

Federal Law and the Physician: Excerpts related to refusal to accept transfers

Organized by Keith Conover, M.D., FACEP, Department of Emergency Medicine, Mercy Hospital of Pittsburgh

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<http://www.pitt.edu/~kconover/ftp/emtala-draft.pdf>

This document prepared specifically for physicians affiliated with Pittsburgh Mercy Health System. Thus, many of the references are specific to Mercy, to southwestern Pennsylvania and to Pennsylvania. Nonetheless, most of the information will be of use to physicians anywhere in the U.S. However, when in doubt, consult your hospital's legal counsel. Your mileage may vary.

From discussions with PMHS Counsel Rebecca O'Connor, J.D.; PMHS Consultant Alan Steinberg, J.D.; MHP Psychiatric Coordinator Patricia Neumeyer, MSW, MPH; MPH Chief of Psychiatry, Sarah Flanders, M.D.; Todd Taylor, M.D., FACEP of Arizona ACEP; and information provided by Stephen Frew, J.D., Robert Bitterman, M.D., FACEP, J.D., and Daniel Sullivan, M.D., FACEP, J.D. Quotations from Stephen Frew reproduced with permission.

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III. Principle the Third: Obligation to Accept Transfers

Under EMTALA and related laws and regulations, there is also, unrelated to Medical Screening Exam or Emergency Medical Condition issues, a responsibility for hospitals to take transfers. If any hospital in the U.S. calls and says they have a patient they can't take care of, for whatever reason, and it's something we can take care of, ***we have to take the patient.*** No ifs, ands, or buts, ***we have to take the patient.*** We shouldn't even ***ask*** about insurance, lack of insurance, or HMO status—unless we have already agreed to take the patient.

Well, there ***are*** actually a few ifs, related to whether we really can take care of the patient or not. If we don't have beds, or the on-call doc isn't available, the emergency physician on duty in the ED can refuse the transfer.

The specifics for PMHS are in the new Pittsburgh Mercy Health System transfer acceptance policy, which now says:

POLICY NUMBER: 217 11/20/02

Administrative Policies and Procedures

TITLE: REQUESTS FOR TRANSFER TO MERCY HOSPITAL OR MERCY PROVIDENCE HOSPITAL ("MERCY")

POLICY: All requests to transfer a patient to Mercy will be managed according to this Policy.

PROCEDURES:

I. Accepting Transfer:

A. Any physician (or DEM Physician designee) has the authority on behalf of Mercy to ACCEPT a patient transfer to Mercy. All such patient transfers require the Physician for Mercy Hospital to contact Mercy TACC at 1-888-TO-MERCY (1-888-866-3729) prior to accepting the Transfer to confirm bed availability. The Physician at Mercy Providence Hospital should contact the Nursing Supervisor to confirm bed availability prior to accepting the transfer

II. Refusing Transfer:

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A. Only DEM Physicians (or designee) have the authority on behalf of Mercy to REFUSE a patient transfer to Mercy. A non-DEM Physician does NOT have the authority on behalf of the Hospital to REFUSE a patient transfer to Mercy. Such Physician can make such recommendation to the DEM Physician.

B. Such REFUSALS may only occur by the DEM physician if one of the following is true:

1) Mercy does not have the capacity (i.e., bed, staff or equipment) to care for patient such as:

a) Mercy is on Condition Red. (However, if the patient with an emergency medical condition is a direct admit to the floor or trauma/critical care unit, and a bed is available, the patient must be accepted unless another exception applies.)

b) Patient requires specialty care, and no one is on-call for a particular specialty where Mercy has less than three (3) staff physicians in that particular specialty and therefore there are gaps in the call schedule.

c) Requested Services are unable to respond due to previous emergency and no backup is available.

d) On-call specialist is too fatigued from current or ongoing care and no back up is available. (Precise details are required to be documented in an Occurrence Report by DEM Physician and the On-call Specialist.)

2) If the patient does not have an emergency medical condition, i.e., the patient never had an emergency medical condition or it has already been resolved.

3) It is a request for Lateral Transfer: If a facility requests to transfer to Mercy a patient with an emergency medical condition that has not been resolved and the requesting facility HAS the capabilities to resolve the emergency medical condition.

III. Inappropriate Transfer:

A. If a physician believes that a facility has, or has attempted to, transfer a patient to Mercy inappropriately, he/she should call the Administrator on Call to report it.

B. Complete attached form.

An official version, with a reporting form, is available online at <http://www.pitt.edu/~mercyres/mercy-transfer.pdf>.

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Precertificationⁱ

If you have a patient who requires admission to the floor, or transfer to another hospital when you don't have appropriate beds, delaying this admission or transfer for "precertification" by the insurance company is likely, if investigated, to be cited as an EMTALA violation. *It is not appropriate to seek, or direct a patient to seek, authorization until after the MSE and commencement of stabilizing treatment.*" [64 Federal Register 61353 (1999), quoted in Bitterman p. 54] [42 USC 1395dd(h)] See the section on **Psychiatric Issues** near the end of this document for more about "precertification."

