countersign the certificate
- The certification must contain a summary of the risks and benefits upon which the certification is based
- The transfer must be an appropriate transfer

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What Is an Appropriate Transfer? 2409

- The transferring hospital provides medical care within its capacity that minimizes the risk to the patient or unborn child
- The receiving facility has space and qualified personnel to care for the patient
- The receiving facility has accepted the transfer

What Is an Appropriate Transfer? (continued)

- The transferring hospital sends all medical records
 - Including history, observations, preliminary diagnosis, test results, copy of certification
- Records not available must be sent as soon as practicable
 - Include the name and address of any on-call MD who refused or failed to show up within a reasonable amount of time

What Is an Appropriate Transfer? (continued)

- There are qualified personnel and appropriate transportation equipment, including the use of life support measures
- Physician from sending hospital determines the appropriate mode of transport, required equipment, and who should be in attendance
- If the patient refuses to consent, the risks and benefits must be documented
- Take all reasonable steps to ensure it is a written informed refusal

Transfers 2409

- Transfers may be made at the request of the patient
- The patient or their legal guardian must be given information about the hospital's obligation to provide stabilizing treatment, regardless of ability to pay
- Patient must be informed of the risks of transfer and sign the transfer certification

Psychiatric Patients 2407

- Psychiatric patients are considered stable when they are protected and prevented from injuring or harming themselves or others
- Administration of medications or physical restraints may stabilize a patient for a period of time for purposes of transferring an individual to another facility

Psychiatric Patients (continued)

- The underlying condition may persist and patient may experience exacerbation of EMC
- Use great care in determining medical condition is stable after administering drugs or using restraints
- CMS has given guidance on what constitutes an EMC

Psychiatric Patients (continued)

- CMS has not given guidance on what needs to be done to stabilize the psych EMC
- MD must use best judgment
- If no psychiatric EMC, may discharge
- May transfer if facility does not have capability to stabilize patient like an inpatient unit

Transfer of Psychiatric Patients

- CMS views the following as psychiatric EMC:
 - History of drug ingestion in comatose or impending comatose condition
 - Depression, with feeling of suicidal hopelessness
 - Delusions, severe insomnia, and hopelessness
 - History of recent suicidal attempt or suicidal ideation

Psychiatric EMCs Identified by CMS

- History of recent assaultive, self-mutilating, or destructive behavior
- Inability to maintain nutrition in a person with altered mental status
- Impending DT's or acute detox
- Seizures (withdraw of toxic substance)
- List is not exclusive

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Psychiatric Patients

- Hospitals with specialized psychiatric capabilities must accept patients if sending hospital does not have capability (unless transfer from outside the country)
- If receiving hospital has capacity (staff, available beds, equipment, etc.)
- Patient may refuse treatment, but must be competent to make informed decision

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Psychiatric Patients (continued)

- Physician should determine if patient lacks understanding or capacity to communicate regarding exam and treatment
- If surrogate decision maker available (guardian or DPOA), then discuss with them
- Consent is presumed in the event of an emergency

Psychiatric Patients (continued)

- Know the involuntary admission procedure in your state
- Behavioral Hospital of Litcher (La.), formerly known as St. James Psychiatric Hospital, paid \$30,000 for allegedly failing to appropriately accept transfers of two patients suffering psychiatric emergencies (see OIG dumping cases previously discussed)

Transfer Certification 2409

- This is a legal written document and it must be filled out completely
- Most facilities have transfer forms and checklists
- Certification must state the reason for the transfer along with benefits
- Hospitals not capable of handling high risk deliveries have written transfer agreements with level three facilities

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Transfer of Woman with Contractions

- Limited circumstances to transfer
- Woman in labor is transferred if she requests it
- Examining MD certifies in writing the benefits outweigh risks to mother and child
- Cannot cite state law or practice as basis for transfer

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Woman with Contractions

- Delivery is expected to be highly complex and needs specialized OB services
- Arrange appropriate transfer
- Send everything along that could possibly be needed
 - Pitocin drip, warm blankets, OB nurse, neonatal nurse, FH monitor, and maybe even an OB doctor

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Transfer Certification 2409

This form should state that:

“Based on the information available to me at the time of this transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risk to the individual and, in the case of labor, to the unborn child from effecting the transfer.”

