Emergency Services and Obstetrical Care

New CMS Requirements for Hospitals

Speaker

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DISCLAIMER

The information provided during this program/webinar is informational only. It is not intended to be legal advice or to establish an attorney-client relationship. Please consult with your in-house counsel or professional legal representative for advice.

Introduction

Appendix A – 2 Sections

State Operations Manual
Appendix A - Survey Protocol,
Regulations and Interpretive Guidelines for Hospita

Table of Contents
(Rev. 220; Issued:04-19-24)

Appendix W CAHs

(CAHs) and Swing-Beds in CAHs

(Rev. 200, 02-21-20)

Transmittals for Appendix W

INDEX

Survey Protocol

Regulations and Interpretive Guidelines for CAHs

In The News

- Recent reports of pregnant women turned away for emergency rooms
- Nine-month pregnant patient presented to Texas hospital and physician on-duty refused to see her
  - Said the hospital did not have obstetric services or capabilities
  - Staff offered to test patient for amniotic fluid, but physician recommended she drive to another hospital 30 miles away

"Not Our Client"

- Front desk personnel refused to check in another patient seeking help in delivering the infant
- Husband told could not help because they were not a client of the hospital
  - Miscarried in the ER lobby restroom while husband called 911
  - When EMS personnel asked hospital staff the gestational age refused to provide as "not our patient"
- The hospital no longer takes Medicare

Care Refused

- Pregnant woman who presented with abdominal pain told could not provide an ultrasound
  - Was not told about risk for leaving without stabilization
  - While in route to a hospital 45 minutes away delivered in the car
  - Infant did not survive
- Security guard refused a pregnant woman access to triage because she had a child with her
  - When returned the next day staff unable to locate fetal heartbeat

Amanda Seitz, Associated Press, reprinted The Denver Post; April 20, 2024

Acute Hospitals – Appendix A

Updates to Tag A-11

EMTALA

Basics

Pregnant Patients

Basic Concept of EMTALA

- Hospitals that participate in the Medicare program must
  - Provide a medical screening exam
  - Determine if the patient is in an emergency medical condition (EMC)
- If EMC exists – must provide stabilizing treatment or transfer
  - Prevent hospitals from denying care to anyone in an emergency,
    - Not just pregnant woman
  - Prevent hospitals from transferring patients before they were adequately stabilized

Basic Section 2400

- All hospitals are governed by EMTALA
  - Includes CAHs
- Requires:
  - A medical screening exam (MSE) be given to any patient who comes to the ED
  - Any patient with an EMC or in labor be provided necessary stabilizing treatment
  - Hospital to provide an appropriate transfer such as when patient requests or hospital does not have the capability or capacity to provide the necessary treatment

3 Criteria - What Constitutes a DED

- 1) If licensed by state as ED
- 2) Holds self out to public as providing emergency care
- 3) During preceding calendar year, provided at least 1/3 of its outpatient visits for treatment of EMC
  - Example: hospital has an emergency department (ED), or trauma center
- It covers all individuals regardless of payment source

No Delay Exam or Treatment 2400

- May not delay an appropriate MSE to inquire about the individual's method of payment or insurance status
- Can obtain basic information such as name, chief complaint, and physician
- May seek authorization for payment and services **after** the medical screening examination and once patient is stabilized

Specialized "Capability" 2400

- Must accept appropriate transfers of individuals with EMCs if the hospital has the specialized capabilities
- AND – the sending or transferring hospital does not have the specialized capabilities
- Receiving hospital must also have the "capacity"

"Medical Screening Examination"

- MSE: 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
  - Extensive bone or soft injury >Vascular or nerve damage
  - Psychiatric disturbance >Pain
  - Symptoms of substance abuse
- If an EMC does not exist – EMTALA does not apply

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 – ED to collaborate with units

MSE for Pregnant Patients – cont.

- May direct women over 20 weeks gestation with pregnancy related complaints to LD
  - Any doubt as to the nature of the complaint can have ED nurse triage
- If pregnant trauma patient – OB nurse should go to the ED to evaluate the patient
- Have a P&P and all staff know
  - ED and OB staff know

Certification of False Labor

- Physician/QMP must examine the patient to determine if EMC exists
- Is true labor an EMC?
- If diagnosed in false labor – MD/NM/QMP must certify before discharge
- Otherwise – considered in *true* labor unless certified to be in false labor after reasonable time of observation
- CMS requires certification of false labor

Emergency Medical Condition 2407

- 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 pregnant woman
  - Serious Impairment to bodily functions or
  - Serious dysfunction of any organ

EMC of Pregnant Women

- Pregnant women with contractions
  - Is inadequate time to affect 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 unborn child
- 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.