On May 9, 2002, CMS published proposed modifications to EMTALA policies in the Federal Register (67(90): 31470 et seq, available at http://www.access.gpo.gov/su_docs/aces/aces140.html). In this proposal, CMS states *we believe that our existing policy will best implement the intent of the statute by prohibiting a participating hospital from seeking authorization from the individual's insurance company for screening services or services required to stabilize an emergency medical condition until after the hospital has provided the appropriate medical screening examination required by EMTALA to the patient and has initiated any further medical examination and treatment that may be required to stabilize the patient's emergency medical condition. We are soliciting comments as to whether the regulations should be further revised to state that the hospital may seek other information (apart from information about payment) from the insurer about the individual, and may seek authorization for all services concurrently with providing any stabilizing treatment, as long as doing so does not delay required screening and stabilization services.*

2. Stable for Transfer (and who decides)

This means the patient is unlikely to suffer deterioration en route to another hospital. This is the minimum level of stability, and is required prior to transfers for purely medical reasons, unless the patient simply can't be stabilized (see above). Note that this is **not** stable enough for you to discuss insurance issues with the patient, or consider transfer for insurance reasons. Specifically, the legal wording is as follows:

For transfer between facilities: a patient is stable for transfer if the patient is transferred from one facility to a second facility and the treating physician attending to the patient has determined, within reasonable clinical confidence, that the patient is expected to leave the hospital and be received at the second facility, with no material deterioration in his/her medical condition; and the treating physician reasonably believes the receiving facility has the capability to manage the patient's medical condition and any reasonably foreseeable complication of that condition.

If there is a disagreement between the treating physician and an off-site physician (e.g., a physician at the receiving facility or the patient's primary care physician if not physically present at the first facility) about whether a patient is stable for transfer, the medical judgment of the treating physician usually takes precedence over that of the off-site physician.

If a physician is not physically present at the time of transfer, then qualified personnel (as determined by hospital bylaws or other board-approved documents) in consultation with a physician can determine if a patient is stable for transfer.

[HCFA Site Review Guidelines, State Operations Manual, *COBRA Investigations*, Tag A407 Effective: June 14, 1998:

http://www.hcfa.gov/pubforms/07%5Fsom/somap_v_001_to_012.htm]

Transfers and Diversion (“Condition Red”)

Transfers

When a Hospital Must Accept Transfers

If a hospital has the capacity to care for a patient with specialty needs (e.g., Mercy Hospital and burn patients, or most any big hospital with monitored beds and a stable “rule-out MI” patient), and that hospital gets a request from a hospital without such a capacity, it must accept the transfer. And this applies so long as **any** sending hospital in the U.S. wants to transfer, even if the hospital is on the other side of the country. Hospitals with appropriate capacity to accept a patient in transfer **cannot** ask about insurance prior to accepting transfers, regardless of “stability.”

And if you try to transfer to a hospital, but the hospital refuses or delays a transfer based on insurance [“reverse dumping”], you should document this carefully in the patient’s medical record and report this to your superior, or otherwise if your hospital has specific reporting procedures, for a possible report to CMS (née HCFA). [Stephen Frew, 3/16/02 website comment] *A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units...) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities of facilities if the hospital has the capacity to treat the individual.* This was added to the EMTALA law in 1989 specifically to prevent “reverse dumping.” [Bittterman pp. 110, 114] Although reporting of “reverse dumping” is not mandatory per CMS, Pittsburgh Mercy Health System, based upon legal advice, has elected to report all such instances. Note that the new PMHS transfer acceptance policy includes such a form and instructions for reporting (available online at <http://www.pitt.edu/~mercyres/mercy-transfer.pdf>)

When a Hospital Can Transfer to Another Hospital

As described above in the section on *EMTALA Stability and the Medical Screening Exam*, patients who have an Emergency Medical Condition can only be transferred if they are Stable for Transfer, and only if there has been Commencement of Stabilizing Treatment for that Emergency Medical Condition. The only exception would be if the patient is unstable, but the hospital lacks the capacity to care for the patient, and, in the view of the emergency physician with the patient, the benefits of the transfer outweigh the risks.

For a patient with an Emergency Medical Condition, transfers for physician convenience are not acceptable until the patient is “out of EMTALA” Once EMTALA is satisfied by making the patient Stable for Transfer and there is Commencement of Stabilizing Treatment, then **at that point** it would be acceptable to discuss a possible transfer for insurance reasons or physician preference. And it is not acceptable under EMTALA to say to a patient “your doctor would prefer we transfer you to Hospital B, is that OK?” and then consider it a transfer based on patient request. If the patient spontaneously asks to be transferred, that’s OK, but physicians and hospitals are not allowed under EMTALA to pressure a patient to agree to a transfer to another hospital. Transfers for patient preference prior to Commencement of Stabilizing Treatment are acceptable, provided the patient is Stable for Transfer.