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Emergency Medical Condition (EMC) Identified: (Mark appropriate boxes), then go to Section II)

PHYSICIAN

I. MEDICAL CONDITION: Diagnosis _____

No Emergency Medical Condition Identified: This patient has been examined and an EMC has not been identified.

Patient Stable - The patient has been examined and any medical condition stabilized such that, within reasonable clinical confidence, no material deterioration of this patient's condition is likely to result from or occur during transfer.

Patient Unstable - The patient has been examined, an EMC has been identified and patient is not stable, but the transfer is medically indicated and in the best interest of the patient.

I have examined this patient and based upon the reasonable risks and benefits described below and upon the information available to me, I certify that the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risk to this patient's medical condition that may result from effecting this transfer.

II. REASON FOR TRANSFER: Medically Indicated Patient Requested _____

On-call physician refused or failed to respond within a reasonable period of time.

Physician Name _____ Address _____

III. RISK AND BENEFIT FOR TRANSFER:

Medical Benefits:	Medical Risks:
<input type="checkbox"/> Obtain level of care / service NA at this facility.	<input type="checkbox"/> Deterioration of condition en route.
<input type="checkbox"/> Service _____	<input type="checkbox"/> Worsening of condition or death if you stay here.
<input type="checkbox"/> Benefits outweigh risks of transfer	<small>There is always risk of traffic delay/accident resulting in condition deterioration.</small>

IV. Mode/Support/Treatment During Transfer as Determined by Physician – (Complete Applicable Items):

Mode of transportation for transfer: IBL5 IALS Helicopter Neonatal Unit Private Car Other _____

Agency _____ Name/Title accompanying hospital employee _____

Support/Treatment during transfer: Cardiac Monitor Oxygen – (Liters) _____ Pulse Oximeter IV Pump

IV Fluid _____ Rate _____ Restraints – Type _____ Other _____ None

Radio on-line medical oversight (if necessary): Transfer Hospital Destination Hospital Other _____

V. Receiving Facility and Individual: The receiving facility has the capability for the treatment of this patient (including adequate equipment and medical personnel) and has agreed to accept the transfer and provide appropriate medical treatment.

Receiving Facility / Person accepting transfer _____ Time _____

Receiving MD _____

Transferring Physician Signature _____ Date/Time _____

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NURSING

VI. ACCOMPANYING DOCUMENTATION – sent via: Patient/Responsible Party Fax Transporter

Copy of Pertinent Medical Record Lab/ EKG/ X-Ray Copy of Transfer Form Court Order

Advance Directive Other _____

Report given (Person / title) _____

Time of Transfer _____ Date _____ Nurse Signature _____ Unit _____

Vital Signs Just Prior to Transfer T _____ Pulse _____ R _____ BP _____ Time _____

PATIENT

VII. PATIENT CONSENT TO "MEDICALLY INDICATED" OR "PATIENT REQUESTED" TRANSFER:

I hereby **CONSENT TO TRANSFER** to another facility. I understand that it is the opinion of the physician responsible for my care that the benefits of transfer outweigh the risks of transfer. I have been informed of the risks and benefits upon which this transfer is being made.

I hereby **REQUEST TRANSFER** to _____. I understand and have considered the hospital's responsibilities, the risks and benefits of transfer, and the physician's recommendation. I make this request upon my own suggestion and not that of the hospital, physician, or anyone associated with the hospital.

