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Message From The President

Happy Holidays, NC ASHRM! I hope you are doing well in the world of Risk Management. We face multiple challenges in our field. To survive and thrive, you must understand and conform to the institutional mission, philosophy, vision, political sensitivities, and fiscal vulnerabilities of your organization. This, in addition to administrative cutbacks, decreased reimbursement rates; nursing shortages and the mere cost of technology have had a profound effect on our ability to meet the needs of our patients. However, when it's all said and done, we still manage to deliver quality patient care.

So, with the multifaceted hats we must wear, how does one succeed in the field of Risk Management? Successful Risk Managers are vibrant, resilient individuals with an uncanny ability to meet the demands of today's healthcare environment. However, in my experience, I have found that it takes more. You must be passionate about what you do. I believe that Risk Management is the one area in which you are allowed to get up close and personal on multiple levels. Whether you are conducting a root cause analysis or prepping staff for depositions, there are certain qualities needed to ensure success. Of course, you will not find this methodology in a book. M&M&M, better known as motive, message and method, is my personal recipe for success.

Your motive must be pure. Why do you do what you do? What motivates you? Power, money, prestige, self-fulfillment? Your motivation will have a direct effect on your ability to successfully lead and direct others. The people you encounter on a daily basis and those you have infrequent, but often, necessary contact with, will know what motivates you. They can become your allies or enemies dependent upon their perception. Be

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On-Call Coverage Under EMTALA: What is Required and What is Reasonable?

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The Centers for Medicare and Medicaid Services (CMS) first promulgated regulations under the Emergency Treatment and Active Labor Act (EMTALA)[1] a number of years ago[2] and CMS has issued new regulations[3] that were effective on November 10, 2003. On May 13, 2004, CMS issued new Interpretive Guidelines that are posted on its website.[4] While CMS has provided a great deal of guidance on this subject, questions still remain. This is particularly true with respect to the requirements for specialists to be on call in order to provide services to hospital patients with emergency medical conditions. This article will attempt to determine what is known to be required, what is believed to be required, and the issues that, at present, remain unresolved. This article draws largely upon the Interpretive Guidelines for its substance.

Basic Call Requirements

The basic rule is that hospitals must have a list of specialists who are on call to provide services to the hospital's patients.[5] The hospital is required to maintain this list in a manner that best meets the needs of the hospital's patients. In general terms, if the hospital provides certain specialized services to the public, it is required to provide these services through its Emergency Department (ED) as well. How it does this is left, in large measure, to the hospital's discretion, but CMS retains the right to determine what is reasonable under any given set of circumstances. If CMS determines that the hospital's actions were not reasonable, it may find that the hospital has violated EMTALA. Unfortunately, rather than specify what is reasonable, CMS has preferred to specify a few things that it knows are not reasonable.

The list of on-call specialists must indicate the physicians who are supposed to be available to see patients with emergency medical conditions, but who do not already have a specialist by whom they have been treated. The list is not meant to include the names and contact information for office practices whose patients may present to the ED. Additionally, the hospital must not allow groups to take call. CMS requires that the names of individuals appear on the call list so that it will be able to hold a named individual responsible for failing

to respond within the specified response period.

CMS has also not given specific guidance on what level of coverage is appropriate. CMS specifically denies claims that there was a "rule of three" mandating coverage 24 hours per day 7 days per week if the hospital had three or more specialists in a given specialty on staff.[6] What is reasonable in this matter will be based on multiple factors such as: the number of physicians on staff; the number of specialists in each specialty; other demands on the physicians; vacations; days off; conferences; the frequency with which the services of a particular specialty are required; and the provisions made by the hospital for occasions on which the services of a particular specialty are not available.[7]

Additionally, CMS does not require that specific physicians be on call. If the hospital only has one specialist, CMS will not require that person to be on call continuously. CMS also recognizes that there may be appropriate reasons for exempting certain physicians from being on call, such as senior status on the medical staff or advanced age.

Each hospital's medical staff bylaws should carefully define the responsibility of specialists to respond, examine and treat patients when required to do so.

Issues in Call Coverage

Is A Specialist Required To Take Call?

CMS has recognized that specialists have been refusing to participate in call panels for a number of years.[8] It appears that specialists are not required to do so. However, if they refuse to participate in the call list, they may not take "selective call." Selective call occurs when a specialist agrees to see a patient with whom the specialist or a colleague has a prior existing relationship, while refusing to see other patients with whom there is no such relationship. CMS indicates that this may be a violation of EMTALA.[9] CMS further indicates that the hospital itself may be in violation of EMTALA if the hospital permits this to practice to occur.

