TASC Training & Advocacy Support Center

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Fact Sheet

Hospital Psychiatric Inpatient Units Refusal to Accept Psychiatric Patients from Emergency Departments: EMTALA Violation or Not?

produced by
Susan Stefan
Center for Public Representation
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P&A agencies frequently hear complaints that their clients remain for hours, even days, in emergency rooms because the ER staff is unable to locate a hospital inpatient psychiatric unit which will accept them, even when there are available beds. Often the refusal is explicitly because the person is uninsured. In some states, hospitals have acknowledged having a policy in which their inpatient units accept uninsured patients from their own emergency departments but not from emergency departments in other hospitals. Sometimes it is because the patient is known to the inpatient unit as someone who has created difficulties in the past.

It has been suggested that refusal to accept uninsured psychiatric patients or those who are perceived to be difficult as transfers from other facilities' emergency departments violates the "reverse dumping" provisions of the Emergency Medical Treatment and Active Labor Act ("EMTALA").[1] The "reverse dumping" provision of EMTALA requires a hospital with specialized capabilities or facilities to accept an appropriate transfer of an individual who requires those capabilities or facilities if the hospital has the capacity to treat the individual, and the transferring hospital does not. Under one theory, if the hospital attempting to secure the transfer has no inpatient psychiatric unit, or if its inpatient psychiatric unit is filled to capacity, and the proposed transferee hospital has an inpatient psychiatric unit with available beds, the transferee hospital violates EMTALA if it refuses to accept a patient from the former hospital's emergency department. Some material in State Operations Manuals at the Department of Health and Human Services suggests that this might be the case. However, the "reverse dumping" provision of EMTALA has rarely been litigated, and the regulations regarding "reverse dumping" are contradictory and create more questions than they resolve. Significantly, if refusal to accept a proposed transfer of a psychiatric patient *is* an EMTALA violation, the hospital requesting the transfer may be under a legal duty

[1] *See* 42 U.S.C. § 1395dd(g).

itself to report the refusing hospital for violating EMTALA.

A. Background

Emergency departments are not optimal venues for individuals with psychiatric disabilities because staff may not have the skills or resources to adequately treat or manage their behavior. Recognizing this, and perhaps in an abundance of caution, emergency room staff try to get an individual admitted to the inpatient psychiatric unit in the hospital. But, beds in these units may not be available. As a result, the individual may be stranded in the emergency room waiting extended hours and even days for admission to the inpatient psychiatric unit. As a preliminary matter, P&A advocates should focus sharply on whether an individual can be discharged from the emergency department with supports in the community. If this is not possible, the P&A should then advocate for the emergency department to transfer the individual to an inpatient unit in another hospital which has space available and which can serve the individual. If the proposed transferee hospital refuses to accept the individual, the P&A can then pursue an EMTALA complaint against the transferee hospital.

EMTALA is a federal statute requiring emergency departments to accept and screen any presenting patient for an emergency medical condition.[2] Emergency medical conditions have been defined by regulation and commentary to include psychiatric conditions. If a patient does have an emergency medical condition, the emergency department cannot "transfer" the patient without stabilizing the emergency medical condition. ("Transfer" is defined in EMTALA to include discharging the patient). The statute was passed to prevent hospitals from refusing to treat or transferring patients with emergency medical conditions simply because they did not have the ability to pay.

However, sometimes the emergency department is not capable of stabilizing the patient, or the best medical treatment of the patient requires a transfer to an inpatient unit. In those situations, a hospital *can* transfer a patient, as long as the transfer is "appropriate" under the Act.

B. "Appropriate Transfer" Under EMTALA

Once an individual arrives at an emergency department, and is identified as having an emergency medical condition, EMTALA prohibits the emergency department from transferring the patient before his or her condition is stabilized unless the transfer is "appropriate." "Appropriate transfer" is defined as meaning that either 1) the patient requested or consented to the transfer; or 2) the physician certified in writing that a transfer is in the patient's medical best interests, taking into account the risks and benefits associated with the transfer.[3]

A number of additional requirements are imposed before a transfer is "appropriate" under EMTALA. The most important one for purposes of this Fact Sheet is

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[2] *See* 42 U.S.C. § 1395dd.

[3] 42 U.S.C. § 1395dd(C)(1)(A).

that a transfer is not considered "appropriate" unless the facility to which the patient is being transferred has consented to the transfer. In addition, the transferring hospital must provide whatever stabilizing treatment that its own facilities permit, ensure that the patient's records and test results accompany the patient, and that the transfer is accomplished with adequate transportation and personnel.