When Does a Hospital “Lack Capacity”?

A letter from November 2001, available on the CMS website (<http://www.hcfa.gov/medicaid/ltcsp/112901.htm>) is worth mentioning. It indicates that a hospital must, before it transfers the patient to another hospital due to “lack of capacity,” do everything it can reasonably do to care for the patient rather than transferring, including calling in staff from home:

Ref: S&C-0206

DATE: November 29, 2001

FROM: Director, Survey and Certification Group, Center for Medicaid and State Operations

SUBJECT: Hospital Capacity-EMTALA ...

1. Requirements for a Sending Hospital When it Lacks Capacity ...

In determining the capability and capacity available at the hospital the surveyor would assess the following criteria as outlined in the SOM [Interpretive Guidelines], Appendix V, Page V-23: ...

The capacity to render care is not reflected simply by the number of persons occupying a specialized unit, the number of staff on duty, or the amount of equipment on the hospital’s premises. Capacity includes whatever a hospital customarily does to accommodate patients in excess of its occupancy limits (§489.24 (b)). If a hospital has customarily accommodated patients in excess of its occupancy limits by whatever means (e.g., moving patients to other units, calling in additional staff, borrowing equipment from other facilities) it has, in fact, demonstrated the ability to provide services to patients in excess of its occupancy limits. ...

2. Recipient Hospital Responsibilities

A recipient hospital is obligated to accept a transfer request if a patient is in need of specialized capabilities offered by the recipient hospital and the recipient hospital has the capacity to receive the patient. Even if both the sending and receiving hospitals have similar capabilities and facilities, a patient may require service beyond the capability of the sending hospital [at the time of the transfer], if these services are available at the recipient hospital. In that instance, the recipient hospital is obligated to accept the patient from the sending hospital.

The interpretive guidelines (SOM, Appendix V, page V-34) are clear that a (recipient) hospital has to accept the patient only if:

“the patient requires the specialized capabilities of the hospital in accordance with this section. If the transferring hospital wants to transfer a patient because it has no beds or is overcrowded, but the patient does not require any specialized capabilities, the receiving ... hospital is not obligated to accept the patient.

If the patient required the specialized capabilities of the intended receiving ... hospital, and the hospital had the capability and capacity to accept the transfer but refused, this requirement has been violated.” ...

Although this last bit might be seen as a way to refuse transfers, in practice it often possible to argue that “specialized capabilities” includes hospital beds with monitors, or a bed with closer observation and treatment than possible in the ED, so this probably does little to restrict the need of hospitals to accept transfers when they have beds and the sending hospital does not.

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When a Hospital can Refuse Transfers

The times a hospital can refuse a transfer are if

1. The ED is on divert status and cannot take a single additional patient in the ED, AND no appropriate inpatient beds are available. OR
2. The patient requires a higher level of care than the ED (e.g., invasive arterial-line or Swan-Ganz monitoring, if not done in the ED) AND there are no appropriate inpatient beds for a direct admission. OR
3. For whatever reason, on-call specialty or subspecialty physicians or surgeons are not available to take care of the patient.

Please see the new PMHS transfer acceptance policy at <http://www.pitt.edu/~mercyres/mercy-transfer.pdf> for PMHS's specific policy in this regard.

If the patient doesn't really require the hospital's special capability, it is acceptable to refuse a transfer – but it is extremely difficult to tell this over the phone, unless it's something obvious like the other hospital wants to send Mercy a patient for HBO treatment that we simply don't have. The fact that there are no "burn" beds doesn't seem to matter as long as we have some sort of ICU beds that could accept a burn patient.

When a patient can be cared for at a hospital, but the physician or patient or family wants the patient transferred to another hospital due to personal choice, the receiving hospital is not required to accept the transfer under EMTALA. That is, unless one could argue, after the fact, that the patient was being transferred to a "better" hospital and that the transferring hospital really didn't have the capacity to care for the patient. If the physician requesting transfer states that his or her hospital cannot adequately care for the patient, regardless of whether the transfer request came from patient or family, then the transfer *is* required by EMTALA. [Stephen Frew, 1/28/02 website comment] Regardless of whether EMTALA *requires* a hospital to accept a transfer, all transfers must meet EMTALA requirements such as adequate notification of the receiving hospital, and sending copies of appropriate documentation and x-rays.

