

# EMTALA and OB Issues



# Welcome and Background

- Chris Clarke, RN, Sr. VP Clinical Services, THA

# Background

- Several TN hospitals cited for OB EMTALA over the past year -18 months
- Citations focused primarily on the role of the RN in the medical screening exam
- Region 4 CMS opinion that TN Scope of Practice for Registered Nurses prohibits medical diagnosis and therefore RN can not do Medical Screening Exam for purposes of EMTALA. Therefore, requires a face to face evaluation by the physician in their opinion

# Background and Steps to Address

- THA consulted with legal counsel and TN Dept. of Health and Board of Nursing
- THA sent a memo out outlining the issue so it would be on the radar screen of hospitals
- THA sponsors an all day EMTALA seminar and does a three part web based webinar that covers all 68 pages of the EMTALA regulation
- THA and member representatives met with CMS leadership in Washington

# Background and Steps to Address

- THA worked with the board of nursing to adopt a position statement last May stating that assessment of the pregnant woman for labor was within the scope of practice
- THA successfully introduced legislation to amend the nurse practice act specific to this issue with broad support from medical and nursing organizations.
- THA sends out memo on the updated Nurse Practice Act, PC 12

# MEMORANDUM

MAR 27, 2019

**TO:**

Chief Executive Officers  
Chief Operating Officers  
Chief Nursing Officers  
Government Affairs Contacts  
Chief Legal Officers/General Counsel

**FROM:**

Chris Clarke, Senior Vice President, Clinical Services

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**THA'S NURSE PRACTICE ACT CLARIFICATION ENACTED AS PUBLIC CHAPTER 12**

Last week, Governor Bill Lee signed THA's legislation to clarify a portion of Tennessee's Nurse Practice Act related to assessments by registered nurses (RN) to determine if an emergency medical condition is present.– SB317 by Sen. Shane Reeves (R-Murfreesboro) / HB199 by Rep. Kevin Vaughan (R-Collierville).

The legislation now has been enacted as [Public Chapter 12](#).

The bill was amended to address minor concerns from the Tennessee Department of Health (TDH) and other stakeholders, while preserving the intent of the original bill.

This legislation was necessary to allow in statute that patient assessments performed by a qualified registered nurse (RN) to determine if an emergency medical condition exists are not prohibited as a medical diagnosis.

THA and some member hospitals and health systems made a trip to Washington, D.C., to meet with CMS officials in 2018 to address the increase in EMTALA citations and seek

# Implementation Guidance

- Today, we want to provide detailed guidance on the EMTALA requirements and considerations for hospitals that perform obstetrical services as you update and reassess your policies and your procedures.



# Speaker



- Sue Dill Calloway RN, Esq.  
CPHRM, CCMSCP, CCMSCP
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# What was the problem?



# What was the Problem?

- In Tennessee there were several hospitals cited for EMTALA regarding OB patients
- The question involved was what is the scope of practice for a RN in assessing a patient who is pregnant who comes to the hospital
- The federal EMTALA law requires that an appropriate medical screening exam (MSE) be done to determine if the patient is in an emergency medical condition (EMC)
- CMS talks about what should be assessed for pregnant women

# What was the Problem?

- The medical records must show evidence that the medical screening examination (MSE) included the following:
  - Ongoing evaluation of fetal heart tones,
  - Regularity and duration of uterine contractions,
  - Fetal position and station,
  - Cervical dilation,
  - And status of the membranes, i.e., ruptured, leaking, intact.

# What was the Problem?

- CMS requires that the exam be done by an individual who is determined to be qualified by the hospital bylaws or rules and regulations (R/R)
- The designation of the qualified medical personnel (QMP) should be set forth in a document approved by the board
- So some hospitals were allowing nurses to do the initial exam without any policies and procedure, board documents, or provision in the bylaws or R/R
- There were no documents that discussed who was competent or trained to perform a MSE

# What was the Problem?

- Many Tennessee hospitals would have the OB RN do an assessment of the pregnant patient and then contact or call the physician or provide and rely the results of the assessment
- The issue was raised whether the obstetrical screenings done by a qualified nurse exceeded the scope of practice under the nurse practice act
- The Tennessee Nurse Practice Act, Section 63-7-103, says that a nurse (other than an advanced practice nurse) may not perform **medical diagnosis** or develop a medical plan of care.

# What was the solution?



# What was the Solution?

- The Tennessee Board of Nursing and the Tennessee legislature works with THA
- The Nurse Practice Act (NPA) was amended as Public Chapter 12
- It was signed into law by Governor Bill Lee SB 317
- It states that the a qualified RN is not precluded from determining whether a patient presenting to the hospital has an emergency medical condition (EMC) if this is made pursuant to three things





# *State of Tennessee*

## **PUBLIC CHAPTER NO. 12**

**SENATE BILL NO. 317**

**By Reeves, Jackson, Robinson, Swann, Yarbro**

Substituted for: House Bill No. 199

By Vaughan, Gant, White, Carter, Hardaway

AN ACT to amend Tennessee Code Annotated, Title 63, Chapter 7, Part 1 and Title 68, relative to the practice of nursing with respect to emergency medical conditions.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Section 63-7-103, is amended by adding the following as a new subsection:

(c)(1) This section does not preclude a qualified registered nurse from determining whether a patient presenting to a hospital has an emergency medical condition if the determination is pursuant to:

(A) A cooperative working relationship with a physician; and

# What was the Solution?

- First, there needs to be a cooperative working relationship with a physician
  - For example, the RN assesses the patient and immediately calls or contacts the physician
- Second, the hospital needs protocols that are jointly developed by the hospital's medical and nursing leadership
  - Note CMS says nursing leadership is more than the CNO
- Third, the protocols must be adopted by the hospital's medical staff (which is usually the MEC) and board

# What was the Solution?

- The statute also provided a definition of what is an emergency medical condition (EMC) which is also defined in the EMTALA law
- This is discussed in more detail later but the following is what is contained in the Tennessee law