A letter dated November 2001 from CMS states that if a hospital is transferring a patient due to "lack of capacity" it must do everything it reasonably can to care for the patient rather than transferring the patient, including calling staff from home. Even if a hospital has exceeded its bed capacity, it may not be able to transfer a patient because of lack of capacity: if a hospital has "customarily accommodated patients in excess of its occupancy limits by whatever means…it has, in fact, demonstrated the ability to provide services to patients in excess of occupancy limits."[4]

C. Requirements Related to Stabilization of Psychiatric Patients

The transfer requirements apply only to a patient who 1) has an emergency medical condition; and 2) is not "stabilized." If a patient is stabilized, the requirements of EMTALA are satisfied, and the patient can be discharged or transferred. Interestingly, EMTALA regulations have been interpreted to have a specific—and separate—set of definitions of "stabilization" for psychiatric patients. As to psychiatric patients only, EMTALA regulations define two different kinds of stabilization: 1) "stable for discharge" means that the patient is no longer a threat to himself or others, and 2) "stable for transfer" means that a patient is protected and prevented from injuring himself or others.[5]

Therefore, while generally under EMTALA an unstable patient can be transferred if the requirements for appropriate transfer are met, it appears that a psychiatric patient cannot be transferred unless he or she is "stable for transfer." And while an emergency department's obligations are generally at an end when the patient is "stable," presumably EMTALA obligations to a psychiatric patient do not end when he or she is "stable for transfer." By creating the category "stable for transfer," the Department of Health and Human Services indicated that psychiatric patients could and should be transferred even when they were not yet stable for discharge.

It should be clear that if a patient opposes a transfer to an inpatient unit, the transfer cannot be made under EMTALA unless a doctor certifies that the transfer is in the patient's best interests. In addition, EMTALA does not permit involuntary retention of a patient. If the patient wishes to leave, there are detailed requirements regarding informing the patient of the risks of departure. A hospital wishing to involuntarily detain a patient must act under the State's civil commitment law.

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[4] This memorandum can be accessed on the CMS website, after clicking on Medicaid, by searching for "Hospital Capacity EMTALA." It was posted on Nov. 29, 2001. *See,* www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR

[5] *See* Interpretive Guidelines to 42 C.F.R. § 489.24(c)(l).

D. Requirements Related to "Reverse Dumping"

Congress amended EMTALA in 1989 to prohibit what has become known as "reverse dumping," forbidding a hospital with "specialized capability" and "capacity" from refusing the "appropriate transfer" of a patient whose condition requires treatment by the hospital's specialized capabilities or facilities.[6] Thus, the statute provides

> A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.[7]

The regulation implementing this section reads:

> *Recipient hospital responsibilities.* A participating hospital that has specialized capabilities or facilities (including, but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers... may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual.[8]

First, the question arises as to whether psychiatric facilities fall under the category of "specialized capabilities or facilities." It is clear that "[i]f 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."[9] Whether the ability to serve psychiatric patients counts as "specialized capabilities or facilities" is open to argument. On the one hand, the Interpretive Guidelines regarding "Responsibilities of Medicare Participating Hospitals in Emergency Cases" state that "capabilities of a medical facility mean that there is physical space, equipment, supplies, and specialized services that the hospital provides, e.g. surgery, *psychiatry*, obstetrics, intensive care, pediatrics, trauma care."[10] On the other hand, it can be argued that the general means used by emergency departments to stabilize psychiatric patients—primarily medications—do not require the kind of specialized training and knowledge associated with the examples of specialized

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[6] Under the Omnibus Budget Reconciliation Act of 1989 (OBRA 89), Pub. L. No. 101-239, Congress amended EMTALA to include, among other things, a separate provision designed to prevent "reverse dumping" -- the practice of large, well-equipped medical centers refusing to accept uninsured transfer patients from smaller hospitals that are unequipped to provide the level of care required by the patient. *See, e.g.*, H.R. Rep. No. 531, 100th Cong., 2d Sess. at 17-21 (1988).

[7] 42 U.S.C. § 1395dd(g).

[8] 42 C.F.R. § 489.24(f)

[9] "Hospital Capacity EMTALA." (Nov. 29, 2001). *See,* www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR.

[10] Interpretive Guidelines to 42 C.F.R. § 489.24(d)(1)(i)(2004) (emphasis added).

care given by Congress in referring to the term "specialized capability" such as burn units, shock-trauma units, and neo-natal intensive care.[11]

Second, the fact that the "reverse dumping" prohibition includes the requirement that the transfer be "appropriate" creates confusion, since an "appropriate transfer" requires the consent of the transferee facility.[12] As the court in the key case interpreting the reverse dumping provision of EMTALA pointed out, a literal interpretation of the "appropriate transfer" requirement literally would nullify the prohibition on reverse dumping, since a receiving hospital could simply refuse to consent to every transfer request.[13] The court, therefore,read the reverse dumping prohibition as requiring the transferee facility to accept a proposed transfer if it had the specialized facilities and the capacity to treat the patient, who was still in an unstable condition and needed the services of the transferee hospital to be stabilized.[14]

E. The Application of "Reverse Dumping" to Psychiatric Patients

In assessing the charge that inpatient psychiatric units which refuse to accept transfers of uninsured patients from other hospitals' emergency departments violate EMTALA's reverse dumping provision, several issues must be kept in mind.