If an inpatient bed is reserved for a transfer, and an equally sick patient comes into the ED, a conservative opinion holds that the transfer "gets dibs" on the inpatient bed, and that the ED patient must be stabilized as best as possible and transferred if necessary. [Stephen Frew, 8/28/00 website comment] This is a gray area, and in such a situation, it is probably best to let people who know the most about the bed situation and the patients in question (likely the emergency physician and the hospital nursing supervisor) jointly make a decision that provides the greatest good for the greatest number of patients.

Trauma centers are allowed to refuse all transfers except for trauma patients, and keep a few beds reserved for trauma patients. This does *not* apply to an ICU bed held open for decompensating inpatients (the "arrest bed") however. [Bitterman p. 113] If beds are reserved for patients currently undergoing catheterization, surgery, etc., they are considered "full" to CMS; but if the bed is for someone planned to come out

of surgery tomorrow, that is not “full” and must be available to accept patients from a transfer. [Stephen Frew, 11/10/01 website comment]

A receiving hospital cannot base its acceptance on an agreement to take the patient back once specialty treatment is complete. “Transfer-back Agreements” can be made between hospitals, but have to be general policies and cannot be applied only to selected patients. [Stephen Frew, 5/11/00 website comment]

Receiving hospitals cannot demand that their ambulances or helicopters or transport teams be used for a transfer. [Stephen Frew, 3/8/01 website comment] If a “sending hospital” is transferring a patient to a “receiving hospital,” under EMTALA the transportation arrangements and costs are the responsibility of the sending hospital. If delays in ambulance transport, due to insurance issues with ambulance payment, might cause the patient harm, the sending hospital may have to make arrangements with another ambulance service and guarantee payment to avoid EMTALA liability. Note too that ambulance services called to perform interhospital transfers may not be bound to respond under EMTALA. [Stephen Frew, 1/16/02 website comment] With virtually no exceptions, **all** transfers, including those to specialty facilities or specialty physician offices, must go by ambulance, with trained medical personnel, rather than privately-owned vehicle; Frew suggests using a patient refusal of ambulance form if a patient refuses to go by ambulance. [Stephen Frew, 11/7/01 website comment]

If a hospital (e.g., an emergency physician at Mercy Providence Hospital) accepts a patient for transfer (regardless of EMTALA “stability”) then it is an EMTALA violation for another physician or nurse to refuse such a transfer, especially if based on insurance status. [Stephen Frew, 8/31/00 and 12/18/01 website comment] If a non-emergency physician wants a patient transferred (for example, after seeing the patient in the ED), then **that** physician has the responsibility for arranging the transfer, not the emergency physician. [Stephen Frew, 2/28/01 website comment] There is no EMTALA requirement that a **physician** accept a transfer; any person acting for the hospital can do so. Frew and other strongly recommend a “on-call” center for accepting transfers. *If it were my choice, I put the ED physician in the coordinator’s role for all transfers, so they are at least aware of what the accepting physicians are doing or not doing and the status of the house to receive additional patients at all times, because the ED doc is the one that ultimately stuck with the patient in a bad situation.* [Stephen Frew, 1/25/01 website comment] Please see the PMHS transfer acceptance policy regarding this: <http://www.pitt.edu/~mercyres/mercy-transfer.pdf>.

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Call Responsibilities

Anyone who is on active staff in a particular specialty, and who doesn’t have senior status (see above) must generally participate in call. CMS doesn’t consider it acceptable for someone to perform elective procedures or admissions and not participate in call—***if someone refuses to participate in call, or refuses to come in when on call, the hospital is expected to discipline that physician, and if repeated violations, terminate that physician’s privileges for elective surgery and medicine***

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as well as emergency call. Although hospitals can reimburse staff for taking call, there is no requirement that they do this. *It is not generally acceptable to CMS to give up only emergency privileges and retain the right to do scheduled patients of the same type of conditions.* [Stephen Frew, 12/6/01 website comment]

The on-call MAY NOT ask about means or ability to pay and MAY NOT lawfully turn down the patient. [Stephen Frew, 4/19/00 website comment] Please see the PMHS transfer acceptance policy regarding this: <http://www.pitt.edu/~mercyres/mercy-transfer.pdf>.

No Excuses: Refusal of Patients When On-Call

By Federal law, on-call responsibilities are on behalf of the hospital, not the practice, and thus apply even if:

- ❖ the on-call physician has discharged a particular patient from his or her practice, [Stephen Frew, 7/2/00 and 10/23/00 website comments]
- ❖ the on-call physician's practice is "full,"
- ❖ the on-call physician has a personality conflict with this patient,
- ❖ the patient is "difficult": verbally abuses staff, likely to file malpractice action, etc. [Stephen Frew, 6/16/00 website comment]
- ❖ the patient has had prior surgery with another surgeon, [Stephen Frew, 7/2/00 website comment]
- ❖ the patient has repeatedly signed out AMA [Stephen Frew, 12/6/01 website comment]
- ❖ the patient has sued the physician for malpractice [Bitterman p. 91]
- ❖ even if the physician doesn't "take" the patient's insurance. [Stephen Frew, 4/20/00, 7/2/00 and 1/17/01 website comments]