# What is an EMC?

- An EMC means:
- A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:
  - Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or the woman's unborn child, in serious jeopardy
  - Serious impairment to bodily function
  - Serious dysfunction of any bodily organ or part and

# What is an EMC?

- With respect to a pregnant woman who is having contractions:
  - That there is adequate time to effect a safe transfer to another hospital before delivery; or
  - That transfer may pose a threat to the health or safety of the woman or the woman's unborn child; and
- A qualified RN who possesses the skills and competency to make a determination of the existence of a specified EMC of a patient presenting to the hospital

# What was the Solution?

- A qualified RN is defined in the law
- A qualified RN is defined to mean a RN who has been approved by the hospital board, based on the recommendations of hospital nursing leadership
- **So in summary:**
- Every hospital in Tennessee should be aware of this law
- You want to cite this law in your EMTALA policy
- You want to make sure all staff are aware of the EMTALA policy

# What the Hospital Needs to do

- You need a **protocol** that is developed by MEC and nursing leadership
  - Remember CMS says nursing leadership is more than just the CNO. It would include the department directors or managers such as the OB nurse manager and the ED nurse manager
  - Also remember that CMS has requirements in the hospital CoPs that address requirements of protocols
  - For example, Tag 457 says all protocols must be reviewed on an annual basis, that all protocols must be entered into the medical record, protocols must be signed off, dated and timed

# What the Hospital Needs to do

- The hospital must determine that the nurse is both educated and competent
  - Many hospitals do a similar process like credentialing
  - One hospital requires all RNs in order to be qualified to have one year of OB experience
  - They require successful passage of two course and one includes a fetal monitoring course
  - The nurse completes a form and once verified it is then approved by the MEC and then the board
  - The OB unit has a current list of qualified RNs



# What the Hospital Needs to do

- Remember the EMTALA law also requires:
  - A section in the medical staff bylaws and R/R to allow a qualified RN or QMP to do a MSE
  - That it is approved by the board in a document that defines what is a qualified RN which is defined in the statute
- The policies should be written so that staff can understand them
- Policies should be consistent with the EMTALA law and OIG requirements

# What the Hospital Needs to do

- Many hospitals will direct a pregnant woman over 20 weeks gestation with pregnancy related medical conditions to labor and delivery
- A licensed physician should be immediately available by telephone or available onsite
- Consider annual education on EMTALA

# CMS EMTALA Requirements




# EMTALA is a Problematic Standard

- Article found that 30% of all hospitals have violated EMTALA
- Violations occur more frequently in hospitals with less than 100 beds (34%)
- More violations in the southeast region
- The three most common violations were failure to do MSE, not transferring patients properly, and the ED log
- From 2016 to 2018 there were 34 patient deaths
- Many related to OB claims

# 30% of hospitals have violated EMTALA, investigation finds


Written by Mackenzie Bean | December 11, 2018 | [Print](#) | [Email](#)

 Share Nearly one-third of U.S. hospitals have violated emergency department care standards set by the Emergency Medical Treatment and Labor Act in the last decade, according to an [investigative report](#) from *WebMD* and *Georgia Health News*.

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3

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 *WebMD* and *Georgia Health News* reporters secured a list of all EMTALA violations reported between 2008-18 from CMS via a Freedom of Information Act request. They also requested full reports for violations in the past 27 months. The geographic information systems company Esri helped analyze the data.

Here are five findings:

1. Reporters found 4,341 EMTALA violations occurred at 1,682 hospitals nationwide between 2008-18.
2. EMTALA violations occurred more often at hospitals with fewer than 100 beds, with these hospitals accounting for 34 percent of violations.
3. Violations were also more likely to occur at hospitals in the Southeast region. Investigators found 1,175 violations occurred at hospitals in this region.
4. The three most common violations were failing to conduct thorough medical screenings (1,353 violations), not transferring patients properly (701) and not following ED log standards (607).
5. Between 2016-18, EMTALA violations were linked to at least 34 patient deaths.

# EMTALA Data on Deficiencies



# Access to Hospital Complaint Data

- CMS issued Survey and Certification memo on March 22, 2013 regarding access to hospital complaint data
- Includes acute care and CAH hospitals
  - Does not include the plan of correction but can request
  - Questions to [bettercare@cms.hhs.com](mailto:bettercare@cms.hhs.com)
- This is the CMS 2567 deficiency data and lists the tag numbers
- Updated quarterly
  - Available under downloads on the hospital website at [www.cms.gov](http://www.cms.gov)

# Updated Deficiency Data Reports



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## Survey & Certification - Certification & Compliance

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- [Psychiatric Hospitals](#)
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## Hospitals

This page provides basic information about being certified as a Medicare and/or Medicaid hospital provider and includes links to applicable laws, regulations, and compliance information.

A hospital is an institution primarily engaged in providing, by or under the supervision of physicians, inpatient diagnostic and therapeutic services or rehabilitation services. Critical access hospitals are certified under separate standards. Psychiatric hospitals are subject to additional regulations beyond basic hospital conditions of participation. The State Survey Agency evaluates and certifies each participating hospital as a whole for compliance with the Medicare requirements and certifies it as a single provider institution.

Under the Medicare provider-based rules it is possible for 'one' hospital to have multiple inpatient campuses and outpatient locations. It is not permissible to certify only part of a participating hospital. Psychiatric hospitals that participate in Medicare as a Distinct Part Psychiatric hospital are not required to participate in their entirety.

However, the following are not considered parts of the hospital and are not to be included in the evaluation of the hospital's compliance:

- Components appropriately certified as other kinds of providers or suppliers. i.e., a distinct part Skilled Nursing Facility and/or distinct part Nursing Facility, Home Health Agency, Rural Health Clinic, or Hospice; Excluded residential, custodial, and non-service units not meeting certain definitions in the Social Security Act; and,
- Physician offices located in space owned by the hospital but not functioning as hospital outpatient services departments

**Accredited Hospitals** - A hospital accredited by a CMS-approved accreditation program may substitute accreditation under that program for survey by the State Survey Agency. Surveyors assess the hospital's compliance with the Medicare Conditions of Participation (CoP) for all services, areas and locations covered by the hospital's provider agreement under its CMS Certification Number (CCN).

