THE PHYSICIAN ON-CALL DILEMMA: Emerging Solutions?

It's a familiar quandary: Your medical staff director calls to report that medical staff members are refusing to provide adequate on-call coverage for emergency services. Finding a solution is paramount. Not only must you provide quality care to emergent patients, but on-call physician coverage is required under the federal Emergency Medical Treatment and Active Labor Act (EMTALA) and many states' licensure laws. A general hospital that does not comply with EMTALA regulations faces monetary sanctions by the Centers for Medicare and Medicaid Services (CMS) and Medicare termination, not to mention exposure under the state licensure requirements and malpractice theories. Even specialty hospitals must provide limited on-call or on-duty physician services for emergencies under letter guidance issued by CMS on April 26, 2007.

INTERPRETING THE RULES FOR ON-CALL SERVICE

The availability of physicians to respond on an on-call basis is a priority for every hospital. Unfortunately, the EMTALA regulations, which set the industry standard, are excessively vague. They require each hospital to maintain a list of on-call physicians "in a manner that best meets the needs for the hospital's patients," in accordance with the hospital's resources, including the availability of on-call physicians. Although the regulations require a hospital to have policies in place to address the situation when a physician is not available "due to circumstances beyond the physician's control," or when the physician is providing on-call services or elective surgery elsewhere, they specifically do not set numeric benchmarks for the amount of on-call coverage that a particular physician or institution must provide. In the event of a bad outcome due to the unavailability of a specialist in the emergency room, these broad regulations may provide some flexibility to a hospital to demonstrate that it did not violate EMTALA, but they do little to resolve the underlying on-call shortage.

COMPLYING WITH EMTALA

So how do you ensure that your institution is staffed appropriately and in compliance with the law? Absent a complete overhaul of EMTALA, there are no easy answers. Many hospitals use EMTALA as the proverbial stick to require the medical staff to develop on-call policies that in many cases go beyond EMTALA's basic requirements. At a minimum, your institution can employ the following policies:

• On-call policies should be prominently located in the medical staff bylaws.
• Medical staff should be educated about the disciplinary consequences of failing to comply with the on-call policies.
• If a major dispute between the administration and the medical staff erupts over on-call coverage, the hospital's governing board may have to get involved.

But what if there are not enough physicians to provide adequate coverage, or physicians balk at providing call? Many institutions have resorted to paying on-call physicians to ensure appropriate coverage. In this case, the institution must be mindful that on-call payments may violate the Stark self-referral prohibition, unless they meet the personal services or fair market exception. This means that the payments must be clearly tied to the fair market value of the services, as may be indicated by survey data, consideration of how much on-call a particular physician provides within her department and other relevant factors. For those hospitals located near medical schools, qualified residents acting as “moonlighters” also may fill the void.

THE MEDICAL COMMUNITY'S RESPONSE

Overall, adequate on-call coverage remains a constant headache for most institutions. Limited relief may come from the EMTALA Technical Advisory Group (TAG), which was established by CMS pursuant to the 2003 Medicare Modernization Act to consider how to improve EMTALA's implementation. TAG, which includes hospital representatives, established an On-Call Subcommittee to specifically address on-call issues. To date, the On-Call Subcommittee has made only one recommendation: that physicians not be required to perform on-call services as a condition of Medicare participation. Despite this recommendation, in its proposed rule updating the hospital inpatient prospective payment system (IPPS) for fiscal year 2008, CMS requested feedback on whether it should amend its hospital provider agreement regulations or conditions of provider requirements to address the types of clinical personnel that must be present 24 hours per day, 7 days a week.

In addition, TAG is currently evaluating a number of other possible solutions to the physician on-call dilemma such as:

• the use of telemedicine for on-call purposes;
• geographic “pooling” of physicians from more than one hospital to satisfy the on-call requirement;
• how to respond to a hospital that does not provide adequate on-call coverage, thereby causing other hospitals in the market to take more patients;
• “selective call,” in which physicians decline general on-call duties but respond to calls for select or established patients; and
• whether specialists with general skills may narrow their practices and effectively avoid on-call duties (for instance, a hand surgeon who is qualified to perform general orthopedic surgery).

Although TAG is not expected to recommend major changes to EMTALA, even discrete changes to the on-call requirements—encouraging telemedicine, pooling or sanctions for physicians who fail to take general call—could ease the burden on hospitals that continually struggle with the on-call issue. Assuming that EMTALA is not significantly modified, TAG offers an important opportunity to develop new on-call requirements, or revise existing ones, to reasonably address both the need for on-call coverage and the realities of the on-call shortage.

If you have a question on this material, or would like to discuss legal services, please contact us at healthcare@duanemorris.com.

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