Necessary Stabilization Treatment

- Necessary treatment must be given to stabilize the medical condition within the capabilities and capacity
- "Capabilities" means there is
  - Physical space >Equipment >Supplies
  - Specialized services provided
- Capabilities of the staff – level of care the hospital can provide
  - Within the training and scope of staffs' professional license
- If the patient refuses care – must be informed of the risks and benefits and discussed in the earlier section on AMA

Stabilization & Capacity

- If lack capability – must stabilize and transfer
- Capacity includes what the hospital does to accommodate a patient in excess of occupancy limits
- Definition:
  - No material deterioration of the condition likely to occur
  - Within reasonable medical probability
  - To result from or during the transfer or with respect to an EMC

  -OR-

  - Until woman has delivered the child and placenta

General Rule 2409

- If individual has an EMC – patient may not be transferred unless appropriate
- May not transfer an unstable patient unless
  - Patient is informed of hospital's obligation under this law
  - The risk of the transfer are in writing (use transfer form)
  - And the physician signs a certification (writing)
    - Benefits reasonably expected outweigh the risk
    - Or person consents in writing to the transfer

Transfer General Rule – continued

- If a physician is not present at the time of transfer
  - A QMP can sign the certification
  - After consultation with the physician
  - The physician must later countersign the certificate
  - The certification must contain a summary of the risks and benefits upon which the certification is based
  - Transfer must be an appropriate one

Transfer of Woman with Contractions

- Limited circumstances to transfer:
  - If patient or physician request transfer or
  - Examining physician certifies in writing the benefits outweigh risks to mother and child
- Cannot cite state law or practice as basis for transfer

Obstetrical Services

Acute Hospitals New Regulations

New Rule

- Part of the 2025 Medicare Hospital Outpatient Prospective Payment system
- Addressed several key goals of Biden-Harris Administration including:
  - Responding maternal health crisis
  - Addressing health disparities
  - Promoting safe, effective and patient-centered care
- Does not modify EMTALA
- Rather – new Conditions of Participation for both Acute and CAH

6 Areas Addressed

- Organization and staffing
- Delivery of service
- Staff training
- QAPI
- Emergency services readiness
- Transfer protocols

Organization and Staffing

- Organization of OB services must be appropriate to scope of services offered and integrated into other departments
  - L&D rooms/suites including labor and delivery rooms, post-partum/recovery rooms
  - OB privileges must be delineated for all practitioners providing OB care
    - With competencies of each practitioners
    - Consistent with credentialing agreements

Organization & Staffing – cont'd

- Services must be well organized
  - Provided per nationally recognized acceptable SOP for physical and behavioral of OB patients
    - Pregnant, birthing and postpartum
  - Be appropriate for scope of services offered and integrated into other departments
  - Department must be supervised by someone with necessary education and training
    - Experienced RN, MD, DO, CNM, NP, PA
  - Privileges be granted subject to written criteria for all providing care

Delivery of Services

- OB services must be consistent with needs and resources
- Added to Emergency Services section A-1114 - 1118
- Policies must be designed to assure achievement and maintenance of high standards of medical practice and patient care and safety A-1114

Provisions & Protocols A-1115

- Must have adequate provisions and protocols per national guidelines for
  - OB emergencies and/or complications
  - Immediate post-delivery
  - Other events
  - Supplies and medications kept and readily available

Equipment A-1116

- Must have basic equipment kept and readily available to treat OB cases per scope, volume and complexity of services
  - Call-in system, cardiac monitor, fetal doppler/monitor
  - Minimum equipment to have readily available
    - Can maintain supplies in "crash carts," "OB emergency carts/bags/boxes/kits, OB hemorrhage carts

Staff Training A-1117

- Must develop policies and procedures to ensure all relevant staff are trained on select topics to improve delivery maternal care
- Training concepts must reflect scope and complexity of services offered including
- Facility-identified evidence-based best practices and protocols to improve deliver of maternal care
- Must use findings from QAPI program to inform staff training needs and any additions, revisions or update to topics on ongoing basis