Although the survey generally occurs during daytime working hours (Monday through Friday), surveyors may conduct

■ [www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Hospitals.html](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Hospitals.html)



# Deficiencies

January 9, 2019

|   |              |
|---|--------------|
| <b>Tag 2400 Compliance with EMTALA 489.24</b> | <b>1,253</b> |
| Tag 2401 Receiving Inappropriate Transfer     | 19           |
| Tag 2402 Posting Signs                        | 258          |
| Tag 2403 Maintain MR                          | 43           |
| <b>Tag 2404 On call physician</b>             | <b>197</b>   |

# Deficiencies, January 9, 2019

|                    |   |       |                    |
|--------------------|---|-------|--------------------|
| Tag<br><b>2405</b> | ED Log  | 438   |                    |
| 2406               | MSE   | 1,040 |                    |
| 2407               | Stabilization Treatment                         | 415   |                    |
| 2408               | Delay in Exam                                   | 102   |                    |
| 2409               | Appropriate Transfer                            | 549   |                    |
| 2410               | Sp Capability & Lateral Transfers Whistleblower | 1     |                    |
| 2411               | Recipient Hospital Responsibility               | 149   | <b>Total 4,472</b> |

# CMS Surveyor Course on EMTALA



# CMS Surveyor Training Website

- CMS has a surveyor training website
- Hospitals can also take the training classes and access webcasts and videos
  - <https://surveyortraining.cms.hhs.gov>
  - Click on “provider” and has user manual
  - Has 13 hospital training courses and infection control
  - Hospital basic training part 1 and 2
  - **Has 28 hour EMTALA course**
- There is a help desk to assist if you need assistance
  - 855 791-8900 or [cmstraininghelp@hendall.com](mailto:cmstraininghelp@hendall.com)
  - Course catalog to see available resources

# CMS Surveyor Training Website

**ISTW** CMS SURVEY AND CERTIFICATION GROUP  
Integrated Surveyor Training Website

User Manual | Support Center | CMS.gov



## WELCOME

Welcome to the CMS, Center for Clinical Standards and Quality, Survey and Certification Group training site. Select an option at the right to continue.

[I AM A SURVEYOR >](#)

[I AM A PROVIDER >](#)

<https://surveyortraining.cms.hhs.gov>

## CMS SCG NEWS

We have been busy developing and testing new functionality for the Integrated Surveyor Training Website (ISTW). We plan to release this functionality on the

# EMTALA and the OIG



# EMTALA and the OIG

- OIG issued final rules that became **effective January 6, 2017**
- Published in the Federal Register
- 32 pages long
- Changed the civil monetary penalty (CMP) or fine for violating the federal EMTALA law
- Any additional questions contact Katie Arnholt at 202 619-0335 Office of Counsel to the OIG
- Also clarified liability under EMTALA

# EMTALA and the OIG

## Medicare and State Health Care Programs: Fraud and Abuse; Revisions to the Office of Inspector General's Civil Monetary Penalty Rules

A Rule by the [Health and Human Services Department](#) on 12/07/2016

[www.federalregister.gov/documents/2016/12/07/2016-28293/medicare-and-state-health-care-programs-fraud-and-abuse-revisions-to-the-office-of-inspector](http://www.federalregister.gov/documents/2016/12/07/2016-28293/medicare-and-state-health-care-programs-fraud-and-abuse-revisions-to-the-office-of-inspector)

PUBLISHED DOCUMENT

Start Printed Page 88334

**AGENCY:**  
Office of Inspector General (OIG), HHS.

**ACTION:**  
Final rule.

**SUMMARY:**  
This final rule amends the civil monetary penalty (CMP or penalty) rules of the Office of Inspector General to incorporate new CMP authorities, clarify existing authorities, and reorganize regulations on civil money penalties, assessments, and exclusions to improve readability and clarity.

**DOCUMENT DETAILS**

**Printed version:**  
[PDF](#)

**Publication Date:**  
12/07/2016

**Agencies:**  
[Department of Health and Human Services](#)  
[Office of Inspector General](#)

**Dates:**  
These regulations are effective on January 6, 2017.

**Effective Date:**  
01/06/2017

**Document Type:**  
Rule

**Document Citation:**  
81 FR 88334



# EMTALA and the OIG

- Published proposed rules on May 12, 2014 and received 27 comments and final Jan 6, 2017
- Clarified that there is a penalty for **each** violation
- OIG will review the facts and circumstances of a violation on a case by case basis
- This includes if there is a pattern
  - Have removed the section on mitigating factors when deciding how much to fine the hospital for an EMTALA violation
- Will also look at if the hospital took appropriate action when it discovered an EMTALA violation

# EMTALA and the OIG

- Clarified that an on-call physician who fails to show up within a reasonable time when requested violates EMTALA and can be fined
- Clarified this includes on-call physicians at hospitals with specialized capabilities
- This includes where a patient may need to be transferred
- Including the on-call physician to accept the transfer when they have specialized capabilities
- Will consider if CMS was notified in advance

# EMTALA and the OIG

- Aggravating circumstances include:
  - A request for proof of insurance prior to screening
  - Request for payment prior to screening or treating
  - Patient harm which could include premature discharge
- OIG may fine a physician for making misrepresentation on the patient's condition
- Also discusses that a penalty may be assessed if the patient is kept there an unreasonable amount of time so the patient leaves

# History

- In 1985, Congress enacts EMTALA which became effective in August 1, 1986
- It has changed dramatically since the original law was enacted
- Called the “genesis of EMTALA”,
- Note the word “**ACTIVE**” is not part of the name anymore
- EMTALA or Emergency Medical Treatment and Labor Act