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Psych Issues

Stability and Psych Patients

EMTALA micro-regulates psychiatric emergency care, and thus there are differences from medical patients. It does provide some exceptions to the standard EMTALA provisions for transfer of psychiatric patients to state institutions (not relevant in the Pittsburgh area). And there are special definitions of stability for psych patients. Specifically, the 1998 interpretive guidelines state:

For purposes of transferring a patient from one facility to a second facility, for psychiatric conditions, the patient is considered to be stable when he/she is protected and prevented from injuring himself/herself or others. For purposes of discharging a patient (other than for the purpose of transfer from one facility to a second facility), for psychiatric conditions, the patient is considered to be stable

when he/she is no longer considered to be a threat to him/herself or to others.

[INTERPRETIVE GUIDELINES : 489.24(c)(l)]

http://www.hcfa.gov/pubforms/07%5Fsom/somap_v_001_to_012.htm. To clarify: a psych patient is "stable for transfer" if protected from self-harm. So if a hospital has no psych beds, and the patient is "stable for transfer" the patient can be transferred. However, ***one cannot transfer a psych patient based on insurance (or lack thereof), until Commencement of Stabilizing Treatment, even if Stable For Transfer.***

Patients with psychiatric problems bad enough to be admitted ***must***, by the interpretation of Stephen Frew, with which Pittsburgh Mercy Health System agrees, have stabilizing care for their "Emergency Medical Condition" initiated. In the case of depressed patients, this means that the patient has been seen by a psychiatrist or psychiatric R.N. (not just an emergency physician or social worker) in the Emergency Department, a detailed and individualized treatment plan has been formulated, and this treatment plan has been started. Sometimes, such patients will be seen in the ED by a psychiatric nurse or psychiatrist, who establishes and documents an individualized treatment plan, including counseling and psychiatric medications, these are started in the Emergency Department, and the patient can then be transferred. However, sometimes, suicidal or psychotic patients will have to be admitted before we can reasonably say there is Commencement of Stabilizing Treatment of their "Emergency Medical Condition." Simply making the patient Stable For Transfer (a lower level of stability, see above under "EMTALA Stability") is not adequate. [Stephen Frew, 12/6/01, 1/9/02 and 1/31/02 website comments] Frew points out that state, county, or city psych arrangements for care of indigent patients (think "catchment areas") are completely preempted by Federal EMTALA law. [Stephen Frew, 7/31/00 and 2/6/01 website comments] However, if your hospital has no psych beds and you need to transfer a patient, it makes sense to make your first call to the hospital in the patient's "catchment area" since that's closest to where the patient lives.

Mercy has decided that, since the "stabilization" of psychiatric patients is such a gray area, we will not transfer patients without Commencement of Stabilizing Treatment. If we receive a psychiatric patient who has had no "stabilization" other than restraining the patient, however, we will not consider this a definite violation, and will not report this for investigation.

Psych Patients, Insurance, and "Precertification"

If a hospital doesn't have any psych beds, then you have to transfer the patient to someplace that does have psych beds. In such a case, delaying the transfer of a patient to obtain "precertification" from an insurance company, is an EMTALA violation. In the same way, delaying the admission of a patient to the psychiatric unit until one obtains "precertification" is an EMTALA violation. [Bitterman p. 115] *a receiving hospital cannot ask a transferring hospital to delay a transfer until it obtains payment authorization from a MCO. This, too, is illegal.* [Bitterman p. 115] *The OIG position on duty to accept on transfers is that the receiving hospital cannot delay acceptance to obtain payment information. If it is a transfer situation, the on-call [physician] is "the hospital" for enforcement purposes. . . . My position now is:*

1) Hospitals seeking to transfer patients to higher levels of care in appropriate circumstances as defined by EMTALA should not be asked about means or ability to

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pay or hospital guarantee of payment prior to the acceptance of transfer by the intended destination hospital or responsible physician accepting or denying acceptance on behalf of the intended destination hospital.

2) If asked, do not provide the information even if the patient is fully insured.

3) In any case where a transfer is turned down after the intended receiving facility has asked about finances of the patient or any guarantee of payment by the sending facility, it should be reported as a possible EMTALA violation within 72 hours of the event to the responsible office of the Centers for Medicare and Medicaid Services (CMS) to avoid possible EMTALA liability on the part of the sending hospital for failure to report.

