

EMTALA Guidance for Hospitals Managing the COVID-19 Pandemic

Insights

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On March 30, 2020, CMS issued [revised guidance](#) for hospitals (including Critical Access Hospitals or CAHs) addressing EMTALA obligations in the context of COVID-19.^[1] In addition, on April 30, 2020, CMS posted [FAQs](#) providing further clarification of these obligations for hospitals managing the COVID-19 pandemic. CMS's guidance now incorporates the [1135 waiver](#) of sanctions under EMTALA for redirection of patients to certain locations to receive a medical screening examination under a state emergency preparedness or pandemic plan.^[2] In particular, CMS has provided additional guidance related to the use of alternate screening sites, drive through testing sites, and the use of telehealth.

Even with expanded clarification regarding these areas, it is important to remember that the 1135 waiver **does not generally waive EMTALA obligations** and that, regardless of whether an individual has, or is suspected of having, COVID-19, **hospitals with dedicated EDs are required to:**

1. Conduct appropriate **medical screening examinations** (although the use of alternate sites is now expanded under the waiver and revised guidance where the use of such an alternate site is under a state emergency preparedness or pandemic plan) of all individuals who come to the ED to determine if they have an emergency medical condition. Moreover, the guidance notes that all qualified medical personnel performing screening examinations should be knowledgeable of the criteria for COVID-19 screening;
2. Provide **stabilizing treatment** for individuals with emergency medical conditions within the hospitals' capability and capacity; and,
3. Effectuate an **appropriate transfer** to a receiving hospital with the capability and capacity to stabilize a patient's emergency medical condition if the transferring hospital is unable to stabilize.

CMS Expectations for Patients with Potential COVID-19 Infection

When the medical screening examination (including, in some cases, triage) suggests possible COVID-19 infection, **the hospital is expected to isolate the patient immediately to the extent of its capacity and capability or to implement appropriate respiratory hygiene** (i.e., place a mask on the patient and appropriate PPE for healthcare personnel, etc.) to minimize potential for transmission and **direct the patient to an alternate site for testing if available**. This expectation is consistent with Medicare Conditions of Participation that require hospitals to adhere to accepted standards of infection control practice to prevent the spread of infectious disease and illness. Thus, **CMS**

PROFESSIONAL



ALICIA MACKLIN
Partner
Los Angeles

expects all hospitals to, within their capability, provide medical screening examinations and initiate stabilizing treatment, while also maintaining the isolation requirements for COVID-19 and coordinating with their State or local public health officials, who will in turn arrange coordination, as necessary, with the Centers for Disease Control (“CDC”).^[3]

In addition to the EMTALA obligations of hospitals with dedicated EDs, **CMS also reminds recipient hospitals (that is, hospitals with capacity and specialized capabilities needed to stabilize a particular patient’s emergency medical condition), that they are required under EMTALA to accept appropriate transfers.** The recipient hospital requirements apply with equal force to hospitals without dedicated EDs.

Use of Alternative Screening Sites

CMS also provides guidance on EMTALA compliance and the use of alternative screening locations to accommodate surges in patients coming to the ED. **As a reminder, however, CMS guidance does not override state licensing laws. Hospitals must continue to comply with such laws, as well as any other applicable laws and regulations.** For California, All Facilities Letters (“AFL”) 20-17 and 18-09, which address program flexibility for the use of alternative spaces, as well as the requirement that hospitals submit [Form 5000-A](#) to the California Department of Public Health (“CDPH”) to request flexibility for increased patient accommodations. In addition, CDPH’s [AFL 20-26](#) temporarily suspended, through June 30, 2020, hospital licensing requirements and regulatory enforcement of all hospital licensing requirements, with limited exceptions, as outlined in the letter.

Hospital Campus^[4] Alternative Screening Sites: CMS’s EMTALA guidance provides that the medical screening examination can take place in an alternative site on the hospital campus. **If a hospital chooses to utilize such alternative sites, in addition to complying with state licensing laws, CMS emphasizes that it would be a violation of EMTALA to use signage that presents a barrier to individuals who are suspected of having COVID-19 from coming to the ED.** However, hospitals can use signage to direct individuals to locations on hospital property for their screening examination.

Specifically, CMS notes that:

Individuals may be redirected to these sites after being logged in. Whether the individual is seen at the alternate on-campus site or in the ED, they should be logged in where they are seen. Individuals do not need to present to the ED, first, and if they do present to the ED, they may still be redirected to the on-campus alternative screening location for logging and subsequent screening.... the person providing the redirection from the ED should be qualified (e.g., a Registered Nurse (RN)) to recognize individuals who are obviously in need of immediate treatment in the ED. Hospital non-clinical staff stationed at other entrances to the hospital may provide redirection to the on-campus alternative screening location for individuals seeking COVID-19 testing.

In addition, consistent with EMTALA, the hospital **must still provide stabilizing treatment or effectuate an appropriate transfer of any individual that is determined to have an emergency medical condition.**

Similar to guidance on alternative sites on the hospital’s campus, CMS also provides guidance regarding whether hospitals can ask patients to wait in their car or outside of the hospital, as suggested by the CDC. While recognizing that the medical screening examination must be timely, taking into account the clinical condition of the patient, CMS notes that if an individual, after an appropriate screening examination, meets the CDC criteria for potential COVID-19 but does not have an emergency medical condition, then the hospitals can request that the patient wait in his or her car or outside. However, CMS cautions that such patients should be monitored to determine whether there is any deterioration of their condition and that a failure to do so could potentially result in an EMTALA violation for failure to conduct an appropriate screening examination and potentially a violation of the Medicare Condition of Participation related to emergency services.