Training – cont'd

- Must provide relevant new staff with initial training
- Governing body must identify and document which staff must complete initial training and subsequent biennial training identified topics
- Must document in personnel records training successfully completed
- Must be able to demonstrate staff knowledge on topics identified

Annual Training

- Must provide ***annual*** training to relevant staff regarding hospital policies and procedures for transferring
- Rationale: staff follow same procedures regarding transfers
- Staff informed about any changes in protocols
- Staff conduct transfers safely and by minimizing errors

Quality Assessment Performance Improvement

- **For hospitals providing OB services**
  - Not part of the September updates
- Effective January 1, 2027 – must use QAPI program to assess and improve health outcomes and disparities among OB patients on ongoing basis
- Must use QAPI program
  - Assess and improve health outcomes and disparities
  - Among OB patients on an ongoing basis
- (1st time hospitals must use QAPI program to address health disparities)

4 Requirements

- 1. Must analyze data and quality indicators collected by diverse subpopulations the facility identifies among their OB patients
- 2. Must measure, analyze and track data, measures and quality indicators
  - On outcomes and disparities in care, services and operations
  - And outcomes among OB patients

Requirements – continued

- 3. Analyze and prioritize health outcomes and disparities
  - Develop and implement actions to improve outcomes and disparities
  - Measure results
  - Track performance to ensure improvement sustained when disparities exist among OB patients

Requirements – continued

- 4. Conduct at least one performance improvement project focused on improving health outcomes and disparities among hospital's population of OB patients **annually**

Other Requirements

- Leadership must engage in OP QAPI activities
- If a Maternal Mortality Review Committee (MMRC) is available at state tribal or local jurisdiction and if offer OB services
  - Must have a process for incorporating publicly available information and data from the MMRC into the QAPI program

Transfer Protocols A-0826

- In Discharge Planning section
- Must have written policies and procedures for transferring patients under care - including inpatients
  - To appropriate level care – including another hospital
  - To meet needs of patient
- Must have written policies and procedures for transfers
  - Includes intra-hospital transfers of inpatients
  - ED to inpatient
  - Transfers between units of same and different hospitals
- To appropriate level of care needed

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- Must provide ***annual*** training to relevant staff regarding hospital policies and procedures for transferring
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Critical Access Hospitals Appendix W

New Regulations August 25, 2025

Critical Access Hospitals

- If offer obstetrical services must be well organized and
  - Provided per nationally recognized acceptable standards of practice for the care provided
    - Includes behavioral and physical health
  - Of pregnant, birthing, postpartum patients
- If outpatient obstetrical services offered
  - Must be consistent with quality with inpatient care
  - According to complexity of services offered

Organization and Staffing

- Appropriate to scope of services offered and integrated into other departments
  - L&D rooms/suites including labor and delivery rooms, post-partum/recovery rooms
  - OB privileges must be delineated for all practitioners providing OB care
    - With competencies of each practitioners
    - Consistent with credentialing agreements

Delivery of Services & Equipment

- OB services must be consistent with needs and resources of the hospital
- Policies must be designed to assure
  - Achievement and maintenance of high standards of medical practice and patient care and safety
- The following equipment must be kept and readily available to treat OB cases per scope, volume and complexity of services
  - Call-in system, cardiac monitor, fetal doppler/monitor

Provisions & Protocols

- Must have adequate provisions and protocols per national guidelines for
  - OB emergencies and/or complications
  - Immediate post-delivery
  - Other health and safety events
    - Identified by QAPI program
  - Supplies and medications kept and readily available

Staff Training

- Must develop policies and procedures to ensure
  - All relevant staff are trained
  - On select topics to improve delivery maternal care
- Training concepts must reflect scope and complexity of services offered including
  - Facility-identified evidence-based best practices and protocols to improve deliver of maternal care
  - Must use findings from QAPI program to
    - Inform staff training needs
    - Any additions, revisions or update to topics
    - On ongoing basis

Training – cont'd

- Must provide relevant new staff with initial training
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Quality Assessment Performance Improvement

- **For hospitals providing OB services**
  - Not part of the September updates
- Must use QAPI program to
  - Assess and improve health outcomes and disparities
  - Among OB patients on an ongoing basis
- 1st time hospitals must use QAPI program to address health disparities
- No Tag numbers but will be in Tag C-1300 under data collection section

4 Requirements

- 1. Must analyze data and quality indicators collected by diverse subpopulations the facility identifies among their OB patients
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Implementation Phase-In