4) The fact that the transfer was turned down after inquiry about means or ability to pay or demand that the sending hospital guarantee the bill should be described in detail in the medical record to adequately protect the sending hospital under EMTALA transfer rules and to assure that all legal defenses and remedies are preserved in the event the resulting delay and outcome causes patient litigation against health care providers. [Stephen Frew, 11/3/01 and 3/2/02 website comments]

Posted by [Stephen A. Frew JD](#) on March 14, 2002 at 22:36:49:

In Reply to: [Psych Patients:](#) posted by Keith Conover, M.D., FACEP on March 12, 2002 at 19:48:20:

: The interpretive guidelines specifically state:

: "For purposes of transferring a patient from one facility to a second facility, for psychiatric conditions, the patient is considered to be stable when he/she is protected and prevented from injuring himself/herself or others. For purposes of discharging a patient (other than for the purpose of transfer from one facility to a second facility), for psychiatric conditions, the patient is considered to be stable when he/she is no longer considered to be a threat to him/herself or to others." [INTERPRETIVE GUIDELINES : 489.24(c)(1) <http://www.medlaw.com/siteguide.htm>].

: As you have pointed out in prior posts on this forum, you have indicated that a psych patient, even though "stable for transfer" (i.e., restrained and protected from suicide) cannot be lawfully transferred until the hospital has "initiated stabilizing care" which, in almost all cases, requires admission. We are considering a policy that requires and defines "initiation of stabilizing care" for psych patients, including (1) psych nurse evaluation, (2) phone consultation with a psychiatrist, (3) an individualized and documented treatment plan, and (4) treatment has been started according to plan and documented.

: Rarely, during the day, this might occur in the ED, but for the most part, patients will have to be admitted first. Any suggestions about the above outline of "initiating stabilizing care" for a psych patient?

: A companion to this commitment will be that when we have no beds, and want to transfer a psych patient to somewhere else, and the patient is "stable for transfer" but we have not "initiated stabilizing care" we will have to, in defiance of time-honored practice in this area, say "no, we didn't precert the patient with the insurance company. No, we won't give you any insurance information about this

patient, as we haven't been able to initiate stabilizing care for his Emergency Medical Condition. Yes, under EMTALA, you are required to accept the transfer anyway."

: So when they refuse, what do we do? "Reverse dumping" isn't mandatory to report under EMTALA. Do we document the refusal, send them a letter from our legal counsel, noting that there seems to be a potential EMTALA violation, and if there is a repeated pattern of refusals of transfers, we will contact CMS OIG?

: (I suspect the best way to avoid this is to let the ED grapevine work for a couple of weeks, but still we may have refusals.)

: Thanks very much once more.

ANSWER: I believe your intended course is necessary to comply with EMTALA, and I also believe that refusal to accept the patient on financial precert grounds is a violation. As I wrote in the E-Bulletin some months ago, some CMS regions believe that refusal of transfers is a mandatory reporting incident and that I now recommend reporting. Politics being what they are, you may want to take your chances for a while and try to let the system work. Just remember—the last hospital that got kicked out of Medicare for EMTALA violations was a private psych hospital that made admission and transfer decisions based on pre-cert (among other sins). [Stephen Frew, 3/14/02 website comment]

There **are** situations where one might be able to legitimately transfer a patient even if one has psych beds, or delay a transfer of a psychiatric patient until precertification. This requires that the patient has had **Commencement of Stabilizing Treatment**, has had counseling about insurance status, and refuses transfer (in writing) until such time as insurance has "approved" the admission. However, this can only occur if the patient is capable of informed consent about the plan of care, and there is documentation of the **Commencement of Stabilizing Treatment**. (See "Stability and Psych Patients," above, for an outline of what is required.) Note that the procedure on this form must be followed in **all** cases, not just those in which we might want to transfer a patient based on insurance (i.e., no difference in treatment of patients until **Commencement of Stabilizing Treatment**).

Psych Subspecialty and Bed Issues

What if the hospital has med-surg beds but no psych beds and is asked to take a psych patient in transfer? CMS (née HCFA) says that hospitals must take the transfer to a med-surg bed and assign a sitter. Stephen Frew suggests that, since there are definite risks associated with this, that hospitals that want to refuse such transfers document why the particular patient cannot be adequately served in that manner. [Stephen Frew, 2/18/02 website comment]

Pittsburgh Mercy Health System considers that a medical bed with a sitter is a poor substitute for the therapeutic environment of a true psychiatric unit. Therefore, we will not accept transfers of psych patients to such beds unless there are no other psychiatric beds available in the region. We will not admit patients to medical beds with a sitter unless required by medical reasons. This will be documented in new psychiatric admission policies and procedures [in development 4/2/02]. [Keith Conover, M.D., FACEP: I spoke with this on 5/8/2002 with Linda Karr of the CMS Region III office in Philadelphia; she says our current policy, of transferring patients if

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we don't have psych beds, is in the best interests of the patient, and would not be considered an EMTALA violation by their office.]