Taking selective call if the specialist refuses to participate in the call list is addressed in the Interpretive Guidelines.[10] However, it is not clear whether the selective call prohibition applies if the specialist accepts a limited amount of call time (e.g., a specialist will only take calls from the call list for one day per month while the hospital remains uncovered the rest of the time). CMS has not determined that this is inappropriate, but it has also not said that it would be reasonable either.

In actual practice, it appears that refusing to take call would place significant limitations on a specialist's hospital practice. If the specialist never sees patients on an emergent basis, or is willing to allow another specialist to see his/her patients in the ED, it may be possible for a specialist to refuse to take call.

Under What Conditions Must A Patient Actually Be Seen By The Specialist?

The general rule is that the ED physician is the practitioner who is in the best position to determine whether the specialist must actually come in and see the patient. If the ED physician determines that the specialist must come in, the specialist may be in violation of EMTALA if he or she refuses or fails to come in.[11]

CMS does allow for some discretion here. If the specialist is seeing patients in his/her office, which is a department of the hospital and is on the campus of the hospital, it may be permissible to send the patient to the specialist's office if accompanied by appropriate medical personnel. However, this may not be permissible unless all patients with the same condition are moved and there is a bona fide medical reason to move the patient.

It may also be appropriate for the specialist to ask a mid-level provider (allied health practitioner) to see the patient under certain circumstances. This depends on the patient's condition, as well as state licensing laws and regulations. Whether mid-level practitioners may actually take call has not been addressed by CMS in the Interpretive Guidelines.

The guidelines do not prohibit the use of telemedicine, but they place significant restrictions on its use. As a basic premise, telemedicine cannot be used unless it allows the specialist to adequately assess the patient. The guidelines also prohibit its use unless the patient's geographic location would otherwise prevent the patient from obtaining the services of a specialist. Additionally, the guidelines state that telemedicine cannot be used except in rural health provider shortage areas or in counties outside metropolitan statistical areas.[12] It seems that telemedicine cannot be used solely for the convenience of the specialist.

If the specialist regularly transfers patients with emergency medical conditions to other hospitals and treats them there, rather than coming to the hospital to which the patients originally came, the specialist may be violating EMTALA.

How Soon Must A Specialist See A Patient?

The response time for specialists to respond to the ED must be specified in the hospital's medical staff bylaws.[13] Additionally, it must be specified in minutes and not in vague terms such as "reasonable" or "promptly." Nevertheless, CMS expects that the medical staff bylaws will specify a reasonable amount of time. It may be unavailing to specify the response time as four hours solely to avoid violation of this requirement by specialists. Since the Interpretive Guidelines specify that the response time should be "stated in minutes,"[14]
it is doubtful that CMS would accept a response time stated in hours.

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CMS anticipates that the time that the specialist was notified will be recorded in the patient's chart, as well as the time that the specialist responded. Investigators typically look at this information to determine whether a violation has occurred. It is important to note that, if a specialist fails to respond within the allotted time, CMS would consider that *both* the specialist and the hospital have violated EMTALA.[15]

CMS has granted hospitals some discretion in this matter, which would make sense considering that a timeframe that may be perfectly reasonable in one geographic location may be wholly unreasonable in another.

May Specialists Take Simultaneous Call?

It is permissible for specialists to take call at more than one hospital at the same time. However, a hospital may specifically prohibit the practice if it deems it prudent to do so. If the hospital allows this practice, and the specialist engages in it, all affected hospitals must be aware that the specialist is on call elsewhere and may not be available if needed. In this event, a hospital must have a plan to manage the specialist's unavailability, which might require a back up call system or a proper transfer of a patient to another facility if the hospital does not have the capability to treat the patient in the absence of the specialist.

The regulations require that hospitals have written policies and procedures to deal with this issue.[16]

sure you do what you do for the right reasons.

You message must be clear. What do you stand for? Some common responses are, “I’m here because I care about healthcare for all people.” “I’m here because I care about my organization and the contribution it makes to ensure patient safety.” “I’m here because I care about the nurses, the radiology techs, the patients, the physicians, the secretaries, etc.” How would your professional epitaph read?

Finally, your method must be kind. What method do you use to convey your message? Risk Managers are frequently the deliverers of sensitive, sometimes devastating information. The method of delivery most often determines whether or not the receiver of the information believes what he/she is told. People today are hungry for truth, honesty and genuine kindness.

Risk Managers are in a unique position to change healthcare one person at a time. The power of one becomes the strength of many. So exert your power through pure motives, clear messages and kind methods.

Sincerely,

Lisa Byrd

President, NC ASHRM

May A Specialist Perform Elective Surgery While On Call?