The first issue to be aware of is that state, county, or city arrangements for the care of indigent patients (such as assignment of various patients to "catchment areas") are preempted by the federal requirements of EMTALA. A hospital may not refuse an appropriate transfer because the patient is not in the hospital's catchment area. While the Interpretive Guidelines to the regulations recognize the possibility of "community wide plans" for "specific hospitals to treat certain emergency medical conditions, e.g. psychiatric…", the guidelines emphasize that a "hospital must meet its EMTALA obligations (screen, stabilize, and/or appropriately transfer) prior to transferring the individual to the community plan hospital."[15] In fact, one of the most common sources of EMTALA violations has been a hospital emergency department sending a psychiatric patient to a specialty hospital without first screening the patient for emergency medical conditions.

The second issue is that it can be argued that the reverse dumping provision was

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[11] 42 USC § 1395dd(g).

[12] As originally passed, EMTALA required that hospitals *not* transfer a patient unless the transfer was "appropriate." Section 1867(c)(2) defines an "appropriate transfer" as one in which: 1) the transferring hospital provides medical treatment within its capacity to minimize the risks to the individual's health; 2) the receiving facility has available space and qualified personnel to treat the patient, and has agreed to accept the transfer; 3) the transferring hospital sends to the receiving facility all medical records available at the time of the transfer; and 4) the transfer is effected through qualified personnel and transportation equipment. The regulations implementing the screening, stabilization and transfer requirements of the statute are set forth at 42 C.F.R. § ###(a), 489.24(c) and 489.24(d).

[13] *See* St. *Anthony's Hospital v. United States Department of Health and Human Services*, 309 F.3d 680, 700 (10th Cir. 2002).

[14] *Id*. at 701.

[15] Interpretive Guidelines to 42 C.F.R. § 489.24.

intended by Congress to apply only when the capabilities of the transferring hospital and transferee hospital were substantially disparate as to ability to stabilize the patient's condition. The transferee hospital must possess "specialized capabilities or facilities" to treat the emergency medical condition. Thus, the factual situation which most seems to implicate the reverse dumping provision is that of an emergency department with no access to a mental health professional or a psychiatrist, which might seek to transfer an acutely psychotic patient to a hospital which did have mental health professionals capable of stabilizing the patient's condition. The reverse dumping provision would only be violated, however, if a court were to accept the argument that in this patient's case, a mental health professional was necessary to stabilize the patient rather than an emergency department physician, which seems unlikely. Under this argument, if the proposed transferee facility, that is, the receiving hospital, had the capacity to treat the patient, as defined below, and refused the transfer, EMTALA would probably have been violated.

The reverse dumping provision of EMTALA has rarely been litigated, although it has sometimes been part of the context of EMTALA litigation. For example, in *Fotia v. Palmetto Behavioral Health,* 317 F.Supp.2d 638 (D.S.C. 2004), the plaintiff was a social worker who was employed by a psychiatric facility. A nearby hospital with no psychiatric staff contracted with plaintiff's employer to provide psychiatric assessments. When a patient presented at the hospital in psychiatric crisis, the hospital called plaintiff's employer, which dispatched the plaintiff. He sought to have the patient admitted to his own facility, which had a bed available. The administrator on call told him that they had taken their share of unfunded patients recently and advised him to send the patient to the state hospital. The social worker reported this as an EMTALA violation and was fired less than a week later. The plaintiff sued under the EMTALA whistleblower provision, which permits those injured by a hospital's violation of EMTALA to sue, and the federal district court upheld his claim against his employer's motion to dismiss. However, the question of whether EMTALA was actually violated was not relevant to the litigation, since the provision at issue makes it illegal to fire a hospital employee for simply reporting a potential EMTALA violation.[16]

Conclusion

As state mental health agencies increasingly retreat from provision of acute psychiatric care, a gap has been created which private psychiatric hospitals are reluctant to fill. Increasingly, emergency departments—expensive and ill-equipped to deal with psychiatric patients—have become the default option for people with acute psychiatric needs.

P&A agencies should investigate the situation in their states and take a proactive stance advocating for organized community crisis alternatives funded by Medicaid and the state mental health agency. Some of the most successful of these alternatives have been founded and run by consumers of mental health services. Other non-hospital

[16] 42 U.S.C.A. § 1395dd(d)(2)(A), (i).

models for crisis care include crisis hostels, and staying with a volunteer family (pioneered in Madison, Wisconsin).

P&As should understand that one source of the perceived problem with private hospital units may be the assumption on the part of emergency departments that they must find an inpatient bed for psychiatric patients rather than discharge them, both because of traditional (but superseded) notions of inpatient treatment as the "gold standard" for psychiatric patients and because of concerns about liability associated with discharge. If a patient is truly still in an unstabilized emergency psychiatric condition, and the emergency department truly does not have the capacity to provide this stabilization, then transfer may be necessary. But a stabilized patient may not need inpatient psychiatric treatment, and EMTALA should not be used as a vehicle to force hospitals to accept acute care patients who do not meet inpatient standards.

There is still a place for P&A advocacy on behalf of patients stranded in emergency departments because they are perceived as "too violent" by some private psychiatric units. Hospitals cannot refuse to accept appropriate transfers for this reason.[17]

[17] *See* the helpful and detailed draft comments at /www.pitt.edu/~kconover/emtala-draft.pdf.