Posted by Stephen A. Frew JD on January 09, 2002 at 15:20:59:

In Reply to: Psych Transfers: type of patient posted by Keith Conover, M.D., FACEP on January 07, 2002 at 17:05:38:

: This is a question about "types" of patient and hospital capabilities, related to psych patients.

: In Pittsburgh, we routinely transfer psych patients from one facility to another (probably more psych transfers here than any other kind.)

: Some of these transfers are because a facility doesn't have any beds, but most are because a facility doesn't have any beds of an appropriate type. For example, there are only two facilities in town that have adolescent and child psych, and only certain places that are "dual diagnosis": both significant psych and significant drugs/alcohol. There are some places that are pure psych (not set up to take care of significant drugs/alcohol) and some places that are pure detox.

: Question 1: who should make the clinical determination as to which "class" of patient we've got: the emergency physician seeing the patient, or the psychiatrist who has been consulted only by phone, and what if they disagree?

ANSWER: EMTALA states specifically that it is the physician with eyes on the patient who determines issues like stability and necessary appropriate care (which I would suggest is what "type" amounts to) appropriate destination, etc. NOT the psychiatrist over the phone.

: Question 2: some psych facilities are cutting back on staff and are worried about handling very violent patients. Up until now the area hasn't used this as a classification or type of patient on which to make transfer decisions. Is there a recognized way to acknowledge a new "type" of patient or hospital capacity? Can we look at other areas, any court decisions, or HCFA publications? EMTALA will surely be in place for these transfers, I would think, as hospitals would be transferring patients because they can't initiate stabilizing care.

ANSWER: Essentially, CMS will look at the "type" of patients mostly in order of: 1) laws 2) regulations 3) policies and procedures 4) quality of care and base their determination on those factors in somewhat of a subjective manner. If a hospital establishes a new policy or procedure that creates the recognized "type" as a specific definition, CMS would probably follow it if it were in writing and reasonably applied without discrimination. Once in writing, deviations would be potential sources for citations.

What about "dual-diagnosis" and adolescent and very violent patients? Can they be transferred from one hospital to another, even though both have psych beds available, because one hospital doesn't "take" that type of patient?

In Pennsylvania, acute care hospitals are licensed in a general sense, and there is no special "licensure" for psychiatric units at hospitals. However, the state does have a special licensure for drug and alcohol detox facilities. Some such facilities are non-hospitals, and since we can't discharge patients with an Emergency Medical Condition to a non-hospital, you can't, for example, transfer a patient to Gateway

Rehab. (If the patient is **Stable for Discharge** however, you can **discharge** to such a facility.)

Some hospitals with psychiatric units are also licensed as drug and alcohol detox centers. However, neither Mercy Hospital of Pittsburgh or Mercy Providence Hospital are so licensed. There is a tradition of transferring patients who have both psychiatric and drug or alcohol problems to hospitals that have special “dual-diagnosis” tracks—Mercy Providence Hospital in particular. However, since hospitals with psychiatric units routinely care for at least some people with drug and alcohol problems as well as psychiatric problems, it is difficult to see how a particular patient fits a profile such that “our hospital doesn’t have the capacity to treat this patient.” Therefore, transfers solely for “dual-diagnosis” reasons are not legitimate transfers under our understanding of EMTALA. [Note that this was agreed to in a meeting 4/17/02 with the PMHS Legal Counsel, the psychiatric coordinators of both MPH and MHP, the Chair of psychiatry at MPH, and the head of social services at MHP.]

In June 2003, I discussed this “dual-diagnosis” refusal of transfers both with CMS and with the state. The bottom line is that refusal of psychiatric patients based on “this patient needs dual-diagnosis” is an EMTALA violation and should be reported to the state for investigation. Not only that, the common procedures of saying “you need to do an alcohol level and a urine drug screen before we can consider accepting this patient” and “we won’t accept the patient until the alcohol level is under 100” are in themselves EMTALA violations and should be reported to the state for investigation. I was told that this “dual-diagnosis unit” does not exist as a state licensure for hospitals, and is recognized neither by the state or by CMS as a legitimate hospital special capacity. It was reputedly an invention of certain hospitals and certain insurance companies.

However, in this area, we are adopting a more conciliatory approach. We are using a reporting form (<http://www.pitt.edu/~mercyres/mercy-transfer.pdf>) to report such refusals (and potential EMTALA violations) to our legal counsel. Our legal counsel then investigates and coordinates with the refusing hospital to discuss the cases. We hope that, rather than engaging in a “tit-for-tat” series of EMTALA reports between area hospitals, as has happened in some areas, we can resolve these issues without recourse to reporting them to the state.

We also will assess patients for potential alcohol or drug withdrawal, and preferentially try to transfer such patients to facilities with a demonstrated capacity to care for such patients.