The reason I request transfer is _____

Signature of Patient Responsible Person _____ Relationship _____

Witness _____ Witness _____

TRANSFER FORM

White: Receiving Facility; Yellow: Medical Record; Pink: QA

Patient Name: _____

Date of Birth: _____

Medical Record Number: _____

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Specialized Capabilities 2411

- There is a duty for hospitals with specialized capabilities to accept patient
- Hospital A does not have a trauma unit and Hospital B is a level one trauma unit
- Hospital B has staff and beds so Hospital B must accept the unstable trauma patient

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Specialized Capabilities 2411 (continued)

- Includes facilities such as burn units, shock-trauma units, or neonatal ICUs
- Hospitals that are rural regional referral centers may not refuse to accept appropriate transfer requiring specialized services (under 42 CFR 412.96)

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Specialized Capabilities 2411 (continued)

- This assumes the sending hospital does not have specialized capabilities
- This includes the requirement that hospitals with specialized capabilities accept patients, even if they do not have an ED
- This was done to level the playing field with specialty hospitals
- Hospitals do not have to accept transfers from outside of the US

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Lateral Transfers 2411

- Lateral transfers are those between facilities of comparable resources
- Hospital A and Hospital B have burn units
- Transfers are not required by EMTALA
- Benefits of transfer do not outweigh risks except when a hospital has a serious capacity problem or other problem like flooding or loss of power

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Consultation with QIOs

- QIO is Qualified Improvement Organization
- Every state has one which is under contract by CMS
- If medical opinion is necessary to determine an MD's or hospital's liability, CMS requests the appropriate QIO to review the allegation

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Consultation with QIO (continued)

- CMS needs to give the QIO all the information relevant to the case
- CMS, in consultation with the OIG, provides the QIO with a list of relevant questions to which the QIO must respond in its report
- Must give hospital/MD reasonable notice of its review and opportunity to submit additional information

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Consultation with QIOs (continued)

- If the QIO determines after a preliminary review that there was an appropriate MSE and the individual did not have an EMC, then the QIO may, at its discretion, return the case to CMS
- CMS may release, upon request, a QIO assessment to:
 - The physician and/or hospital
 - The affected individual, or his or her representative

Round Trip Transfers

- Transfers to another hospital with the intention of returning to the original hospital
- Sent to get test such as CT-scan, MRI, or angiography
- EMTALA compliance with transfer requirements must occur
- Ensure documentation, certification, and acceptance by the receiving hospital
- Implementing an appropriate transfer back to the sending hospital is not necessary

Important Tag Numbers

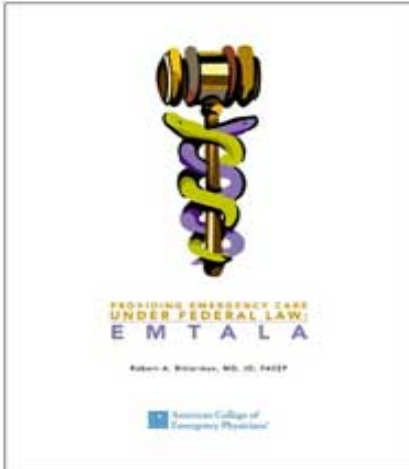
Look at the following important documents:

- EMTALA policy TAG 2400
- EMTALA signs TAG 2402
- Medical records
 - Make sure they are maintained for five years
 - TAG 2403
- List of on-call physicians 2404
- Central log 2405

Important Tag Numbers and Deficiencies

- Appropriate MSE 2406
- Stabilizing treatment 2407
- No delay in exam 2408
- Appropriate transfer 2409
- Whistle blower protection 2410
- Recipient hospital responsibilities 2411

Questions?



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EMTALA

- Are you up to the challenge?
- Sample educational memo for physician follows this slide
- List of regional offices follows this section

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Physician Education

- The following lists important elements that a hospital could use to provide a memo to physicians to educate them on EMTALA
- Make sure they know how to complete an EMTALA transfer form
- Include a sample of a completed one for reference

Physician Education (continued)

On-call Memo for your physicians on EMTALA might include the following points:

- The hospital has a legal duty to provide on-call physicians for emergency patients under the federal EMTALA law
- Whenever you are on call you are representing the hospital and not your office practice

Physician Education (continued)

- It is the treating Emergency Department physician who makes the final decision regarding which on-call individual to contact and whether or not that physician must come to the hospital
- The ED physician can do a phone consult or may require the on-call physician to come to the Department to actually see the patient