- Effective date of the Rule – January 1, 2025
  - 3 phases of implementation:
- Phase 1: by July 1, 2025
  - Emergency Services' Readiness
  - Transfer protocols for Acute hospitals
- Phase 2: by January 1, 2026
  - Organization, staffing and delivery of services
- Phase 3: by January 1, 2027
  - OB staff training
  - QAPI program for OB services

Final Discussion

18-year-old pregnant patient NC awoke with a headache. Nausea set in with vomiting and fever and six hours later, she presents to the ER with abdominal pain and vomiting. A NP orders a strep test that returns positive. NC does not receive an evaluation of her pregnancy. Rather, she is discharged with a prescription for antibiotics. At 9 p.m., she is asleep but awakens her mother at 3 a.m. with severe abdominal pain.

Her mother drives her to another hospital; an OB saw her at 0420 and noted a temp of 102.8, high pulse and abdominal pain at 7 out of 10

Final Discussion – cont'd

In an OB ER room, nurse applied a sensor belt to check fetal hear rate; was told "baby's fine".

After 2 hours of IV fluids, one dose antibiotic, some Tylenol, CN's fever did not go down; she remined tachycardic and FHR was abnormally fast. Notes show CN had step and UTI. Another prescription was written and CN discharged home.

CN is home around 0700, crying and moaning. She was helped to the bathroom and noticed blood on her clothes. At 0900, full day after the first ER visit, she returns to the first ER where she is noted to have lips drained of color and reports of feeling of syncope.

Final Discussion – cont'd

IV was started, antibiotics administered and bedside ultrasound done. At 0930 OB on duty was unable to find fetal heart rate. Family notified of fetal demise.

At 1000, L&D nurse notified OB on duty of patient's condition and that she having contractions. Second OB ultrasound ordered but not done. At 1040, CN's blood pressure began to drop and RRT called.

At 1100, second US performed to confirm fetal demise "per orders". CN sent to ICU at 1120. Consent for "unplanned D&C" or "unplanned C-section" given by mother.

Final Discussion – cont'd

However, physicians determined surgery was too risky to due to possible DIC from sepsis. At one point, old black blood was noted from CN's mouth and nose. CN died shortly after the decision not to operate.

The family filed a wrongful action and complained to the state under EMTALA and care for emergency services/pregnancy care.

Final Discussion – cont'd

What possible citations, if any, might both or one hospital face?

- Failure to stabilize
- Premature discharge
- Failure to monitor/assess prior to discharge
- Failure to transfer
- Inadequate training of staff
- Others

Outcome

(See next slide for the reference to this case)

Final Discussion – cont'd

THE TEXAS TRIBUNE

DONATE Constitutional Amendments Brian Harrison Robert Roberson School Vaccinations

HEALTH CARE, POLITICS, STATE GOVERNMENT

A pregnant teenager died after trying to get care in three visits to Texas emergency rooms

It took 20 hours and three ER visits before doctors admitted the pregnant 18-year-old to the hospital as her condition worsened. She's one of at least two women who died under Texas' abortion ban.

BY LIZZIE PRESSER AND KAVITHA SURANA, PROPUBLICA
NOV. 1, 2024, 4:00 A.M. CENTRAL

Final Discussion – cont'd

HEALTH CARE, POLITICS, STATE GOVERNMENT

BY LIZZIE PRESSER AND KAVITHA SURANA, PROPUBLICA

NOV. 1, 2024, 4:00 A.M. CENTRAL

https://www.texastribune.org/2024/11/01/nevaeh-crain-death-texas-abortion-ban-emtala/

Thank You

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Appendix

Resources

and

Internet Links

Sample Form: Certification of False Labor

- 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_____

- Can use stamp, sticker, or form

Fact Sheets Nov 01, 2024

CY 2025 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS 1809-FC)