# Who are the Players?

- **CMS** or the Center for Medicare and Medicaid Services
- **OIG** is the Office of Inspector General
- **QIO** (Quality Improvement Organization)
- **State survey agencies** (abbreviated SA and an example is the Department of Health)
  - In Ky it is the OIG

# EMTALA Penalties

- It is especially important for physicians and hospitals to make sure they are in compliance with the federal EMTALA law
  - The penalties have recently gone up significantly
  - In fact, it more than doubled now
- This is as a result of the Federal Civil Penalties Inflation Adjustment Act of 2015
- From \$50,000 to 103,139.00 for hospitals with 100 beds or more and Feb 2017 inflation to **104,826**
- From 25,000 to \$51,570 hospitals less than 100 with Feb 2017 inflation to **\$52,414**




# CMS EMTALA Website

- CMS has a website that lists resources on this issue
- It includes CMS guidance to state survey agency directors and CMS regional offices
- Includes information about the Technical Advisory Group (TAG), complaint procedures, EMTALA survey and certification letters, transmittals, etc.
- Available at <http://www.cms.gov/EMTALA/>

# CMS EMTALA Website

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Home > Regulations and Guidance > Emergency Medical Treatment & Labor Act (EMTALA) > Emergency Medical Treatment & Labor Act (EMTALA)

## Emergency Medical Treatment & Labor Act (EMTALA)

[CMS Guidance to State Survey Agency Directors](#)

[Emergency Medical Treatment and Labor Act Technical Advisory Group \(EMTALA TAG\)](#)

## Emergency Medical Treatment & Labor Act (EMTALA)

In 1986, Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented.

### Downloads

[CMS-1063F \[PDF, 716KB\]](#) 

[State Operations Manual: Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases \[PDF, 531KB\]](#) 

### Related Links

[Revisions to Appendix V - Inpatient Prospective Payment System \(IPPS\) 2009 Final Rule Revisions to EMTALA Regulations \[Survey and Certification Letter 09-26\]](#)

[Policy & Memos to States and Regions](#)

[Transmittal \(05/21/2004\): Release of Basic Manual \(State Operations Manual\)](#)

[Transmittal \(11/22/2004\): Payment for Emergency Medical Treatment and Labor Act \(EMTALA\) - Mandated Screening and Stabilization Services](#)

[CMS-1350-NC: Emergency Medical Treatment and Labor Act \(Published February 2, 2012\) -- PDF Version](#)

[CMS-1350-NC: Emergency Medical Treatment and Labor Act \(Published February 2, 2012\) -- Text Version](#)

[CMS-1350-ANPRM: Emergency Medical Treatment and Labor Act: Applicability to Hospital and Critical Access Hospital Inpatients and Hospitals with Specialized Capabilities \(Published December 23, 2010\) -- PDF Version](#)

[www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html](http://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html)



# How to Keep Up with Changes

- First, periodically check to see you have the most current CoP manual and sign up to get the Federal Register<sub>1</sub>
- Once a month go out and check the survey and certification website<sub>2</sub>
- Once a month check the CMS transmittal page and see if new manual<sub>3</sub>
  - Have one or two person in your facility who has this responsibility

■ <sub>1</sub> [http://www.cms.hhs.gov/manuals/downloads/som107\\_Appendicestoc.pdf](http://www.cms.hhs.gov/manuals/downloads/som107_Appendicestoc.pdf)

■ <sub>2</sub> <http://www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage>

■ <sub>3</sub> <http://www.cms.gov/Transmittals>

# Location of CMS Hospital CoP Manuals

## Medicare State Operations Manual Appendix

Email questions to CMS at [hospitalscg@cms.hhs.gov](mailto:hospitalscg@cms.hhs.gov)

- Each Appendix is a separate file that can be accessed directly from the SOM Appendices Table of Contents, as applicable.
- The appendices are in PDF format, which is the format generally used in the IOM to display files. Click on the red button in the "Download" column to see any available file in PDF.
- To return to this page after opening a PDF file on your desktop, use the browser "back" button. This is because closing the file usually will also close most browsers.

| App. No. | Description           | PDF File   |
|----------|-----------------------|--|
| A        | Hospitals             |  <a href="#">2,185 KB</a> |
| AA       | Psychiatric Hospitals |  <a href="#">606 KB</a>   |

# EMTALA is Appendix V

| Appendix Letter | Description   |
|-----------------|---|
| PP              | Interpretive Guidelines for Long-Term Care Facilities                                   |
| Q               | Determining Immediate Jeopardy  |
| R               | Resident Assessment Instrument for Long-Term Care Facilities                            |
| S               | Mammography Suppliers - Deleted   |
| T               | Swing-Beds  |
| U               | Responsibilities of Medicare Participating Religious Nonmedical Healthcare Institutions |
| V               | Responsibilities of Medicare Participating Hospitals In Emergency Cases                 |
| W               | Critical Access Hospitals (CAHs)  |
| Y               | Organ Procurement Organization (OPO)  |

# Policy & Memos to States and Regions

- This is a very **important website**
- Hospitals may want to have one person periodically check this, at least once a month
- This is where **new interpretive guidelines** are published
- This is where new EMTALA memos are posted
- <http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage>

# CMS Survey and Certification Website

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## Survey & Certification - General Information

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- » CMS National Background Check Program
- » Nursing Home Quality Assurance & Performance Improvement Initiative
- » Revisit User Fee Program
- » Accreditation
- » **Policy & Memos to States and Regions**

## Policy & Memos to States and Regions



CMS Survey and Certification memoranda, guidance, clarifications and instructions to State Survey Agencies and CMS Regional Offices.

### Select From The Following Options:

- Show all items
- Show only (select one or more options):
  - Show only items whose  is within the past
  - Show only items whose Fiscal Year is
  - Show only items containing the following word

There are 455 items in this list.

■ [www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp](http://www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp)  
#TopOfPage

■ Click on policy and memos to states and regions!