What about children and adolescents with psychiatric problems that require admission? Do we have to admit them to our “adult” psychiatric unit? Or should we transfer the patient to a facility that has a “child and adolescent” psychiatric unit?

CMS (née HCFA) maintains that they have to mandate a similar level of care in rural and urban areas. And in rural areas, psychiatric facilities take care of both adult and adolescent/child patients. Ergo, urban hospitals with psych facilities cannot transfer psych patients as long as they have beds, regardless of age.

However, one can make a powerful argument to the contrary, as follows. A rural psych hospital that cares for patients of all ages has staff and physicians who have experienced at providing care for psych patients of all ages. However, in many urban

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areas, child and adolescent patients are routinely sent to hospitals that specialize in such patients. Therefore, the urban hospitals with “adult” psych units actually have **less** capacity to care for child/adolescent patients than the urban psych hospital that cares for all ages. To put it bluntly, the adult psych units are incompetent to take care of child/adolescent psych patients. Based on this, PMHS considers that it does **not** have the capacity to care for child or adolescent psychiatric patients, and will transfer such patients to hospitals with specialty capacity in such areas. (The facilities here are Southwood and Allegheny General Hospital, both of which bill Medicare and Medicaid as acute care hospitals and thus are “hospitals” in the eyes of CMS). The psychiatric admission policies for Mercy Hospital of Pittsburgh and Mercy Providence Hospital provide objective criteria on how to decide if a patient requires specialty adolescent/child psychiatric care, or whether the patient can be treated as an adult.

What about very violent patients? It is generally accepted that any psychiatric facility must be able to deal with very violent patients. Therefore, transferring a patient from one psych facility to another just because the patient is very violent will be difficult to justify under EMTALA, and would have to have very careful and specific documentation, and if it occurs at all, should only occur after admission and careful evaluation.

It might be the case that a psychiatric unit might not be able to accept a very violent patient due to lack of staff. In such a case, just like in the case of low nursing staff on a medical unit, the unit would be expected to exhaust all avenues for obtaining additional staff (calling in backups, “pulling” staff from other units) before refusing such a patient.

However, also see the section about prison inmates, above: ***Transfers, Special Facilities, and “Level of Care.”***

Reporting Issues

All reporting of potential EMTALA violations should be through the normal chain of command at a hospital—it is hospitals, not individual physicians or nurses, who are responsible for reporting. [Stephen Frew, 11/2/01 website comment]

It is mandatory, on pain of citation, for hospitals to report of inappropriate unstable transfers they receive. If a hospital investigates a potential case and finds there did seem to be an EMTALA violation, it is mandatory that the hospital report this to CMS (née HCFA) on pain of being cited itself—however, there is no mandatory reporting requirement for individual physicians or nurses. Reporting of other violations is not mandatory. CMS has a 72-hour timeframe for reporting violations but as best is known this is not mandatory. [Stephen Frew, 8/3/00 and 2/20/02 website comments] [Bitterman p. 114]

Although reporting of “reverse dumping” (refusing to accept transfers) is not mandatory, Frew now strongly recommends reporting all such incidents:

1) Hospitals seeking to transfer patients to higher levels of care in appropriate circumstances as defined by EMTALA should not be asked about means or ability to pay or hospital guarantee of payment prior to the acceptance of transfer by the

intended destination hospital or responsible physician accepting or denying acceptance on behalf of the intended destination hospital.

2) If asked, do not provide the information even if the patient is fully insured.

3) In any case where a transfer is turned down after the intended receiving facility has asked about finances of the patient or any guarantee of payment by the sending facility, it should be reported as a possible EMTALA violation within 72 hours of the event to the responsible office of the Centers for Medicare and Medicaid Services (CMS) to avoid possible EMTALA liability on the part of the sending hospital for failure to report.

4) The fact that the transfer was turned down after inquiry about means or ability to pay or demand that the sending hospital guarantee the bill should be described in detail in the medical record to adequately protect the sending hospital under EMTALA transfer rules and to assure that all legal defenses and remedies are preserved in the event the resulting delay and outcome causes patient litigation against health care providers. [Stephen Frew, 11/3/01 and 3/2/02 website comments]

EMTALA prohibits hospitals from taking action against “whistle-blowers.” A whistle-blower is any physician, medically-qualified person or employee, who refused to authorize a transfer of a patient with Emergency Medical Conditions that have not been stabilized, or reported an EMTALA violation. [Bitterman p. 110]

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ⁱ There was a brief flurry of excitement in January 2003 when CMS indicated it was OK for Medicaid managed care programs to limit Emergency Department access, despite Balanced Budget Act requirements that these programs pay for all ED visits that met “prudent layperson” criteria. But in short order, after a loud outcry from both Congress and the public, CMS quickly retracted this, and we’re back where we started. See <http://www.medlaw.com> for more.