Off-Campus, Hospital-Controlled^[5] Sites: Off-campus sites may be used for screening potential COVID-19 cases, and EMTALA would not apply unless those sites were dedicated EDs of the hospital. CMS notes that such sites should not be held

out as an urgent care site, but can be held out as a “respiratory or potential/presumed COVID-19 patient screening center.”

Normally, a hospital may not redirect or transfer patients who have already come to the ED to an off-site location to receive a medical screening examination. As noted above, however, CMS has issued a blanket waiver which permits hospitals to “screen patients at a location offsite from the hospital’s campus to prevent the spread of COVID-19, so long as it is not inconsistent with a state’s emergency preparedness or pandemic plan.”

Thus, hospitals may now redirect patients to an off-campus, hospital-controlled site for the medical screening examination, in accordance with a state emergency preparedness or pandemic plan. If a particular individual requires emergency care, the hospital is required to arrange a referral or transfer under the Medicare Conditions of Participation.

Community Screening Clinics, not under hospital control. Communities may also set up screening clinics at sites not under the control of a hospital, and EMTALA would not apply at those sites. Public health officials and hospitals can encourage the public to utilize these sites for screening instead of coming to the ED. But, again, **a hospital may not redirect or transfer patients who have already come to the ED to a community screening clinic to receive a medical screening examination.** CMS further suggests that the community, local hospitals, and local emergency medical services have a plan in place for referral and/or transport of any individuals that need emergency care after presenting to a community screening clinic.

While signage that presents a barrier to individuals who are suspected of having COVID-19 from coming to the ED, CMS now states that it is acceptable to post signage informing individuals, who are seeking COVID-19 testing (but do not want a medical screening exam or think they have an emergency medical condition) about alternative community locations (non-hospital controlled sites) for COVID-19 testing.

Drive-Through Testing Sites. Drive-through testing sites established for COVID-19 testing alone, even if on a hospital campus, do not have EMTALA implications according to CMS’s revised guidance. However, EMTALA would still apply if a patient at a testing site on the hospital campus made a request for emergency medical treatment.

Telehealth

The revised guidance also permits hospitals (and their qualified medical personnel (QMP)) to utilize telehealth to perform the screening examination for individuals who have come to the ED. Such QMPs may be on-campus or offsite, however, the guidance stresses that the QMPs must be acting within their scope of practice and be approved by the hospital’s governing body to perform screening examinations.

CMS’s new FAQs list the new codes that CMS has made available for ED physicians to use when they perform telehealth services from the ED (for the duration of the public health emergency):

- ED E/M codes (CPT codes 99281 to 99285);
- Critical care codes (CPT codes 99291 and 99292); and,
- Observation codes (CPT codes 99217-99220, 99224-99226, and 99234-99226).

ED physicians should use the place of service code that they would have used if that service was delivered in-person. They should also attach modifier 95 to the claim.

The above billing guidance only applies when the patient and the practitioner are in different locations. When they are in the same location, such as in different areas of the same hospital buildings, they are not considered to be furnishing Medicare telehealth services, and the services are not subject to telehealth rules and restrictions.

Review of Alleged EMTALA Violations

In reviewing alleged violations of EMTALA, CMS notes that it would evaluate the capability and capacity of both the referring and recipient hospital and would consider a number of factors when making a determination as to whether any EMTALA violation occurred, including:

- The screening and treatment activities performed by the referring hospital for the individual;
- Clinical considerations specific to the individual case(s), and the patient's clinical condition at the time of presentation to the referring hospital and at the time of the transfer request;
- Whether the request for transfer was consistent with any nationally recognized guidelines in effect at the time of the transfer request for COVID-19 screening, assessment, including guidance about transfer for further assessment or treatment of suspected or confirmed COVID-19; and,
- The CDC recommendations at time of event.

With respect to the last consideration, at the time CMS issued the guidance, CDC's recommendations focused on factors "such as the individual's recent travel or exposure history and presenting signs and symptoms in differentiating the types of capabilities hospitals should have to screen and treat that individual." Given these factors, CMS notes that the presence or absence of negative/positive pressure rooms would not be the sole determining factor in whether a hospital had the specialized capability to stabilize an individual's emergency medical condition involving COVID-19.

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For further information, please contact [Alicia Macklin](#) or [Nina Adatia Marsden](#) in Los Angeles, [Katrina Pagonis](#) in San Francisco, [Amy Joseph](#) in Boston or your regular Hooper, Lundy & Bookman contact.

[1] This alert provides a summary of CMS's revised guidance. Hospital staff are advised to read the guidance (and FAQs) in its entirety as it provides detailed information regarding EMTALA compliance during the COVID-19 pandemic.

[2] The waiver is effective only if actions taken by hospitals do not discriminate as to source of payment or ability to pay. In addition, this 1135 waiver does not apply to transfer of an individual who has not been stabilized if the transfer arises out of an emergency.

[3] CDC's screening guidance can be accessed at: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>

[4] For EMTALA purposes, the "hospital property" means the entire main hospital campus, including the parking lot, sidewalk and driveway or hospital departments, including any building owned by the hospital that are within 250 yards of the hospital.

[5] While the CMS guidance is not clear in defining what "hospital-controlled sites" are, this likely refers to provider-based hospital departments billing under the hospital's provider number. EMTALA will not apply to other off-campus sites that are not provider-based.

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