# EMTALA Requirements

- Do not delay a MSE to inquire about insurance or seek financial information first
- Understand when patients can sign out AMA and what the hospital's responsibility is
- Understand the specialized capability requirements such as a hospital that does not have an OB department needs to send the hospital a transfer and they have beds and staff
- Make sure the OB area has a sign as required



# **IT'S THE LAW**

**IT'S THE LAW!**  
IF YOU HAVE A MEDICAL EMERGENCY OR ARE IN LABOR  
YOU HAVE THE RIGHT TO RECEIVE, within the capabilities  
of this hospital's staff and facilities:  
• An appropriate MEDICAL SCREENING EXAMINATION  
• Necessary STABILIZING TREATMENT (including  
treatment of an unborn child)  
and if necessary  
• An appropriate TRANSFER to another facility  
even if  
**YOU CANNOT PAY or DO NOT HAVE MEDICAL INSURANCE**

**IF YOU HAVE A MEDICAL EMERGENCY OR ARE IN  
LABOR, YOU HAVE THE RIGHT TO RECEIVE,  
within the capabilities of this hospital's staff  
and facilities:**

**An appropriate Medical SCREENING EXAMINATION**

**Necessary STABILIZING TREATMENT  
(including treatment for an unborn child) and, if necessary,**

**An appropriate TRANSFER to another facility**

**Even if YOU CANNOT PAY or DO NOT HAVE  
MEDICAL INSURANCE**

**or**

**YOU ARE NOT ENTITLED TO MEDICARE OR MEDICAID**

**This hospital (DOES/DOES NOT) participate in the Medicaid Program**

# EMTALA Requirements

- Hospitals are required to adopt an EMTALA policy which needs to comply with the EMTALA requirements
- The OIG and CMS recommend training of all on-call physicians including OB physicians
- Make sure the MSE is well documented in the medical record
- Make sure the on-call physician shows up timely
- Don't forget to have a central log in OB



# Central Log 2405

- A central log must be kept on each individual who comes to the emergency department or OB seeking assistance
- Can be paper or electronic log
- Log has to include a number of things
  - Whether patient refused treatment or left AMA
  - Whether patient was transferred

# Central Log 2405

- Must include if admitted, stabilized, transferred or discharged
- Often hospitals will include other things such as a diagnosis, chief complaint, age, and physician
- Purpose is to track care provided to each individual
- Must include or by reference, patient logs from other areas of the hospital considered DED (such as OB)

# EMTALA Requirements

- Make sure staff understand the MSE requirements under tag 2406

# MSE 2406

- MSE is an ongoing process
- ED Triage is not generally considered to be a MSE, OB triage may be done or a more comprehensive assessment (discussed later)
  - 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 who is 4 cm dilated is treated differently than one who is 10 cm dilated and 100% effaced or a patient with preeclampsia

# Medical Screening Examination

- The MSE must be adequate and appropriate (again will vary based on the patient's condition, complaints and history except for pregnant women)
- This means the same screening exam as all others presenting to the ED (same standard of care)
- Request for MSE or treatment can be made by anyone, family member, squad, police, or bystander

# 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
- Including fetal position and station
- Including cervical dilation, status of membranes (leaking, intact, ruptured)

# MSE for Pregnant Patients

- Most emergency departments direct women over 20 weeks gestation with pregnancy related complaints to LD
- Any doubt about the nature of the complaint, then can have ED nurse triage
- Acceptable to CMS
- If pregnant trauma patient, OB nurse should go to the ED to evaluate the patient
- Make sure hospital has P&P and all staff in the ED and OB know the policy

# 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 is experiencing contractions is in true labor unless 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, after a reasonable time of observation, the woman is in false labor



# Certification of False Labor

- Physician or QMP have to examine patient to determine if EMC exists
- True labor is an EMC? (never defined in original statute as an EMC)
- This means if the physician or QMP diagnoses that the woman is in false labor, then the MD, QMP or nurse midwife is required to certify diagnosis before discharge
- Woman experiencing contractions are in true labor unless MD, certified nurse midwife or QMP acting within their scope of practice certifies that... woman is false labor after a reasonable time of observation

# Certification of False Labor

- If woman is in false labor, the MD, QMP or nurse midwife is required to certify diagnosis before discharge
- And 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)

# Certification of False Labor Sample Form

- CMS requires the certification of false labor.
  - Section 489.24(B) defines what constitutes labor.
- Labor is defined to mean the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta.
- A woman is experiencing contractions is in true labor unless a physician, certified nurse-midwife, or other qualified medical personnel acting within his or her scope of practice, as defined in the hospital medical staff bylaws and State law.
- Certifies that, after a reasonable time of observation, the woman is in false labor,

# Certification of False Labor Sample Form

- 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 \_\_\_\_\_

# Born Alive law

- Born-Alive Infants Protection Act of 2002, and CMS added to EMTALA interpretive guidelines under Tag 2406
- CMS Issued April 22, 2005, Reference S&C-05-26, bulletin that advises state survey agencies that violations of this Act should be investigated as potential EMTALA violations
- Available at <http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter05-26.pdf>

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 and hospital would have to be resuscitate if request made for MSE on infant's behalf
- Infant is deemed an individual
- ED and L&D meets the definition of DED and EMTALA applies
- If born else where on campus and the lay person standard that infant had EMC
- <http://pediatrics.aappublications.org/cgi/content/full/116/4/e576>

# Born Alive Law

- In complaint manual, has section updated 2013
- Tells surveyor how to handle a complaint
- Definition of person and individual under 1 USC 8(a) it is clear that EMTALA is applicable to infant born alive
- Does say if request was made on infant's behalf or based on infant's appearance that infant needed examination and treatment
- At <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>



# Transfer of OB Patients

- Sometimes it is the best interest of the patient to transfer them to another facility
- CMS says:
  - In the case of a pregnant woman, is there inadequate time to affect a safe transfer to another hospital before delivery, or the transfer posed a threat to the health and safety of the woman or the unborn child
- Only a physician can authorize a transfer and the transfer agreement

# Transfer of OB Patients

- A qualified medical person (QMP) may sign the certification of benefits versus risks of a transfer only after consultation with a physician who agrees with the transfer
- The physician must subsequently countersign the certification