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Physician Education (continued)

- The ED physician may agree if it is appropriate for the physician's PA, NP, or orthopedic tech to come and see the patient
- Under the federal EMTALA law, if you are on call you must show up within a reasonable time when called and requested to show up

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Physician Education (continued)

- The rule of thumb that has been used by CMS surveyors for a patient covered by EMTALA is 30–60 minutes, absent extenuating circumstances (e.g., in surgery, weather, etc.)
- Federal law requires the hospitals to have a time specified in their policy which for true emergencies is ___ minutes

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Physician Education (continued)

- If the hospital has to transfer a patient because the on-call MD did not show up, the sending hospital must provide the name and address of that physician to the receiving hospital
- The receiving hospital must report the violation to CMS
- The sending hospital and on-call physician could be surveyed and scrutinized to determine if a violation of EMTALA occurred

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Physician Education (continued)

- Physicians and hospitals may be subject to penalties for violating EMTALA's on-call provisions
- Physician risks include:
 - Civil monetary penalties, loss of license, termination from Medicare and other federal health programs, criminal prosecution or civil lawsuits, and medical staff suspension
 - Physicians can be reported to the State Medical Board by OIG

Physician Education (continued)

- Per CMS, having an office full of patients is not an allowable excuse for not coming to the ED timely, when on call and requested by the ED physician
- EMTALA requires the name of individual physician and not the name of the physician's group practice to be included on the on-call list

Physician Education (continued)

- EMTALA is a requirement to treat
 - It is not a requirement to pay
- The on-call physician must respond whether or not the patient:
 - Belongs to a Managed Care Organization in which that physician participates
 - Is a Medicaid or Medicare patient, or
 - Whether the patient has no insurance

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Resources

- “20 Common Practices that will Get On-Call Physicians Cited”, located at:
<http://medlaw.com/healthlaw/EMTALA/education/20-common-practices-that-.shtml>
- “The EMTALA Answer Book 2009”, by Mark Moy, Aspen Publication
- Bitterman, Robert A, MD, JD. “Providing Emergency Care Under Federal Law-EMTALA”, American College of Emergency Physicians. 2001. Supplement 2004.

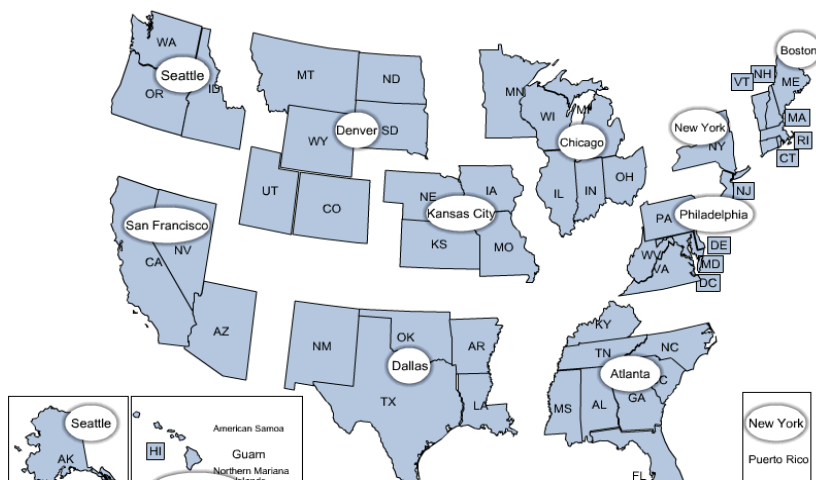
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Resources (continued)

- “On Call Specialist Coverage in ED, ACEP Survey of ED Directors”, Sept 2004, and 2006 ACEP Survey
- “Surgeons Violate Sherman Act by Refusing On Call Emergency Care Duty, Hospital Says”, Health Law Reporter, Vol 15, Number 2, January 12, 2006