It is permissible for specialists to perform elective surgery while on call, however, a hospital may specifically prohibit the practice if it deems it prudent to do so. If the hospital allows this practice, and the specialist engages in it, the hospital must be aware that the specialist may be performing elective surgery and may not be available if needed. In this event, the hospital must have a plan to manage the specialist's unavailability, which might require a back up call system or a proper transfer of a patient to another facility if the hospital does not have the capability to treat the patient in the absence of the specialist.[17]

The situation is different, however, if the specialist is on call at a critical access hospital and wishes to perform elective surgery while on call.[18] Specialists are reimbursed for taking call at critical access hospitals and are prohibited from providing services at another facility while they are on call. CMS is silent on the issue of compensating specialists to be on call generally and it is not clear if this prohibition in the case of critical access hospitals extends to other acute care hospitals (critical access hospitals are on cost-based reimbursement).

The regulations require that hospitals have written policies and procedures to deal with this issue.

What If The Specialist Cannot Respond For Reasons Beyond His Or Her Control?

There will always be situations in which specialists may be unable to respond through no fault of their own. Each hospital must have policies and procedures in place to deal with this situation. Again, the better solutions are either to have a back up call system or to provide for an appropriate transfer of the patient if the hospital does not have the capability to treat the patient in the absence of the specialist.

It should be noted that the hospital is under an affirmative obligation always to manage its on call schedule in a manner that best meets the needs of its patients. CMS appears to take the position that this obligation cannot be passed onto the specialists.[19] If a specialist fails to respond within the allotted time, the hospital itself may have violated EMTALA if it fails to provide appropriate treatment for the patient. If the specialist leaves town while on call and fails to notify the hospital, and his or her presence is required, the hospital may have violated EMTALA if it fails to provide appropriate treatment for the patient. Hospitals need to do everything possible to ensure that specialists understand their obligations and that specialist coverage, if required, is assured.

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Conclusion

Taken together, the regulations and the Interpretive Guidelines provide a fair amount of guidance to hospitals regarding their obligations with respect to specialist coverage. However, they rely heavily on the concept of "reasonableness," which is a term that frequently defies precise definition. Unfortunately, hospitals will need to await further guidance before the concept of what is reasonable under different circumstances is fully understood.

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[1] 42 U.S.C. §1395dd
[2] The primary regulations that implement the statute are 42 CFR §§489.24, 489.20(m), (q) and (r), and 489.65. The primary regulation governing the availability of on-call specialists is 42 CFR §489.24(j).
[3] 68 Fed. Reg. 53222 (Sept. 9, 2003)
[4] CMS State Operations Manual, Interpretive Guidelines, Appendix V, available at http://www.cms.hhs.gov/providers/emtala/emtala.asp.
[5] Interpretive Guideline §489.24(j)(1)
[6] Interpretive Guideline §489.20(r)(2)
[7] Interpretive Guideline §489.24(j)(1)
[8] Dept. of Health and Human Services, Office of Inspector General, "The Emergency Medical Treatment and Active Labor Act: The Enforcement Process" No. OEI-09-98-00221 (January 2001) available at http://oig.hhs.gov/oei/reports/oei-09-98-00221.pdf; Dept. of Health and Human Services, Office of Inspector General, "The Emergency Medical Treatment and Active Labor Act: Survey of Hospital Emergency Departments" No. OEI-09-98-00220 (January 2001) available at http://oig.hhs.gov/oei/reports/oei-09-98-00220.pdf.
[9] Interpretive Guideline §489.24(j)(1)
[10] Id.
[11] Id.
[12] Id.
[13] Id.
[14] Id.
[15] Interpretive Guideline §489.24(j)(1)
[16] Interpretive Guideline §489.24(j)(2)(ii)
[17] Id.
[18] Id.
[19] Interpretive Guideline §489.24(j)(2)(i)

DISCLAIMER

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MEMBER NEWS . . .

Degrees:

Wendy Walker, Marsh, has received her Master's Degree in Health Administration -December, 2003.
Alisa Hollifield, Catawba Valley Medical Center, has received her Masters of Health Administration from UNC-CH -May, 2004.

Certifications:

Janna Jones, Consortium Management, has obtained her CPHRM designation -Spring, 2004.

Graduations, Weddings, Etc:

Lisa Byrd, Scotland Memorial Hospital, has a daughter, April Dawn Nye, getting married on November 20, 2004. The bridegroom is Jeffrey Stone.

Connie Lamb's daughter, Holly, graduated from the University of North Carolina at Pembroke with a BS in Special Education on May 7, 2004. She also got married on June 26, 2004 to John Paul Robinson. Connie's son, Brent graduated from NASCAR Technical Institute's Automotive Technology Program on September 17, 2004.

Retirements:

Mildred Farrior is retiring from Carteret

Janet Mercer will retire on December 30, 2004. Her new e-mail address will be JRMERCER@GOTRICOUNTY.COM. “Hope to hear from every one!”