# Resources



# ACOG Hospital Based Triage of OB Patients

- ACOG has a committee opinion on this
- Hospital based OB units are urged to collaborate with the Emergency Department to establish guidelines for triage of pregnant patients
- Recently developed, validated ob triage acuity tools may improve the quality and efficiency of care
- EMS should have guidelines and take the pregnant patient to the most appropriate facility
- EMTALA requires a MSE to determine if a true emergency exists



The American College of  
Obstetricians and Gynecologists  
WOMEN'S HEALTH CARE PHYSICIANS

[www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Hospital-Based-Triage-of-Obstetric-Patients](http://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Hospital-Based-Triage-of-Obstetric-Patients)

# COMMITTEE OPINION

Number 667, July 2016

(Reaffirmed 2018)

## Committee on Obstetric Practice

*This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Obstetric Practice in collaboration with committee members George A. Macones, MD; Christian M. Pettker, MD; Maria A. Mascola, MD, MPH; and R. Phillips Heine, MD.*

*This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.*

[PDF Format](#)

## Hospital–Based Triage of Obstetric Patients

**ABSTRACT:** Emergency departments typically have structured triage guidelines for health care providers encountering the diverse cases that may present to their units. Such guidelines aid in determining which patients must be evaluated promptly and which may wait safely, and aid in determining anticipated use of resources. Although labor and delivery units frequently serve as emergency units for pregnant women, the appropriate structure, location, timing, and timeliness for hospital–based triage evaluations of obstetric patients are not always clear. Hospital–based obstetric units are urged to collaborate with emergency departments and hospital ancillary services, as well as emergency response systems outside of the hospital, to establish guidelines for triage of pregnant women. Recently developed, validated obstetric triage acuity tools may improve quality and efficiency of care and guide resource use, and they could serve as a template for use in individual hospital obstetric units.

---

## Recommendations

# ACOG Hospital Based Triage of OB Patients

- This might include pre-term labor, large abruptio placenta, seizure, preeclampsia, decreased fetal movement, etc.
- A woman having contractions is not an emergency if there is adequate time for her safe transfer before delivery
  - If the transfer would not pose a threat to mom or the baby
- Elaborates on key principles in two books;  
Guidelines for Perinatal Care and Liability in Triage:  
Management of EMTALA Regulation and Common  
OB Risks

# ACOG Hospital Based Triage of OB Patients

- Requirements include:
  - Qualified person must do an appropriate MSE to determine if a EMC exists
  - This person must be qualified and designated by hospital policy
  - If an EMC exists then the patient must be stabilized
  - If the patient is transferred the EMTALA requirements must be followed
  - This includes transfer by qualified personnel and equipment and risks verses benefits must be considered
  - Can't delay MSE to ask about payment or insurance

# ACOG Hospital Based Triage of OB Patients

- Best to have a separate triage area to do an initial assessment and set a priority level
- Can be done by RN, CNM, PA, NP, OB resident, or physician as designated by policy
- Triage is followed by a complete evaluation by a healthcare provider with skills and training in the issues identified during triage
- Should have written guidelines on which is the appropriate unit based on gestational age, delivery status, symptoms, medical condition, and available medical staff



# ACOG Hospital Based Triage of OB Patients

- For example: non-ob conditions such as highly transmissible infectious diseases like the flu in another area of the hospital
- Trauma from a serious auto accident might be treated in the emergency department and ED uses 5 level ESI level
- Note that many hospitals send the patient who is 20 weeks or more to the OB unit for their MSE, with exceptions
- Several OB tools have been developed based on this model such as the MFTI

# Maternal Fetal Triage Index (MFTI)

Implement appropriate infectious disease control processes for triage and evaluation.

**YES** Is the woman presenting for a scheduled procedure and has no complaint?

**NO**

Does the woman or fetus have STAT/PRIORITY 1 vital signs?

OR

Does the woman or fetus require immediate lifesaving intervention?

OR

Is birth imminent?

**YES**

**STAT/  
PRIORITY 1**

## Abnormal Vital Signs

Maternal HR <40 or >130, apneic, SpO<sub>2</sub> <93%, SBP ≥160 or DBP ≥110 or <60/palpable, No FHR detected by doppler (unless previously diagnosed fetal demise), FHR <110 bpm for >60 seconds

### Immediate lifesaving intervention required, such as:

#### Maternal

- Cardiac compromise
- Severe respiratory distress
- Seizing
- Hemorrhaging

- Acute mental status change or unresponsive (cannot follow verbal commands)
- Signs of placental abruption
- Signs of uterine rupture

#### Fetal

- Prolapsed cord

#### Imminent Birth

- Fetal parts visible on the perineum
- Active maternal bearing-down efforts

**STAT**

**PRIORITY 1**

**NO**

Does the woman or fetus have URGENT/PRIORITY 2 vital signs?

OR

Is the woman in severe pain without complaint of contractions?

OR

Is this a high-risk situation?

OR

Will this woman and/or newborn require a higher level of care than institution provides?

**YES**

**URGENT/  
PRIORITY 2**

## Abnormal Vital Signs

Maternal HR >120 or <50, Temperature ≥101.0°F, 38.3°C, RR >26 or <12, SpO<sub>2</sub> <95%, SBP ≥140 or DBP ≥90 symptomatic\* or <80/40, repeated; FHR >160 bpm for >60 seconds; decelerations

### Severe Pain: (unrelated to ctx) ≥7 on a 0-10 pain scale

### Examples of High-Risk Situations

- Unstable, high risk medical conditions
- Difficulty breathing
- Altered mental status
- Suicidal or homicidal
- <34 wks c/o of, or detectable, uterine ctx
- <34 wks c/o of SROM/leaking or spotting
- Active vaginal bleeding (not spotting or show)
- c/o of decreased fetal movement
- Recent trauma?