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CMS Regional Offices



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Regional Offices

- **Region I: Boston Regional Office**
States served: Connecticut, Maine, Massachusetts,
New Hampshire, Rhode Island, Vermont
- **Health Standards & Quality**
Center for Medicare Services
JFK Federal Building, Room 2325
Boston, MA 02203
Phone: (617) 565-1298
Fax: (617) 565-4835

Regional Offices (continued)

- **Region II: New York Regional Office**
States and territories served: New Jersey, New York,
Puerto Rico, Virgin Islands
- **State Operations Branch (NY)**
Center for Medicare Services
26 Federal Plaza, Room 3811
New York, NY 10278-0063
Phone: (212) 264-3124
Fax: (212) 861-4240

Regional Offices (continued)

- State Operations Branch (NJ, PR & VI)
Center for Medicare Services
26 Federal Plaza, Room 3811
New York, NY 10278-0063
Phone: (212) 264-2583
Fax: (212) 861-4240

Regional Offices (continued)

- Region III: Philadelphia Regional Office
- States and territories served: Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia
- Division of Medicaid and State Operations
Center for Medicare Services
Suite 216, The Public Ledger Bldg.
150 S. Independence Mall West
Philadelphia, PA 19106
Phone: (215) 861-4263
Fax: (215) 861-4240

Regional Offices (continued)

- **Region IV: Atlanta Regional Office**
States served: Alabama, North Carolina, South Carolina, Florida, Georgia, Kentucky, Mississippi, Tennessee
- **Health Standards & Quality**
Center for Medicare Services
61 Forsythe Street, SW, #4T20
Atlanta, GA 30301-8909
Phone: (404) 562-7458
Fax: (404) 562-7477 or 7478

Regional Offices (continued)

- **Region V: Chicago Regional Office**
States served: Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin
- **Health Standards & Quality**
Center for Medicare Services
233 N. Michigan Ave, Suite 600
Chicago, IL 60601
Phone: (312) 353-8862
Fax: (312) 353-3419

Regional Offices (continued)

- Region VI: Dallas Regional Office
States served: Arkansas, Louisiana, New Mexico,
Oklahoma, Texas
- State Operations Branch (TX)
Center for Medicare Services
1301 Young St., 8th Floor
Dallas, TX 75202
Phone: (214) 767-6179
Fax: (214) 767-0270

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Regional Offices (continued)

- State Operations Branch (OK, NM)
Center for Medicare Services
1301 Young St., 8th Floor
Dallas, TX 75202
Phone: (214) 767-3570
Fax: (214) 767-0270
- State Operations Branch (AR, LA)
Center for Medicare Services
1301 Young St., 8th Floor
Dallas, TX 75202
Phone: (214) 767-6346
Fax: (214) 767-0270

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Regional Offices (continued)

- **Region VII: Kansas City Regional Office**
States served: Iowa, Kansas, Missouri, Nebraska
- **Center for Medicare Services**
Richard Bolling Federal Building
601 E. 12th St., Room 235
Kansas City, MO 64106-2808
Phone: (816) 426-2408
Fax: (816) 426-6769

Regional Offices (continued)

- **Region VIII: Denver Regional Office**
States served: Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming
- **Health Standards & Quality**
Center for Medicare Services
1600 Broadway, Suite 700
Denver, CO 80202
Phone: (303) 844-2111
Fax: (303) 844-3753

Regional Offices (continued)

- Region IX: San Francisco Regional Office
States and territories served: American Samoa, Arizona, California, Commonwealth of Northern Marianas Islands, Guam, Hawaii, Nevada
- Health Standards & Quality
Center for Medicare Services
75 Hawthorne Street, 4th Floor
San Francisco, CA 94105-3903
Phone: (415) 744-3753
Fax: (415) 744-2692

Regional Offices (continued)

- Region X: Seattle Regional Office
States served: Alaska, Idaho, Oregon, Washington
- Health Standards & Quality
Center for Medicare Services
2201 Sixth Ave.
Mail Stop RX40
Seattle, WA 98121-2500
Phone: (206) 615-2410
Fax: (206) 625-2435

EMTALA



Are you up to the challenge?

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