Ambulatory surgical centers Hospitals

Share

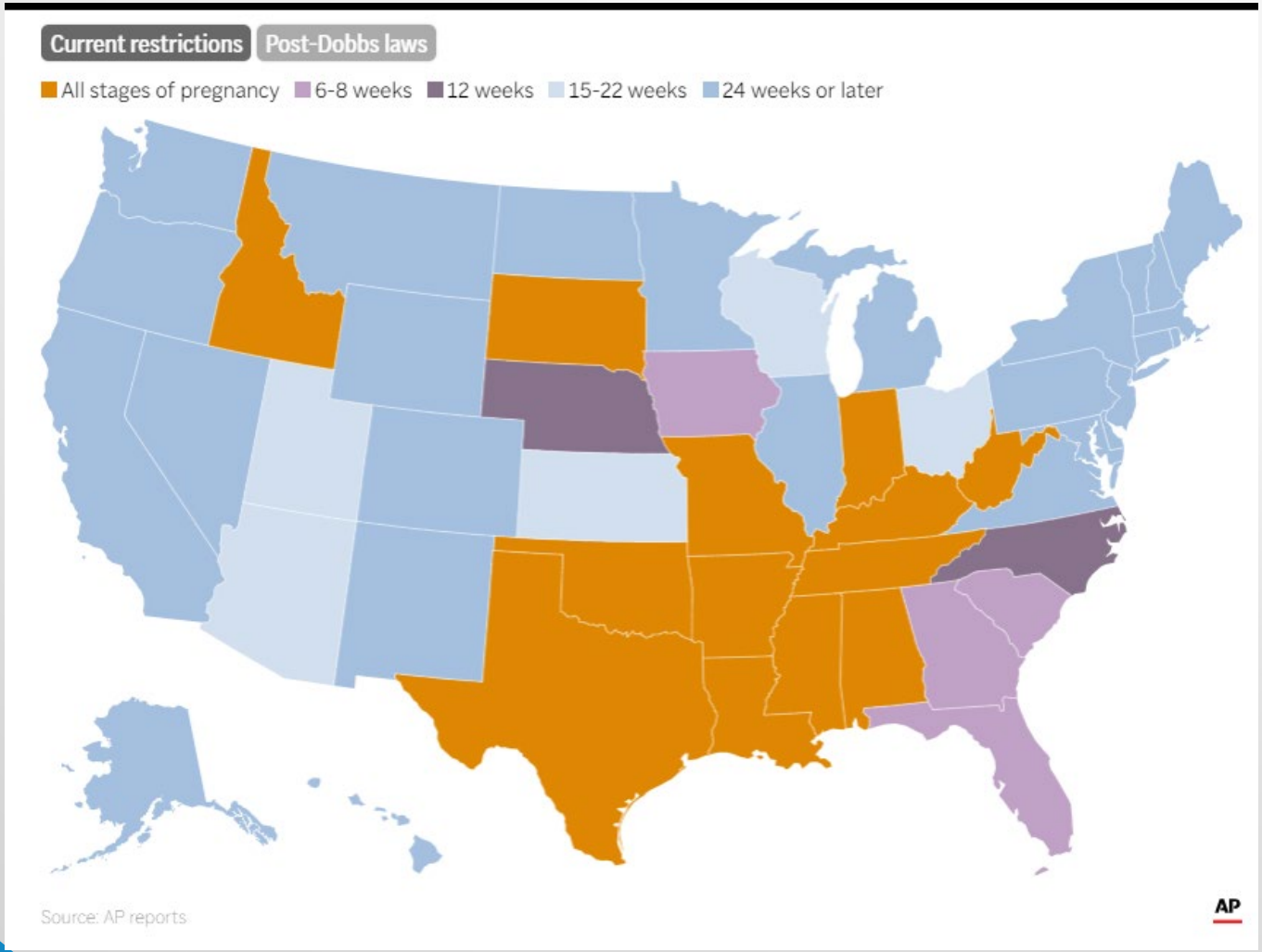
On November 1, 2024, the Centers for Medicare & Medicaid Services (CMS) issued Medicare payment rates for hospital outpatient and Ambulatory Surgical Center (ASC) services for calendar year (CY 2025). The Hospital Outpatient Prospective Payment System (OPPS) and ASC Payment System final rule is published annually.

In addition to finalizing payment rates, this year's rule includes policies that align with several key goals of

Internet Links

- https://www.cms.gov/newsroom/fact-sheets/cy-2025-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0
- https://saferbirth.org/aim-obstetric-emergency-readiness-resource-kit/
- https://saferbirth.org/wp-content/uploads/3-FINAL_AIM_OERRK_Readiness.pdf
- https://www.cms.gov/files/document/qso-25-24-hospitals.pdf
- https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-485/subpart-F/section-485.635

By State


Current restrictions
Post-Dobbs laws
All stages of pregnancy
6-8 weeks
12 weeks
15-22 weeks
24 weeks or later
Source: AP reports
AP