### ≥34 wks with regular contractions or SROM/leaking with any of the following

- HIV+
- Planned, medically-indicated cesarean (maternal or fetal indications)
- Breech or other malpresentation
- Multiple gestation
- Placenta previa

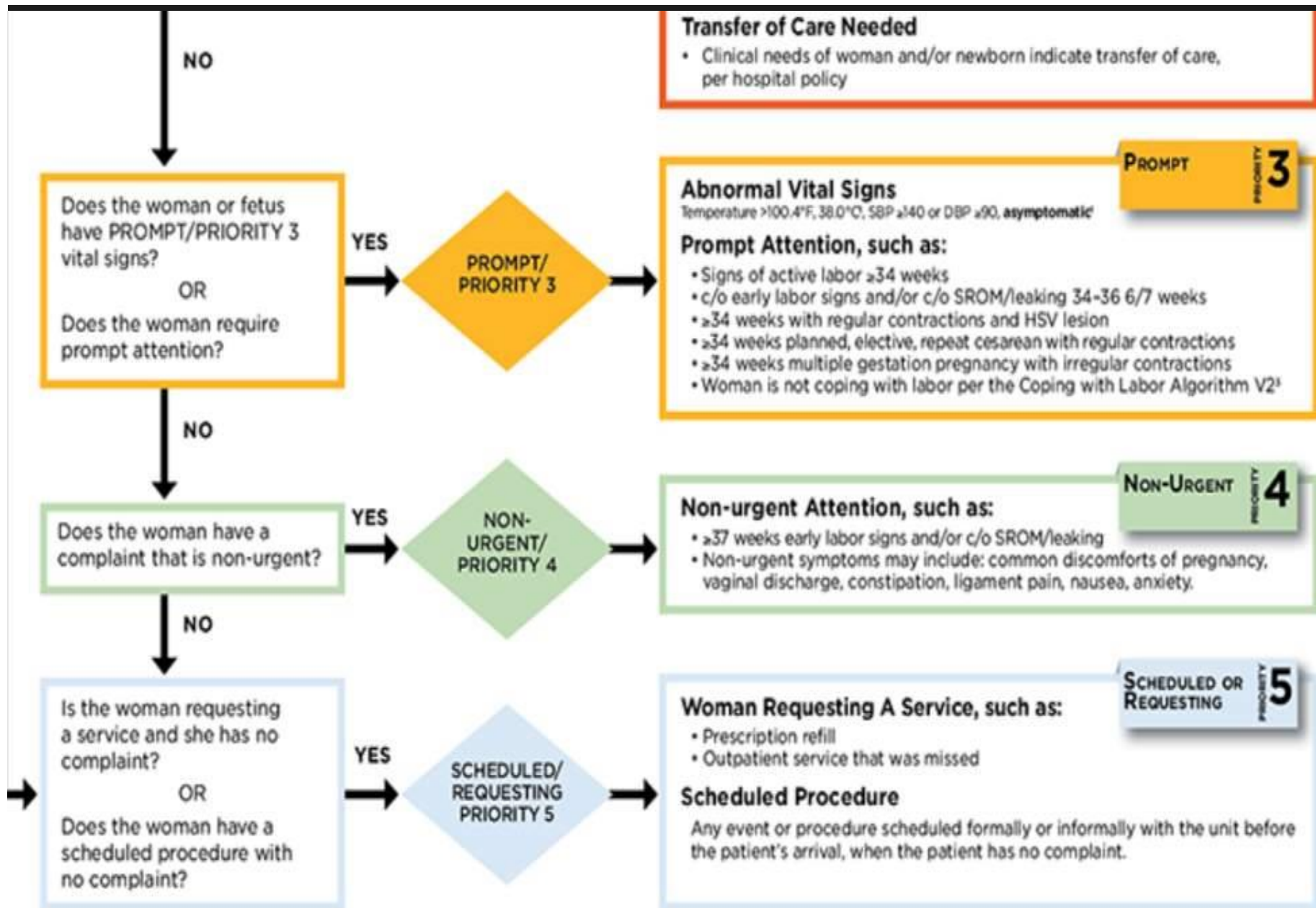
### Transfer of Care Needed

- Clinical needs of woman and/or newborn indicate transfer of care, not hospital policy

**URGENT**

**PRIORITY 2**

**NO**



### Transfer of Care Needed

- Clinical needs of woman and/or newborn indicate transfer of care, per hospital policy

### Abnormal Vital Signs

Temperature >100.4°F, 38.0°C, SBP ≥140 or DBP ≥90, asymptomatic<sup>1</sup>

### Prompt Attention, such as:

- Signs of active labor ≥34 weeks
- c/o early labor signs and/or c/o SROM/leaking 34-36 6/7 weeks
- ≥34 weeks with regular contractions and HSV lesion
- ≥34 weeks planned, elective, repeat cesarean with regular contractions
- ≥34 weeks multiple gestation pregnancy with irregular contractions
- Woman is not coping with labor per the Coping with Labor Algorithm V2<sup>1</sup>

PROMPT PRIORITY 3

### Non-urgent Attention, such as:

- ≥37 weeks early labor signs and/or c/o SROM/leaking
- Non-urgent symptoms may include: common discomforts of pregnancy, vaginal discharge, constipation, ligament pain, nausea, anxiety.

NON-URGENT PRIORITY 4

### Woman Requesting A Service, such as:

- Prescription refill
- Outpatient service that was missed

### Scheduled Procedure

Any event or procedure scheduled formally or informally with the unit before the patient's arrival, when the patient has no complaint.

SCHEDULED OR REQUESTING PRIORITY 5

# For More Information

## More Information: For Committee Opinion #667—Hospital-Based Triage of Obstetric Patients

The American College of Obstetricians and Gynecologists has identified the following resources that may be helpful for ob-gyns, other health care providers, and patients on topics related to Committee Opinion #667 "[Hospital-Based Triage of Obstetric Patients](#)." These materials are for information purposes only and are not meant to be comprehensive. Referral to these resources does not imply ACOG's endorsement of the organization, the organization's website, or the content of the resource. The resources may change without notice.

### External Resources

[The Emergency Medical Treatment & Labor Act \(EMTALA\)](#), Centers for Medicare and Medicaid Services

The US Centers for Medicare and Medicaid Services provide the full text of this US [law](#), which ensures public access to emergency services regardless of ability to pay, and provides links to related materials.

[Implementing an obstetric triage acuity scale: interrater reliability and patient flow analysis](#), *American Journal of Obstetrics and Gynecology*

This [article](#) measures the interrater reliability and validity of the Obstetric Triage Acuity Scale (OTAS), an obstetric triage algorithm developed by the Canadian Association of Emergency Physicians. The study also determines the distribution of patient acuity and flow by OTAS level.

[Maternal Fetal Triage Index \(MFTI\)](#), Association of Women's Health Obstetric and Neonatal Nurses (AWHONN)

AWHONN's validated [tool](#) provides a standardized approach to obstetric triage.


# Implementing an obstetric triage acuity scale: interrater reliability and patient flow analysis

[David S. Smithson](#), MD, [Rachel Twohey](#), MET, [Tim Rice](#), BScN, [Nancy Watts](#), MN, [Christopher M. Fernandes](#), MD, [Robert J. Gratton](#), MD\*  

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DOI: <https://doi.org/10.1016/j.ajog.2013.03.031>

 Article Info

Abstract

Full Text

Images

References

A 5-category Obstetric Triage Acuity Scale (OTAS) was developed with a comprehensive set of obstetrical determinants. The objectives of this study were as follows: (1) to test the interrater reliability of OTAS and (2) to determine the distribution of patient acuity and flow by OTAS level. To test the interrater reliability, 110 triage charts were used to generate vignettes and the consistency of the OTAS level assigned by 8 triage nurses was measured. OTAS performed with substantial (Kappa, 0.61 – 0.77, OTAS 1-4) and near perfect correlation (0.87, OTAS 5). To assess patient flow, the times to primary and secondary health care provider assessments and lengths of stay stratified by acuity were abstracted from the patient management system. Two-thirds of triage visits were low acuity (OTAS 4, 5). There was a decrease in length of stay (median [interquartile range], minutes) as acuity decreased from OTAS 1 (120.0 [156.0] minutes) to OTAS 3 (75.0 [120.8]). The major contributor to length of stay was time to secondary health care provider assessment and this did not change with acuity. The percentage of patients admitted to the antenatal or birthing unit decreased from 80% (OTAS 1) to 12% (OTAS 5). OTAS provides a reliable assessment of acuity and its implementation has allowed for triaging of obstetric patients based on acuity, and a more in-depth assessment of the patient flow. By standardizing assessment,

# AWHONN OB Triage and EMTALA

## Obstetric Triage & EMTALA Regulations

Practice Strategies for Labor and Delivery Nursing Units

[Carol Caliendo](#), ND, CNM, CRNP (professor of nursing)<sup>1</sup>, [Linda Millbauer](#), MSN, CRNP (certified registered nurse practitioner)<sup>2</sup>, [Bonnie Moore](#), MSN, CRNP (triage coordinator)<sup>3</sup>, [Elaine Kitchen](#), MHRM, RN (director)<sup>4</sup>



DOI: <https://doi.org/10.1177/1091592304271627>

[https://nwhjournal.org/article/S1091-5923\(15\)31181-X/fulltext](https://nwhjournal.org/article/S1091-5923(15)31181-X/fulltext)

Abstract Full Text Images References

The purpose of EMTALA (a component of the Consolidated Omnibus Budget Reconciliation Act of 1986 [COBRA]) is to ensure that patients receive emergency or active labor care when they seek it. The EMTALA regulations seek to prevent situations that might result in injuries or deterioration of a condition, such as an institution or provider refusing to treat a client who is not able to pay for care, unnecessary transfers to another hospital or neglect by health care providers when timely care is needed. Since 1996, the Office of the Inspector General (OIG) has made enforcing EMTALA a high priority, fining institutions up to \$250,000 and individuals up to \$50,000 per violation. EMTALA regulations apply to all hospitals that participate in Medicare and to all patients, whether or not they are eligible for Medicare. This includes women presenting to an L&D, as well as all pregnant women seeking care at a hospital for any reason. L&D nurses need pertinent information about EMTALA and how it relates to obstetric triage. This information will allow the obstetric triage nurse to provide care that is safe, efficient and in compliance with federal regulations.

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# Liability in Triage: Management of EMTALA Regulations and Common Obstetric Risks

Diane J. Angelini CNM, EdD, Laura R. Mahlmeister RN, PhD

First published: 24 December 2010 | <https://doi.org/10.1016/j.jmwh.2005.07.006> | Cited by: 11

[Read the full text >](#)



PDF



TOOLS



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## Abstract

<https://onlinelibrary.wiley.com/doi/abs/10.1016/j.jmwh.2005.07.006>

The Emergency Medical Treatment and Active Labor Act (EMTALA) affects all clinicians who provide triage care for pregnant women. EMTALA has specific regulations for hospitals relative to women in active labor. Violations can carry stiff penalties. It is critical for clinicians performing obstetric triage to understand the duties and obligations of this law. This article discusses EMTALA and reviews common liability risks in obstetric triage as well as strategies to modify those risks.


# Implementing an Obstetrics-Specific Triage Acuity Tool to Increase Nurses' Knowledge and Improve Timeliness of Care

[Heather Quaile](#) ✉ 

 PlumX Metrics

DOI: <https://doi.org/10.1016/j.nwh.2018.05.002> |



 Article Info

Abstract **Full Text** Images References

## Abstract

### Objective

To implement an obstetrics-specific triage acuity tool called the Maternal Fetal Triage Index (MFTI) in two maternity units, test the change in nurses' knowledge of triage assessment, and improve timeliness of care.

### Design

A quality improvement project that included pre- and posttesting of nursing knowledge using the MFTI and measuring the difference in time based on time stamps from pregnant women's intake sheets.



# The End! Questions???



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