

# **WHO YOU GONNA CALL? PHYSICIAN CALL COVERAGE OBLIGATIONS UNDER WYOMING AND FEDERAL LAW**

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Wyoming physicians have for many years regarded call coverage as a public service, a practice-building mechanism. Call coverage has been a minor inconvenience for some specialties and in some hospitals. For other specialties and hospitals, call coverage has been a major imposition on the physician's quality of life. Increasingly, it is being regarded (particularly by newer physicians) as something they simply will not do (at least not for free).

Many Wyoming physicians still regard a reasonable amount of call coverage as a public service, and are happy to do it, without compensation, to serve their community. More and more physicians are finding themselves, however, squeezed between time pressures (such as family obligations) on one hand, and perceived state and federal legal obligations for on the other. Increasingly (and unfortunately) those physicians are simply opting out, resigning medical staff membership and clinical privileges solely to avoid hospital call coverage burdens. This article provides general guidance on state and federal law requirements for physician call coverage, both in the physician's private practice and in the hospital. With better understanding of these obligations, it may be easier to find middle ground between the competing demands on physicians' time.

## **I. Wyoming law requires physicians to provide private practice on-call coverage, but not for hospital emergency departments.**

Wyoming physicians will not be surprised to learn they are required to provide call coverage for their private practices. The Wyoming Board of Medicine's Rules and Regulations require Wyoming physicians to "make reasonable efforts to arrange adequate and appropriate coverage for their practices and patients" when the physician unavailable.<sup>1</sup> The Rules require that these coverage arrangements take into account the "general nature, complexity and severity of illnesses and the care and treatment in the patient population regularly seen by the physician". Physicians must also take into account the availability of other qualified, available providers to respond to their patients when developing a coverage plan.

The Rules do not require a physician to be on-call at all times. The Board's Rules recognize that "physicians cannot be continuously available to respond to patients and their emergencies", but recommend the physician instruct patients about what to do in case of unavailability. The Rules indicate that directing patients to simply go to the local hospital's Emergency Department should be a last resort; if physicians do so, they should confer with the Emergency Department's medical director to ensure that those providers

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<sup>1</sup> Wyoming Board of Medicine Rules and Regulations, Ch. 3, Section 6, *Practice Coverage* (<http://wyomedboard.state.wy.us/PDF/Rules/BOM%20New%20Rules.pdf>)

“are able to communicate with the physician, or another provider qualified and available to respond to the patient’s needs, about the care of their patients who may present for care at the facility.”<sup>2</sup>

The Rules unfortunately do not answer an important question: can a Wyoming physician ever be completely unavailable? The Rules require the physician to always be available to the Emergency Department, at least by phone, unless he or she has made arrangements with another appropriate provider to cover his or her patients. In many small Wyoming towns, arranging for another provider for call-coverage is difficult, particularly for specialties with few practitioners. In many cases, the only alternative is to pay for *locums* coverage, which is often prohibitively expensive for many Wyoming practitioners. In the absence of other arrangements, however, it appears that Wyoming physicians must always be available for call coverage, at least by phone.

Wyoming hospitals are, however, legally required to provide emergency and trauma services. Wyoming’s hospital licensing statutes require Wyoming-licensed hospitals that operate emergency departments to provide emergency care for “any condition in which the person is in danger of loss of life, or serious injury or illness” at the regularly established charges of the hospital”.<sup>3</sup> The Wyoming Department of Health’s hospital licensing regulations provide simply that the hospital shall meet the emergency needs of patients in accordance with acceptable standards of practice.<sup>4</sup> The Rules also provide that “services” (not further defined) shall be available 24 hours per day, and emergency room staff coverage shall be adequate to ensure that a patient for treatment will be seen within a reasonable time relative to her/her illness or injury. The Rules contain a catch-all requiring all hospitals to receive a trauma center designation, and the Department of Health’s Trauma Rules, Chapter 4, require most Wyoming hospitals to have specific specialists on-call and promptly available for traumas.

Nothing in these statutes or Rules obligates the physician to provide hospital call coverage. Legally, they only describe the hospital’s obligation, since the hospital is the licensee under the Department’s licensing statutes and Rules. Under the hospital licensing statutes, the hospital must provide such emergency services when it “has appropriate facilities and qualified personnel available”.<sup>5</sup> Physicians are not required, as “personnel”, to make themselves available to provide emergency care at the hospital. Likewise, the hospital receives the Wyoming Trauma Program designation, not the physician. Although the hospital may be required to make sure certain specialists are available for traumas, it is up to the hospital, not the physician, to make those arrangements. There is, therefore, nothing under Wyoming’s statutes or Rules requiring physicians to provide call coverage for hospitals.

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<sup>2</sup> Although the “practice coverage” Rule is written in “advisory” terms (using language such as “should”, and “recommended”, rather than “shall”) it also states that “failure to adequately address coverage needs of physician’s patients” may serve as the grounds for disciplinary action by the Board, potentially as “unprofessional conduct”.

<sup>3</sup> Wyo. Stat. §35-2-115(a)

<sup>4</sup> Wyoming Department of Health, Rules and Regulations for Licensure of Hospitals, Chapter 12, section 8.

<sup>5</sup> Wyo. Stat. §35-2-115(a)

**II. The Emergency Medical Treatment and Active Labor Act requires the hospital to provide for call coverage for its emergency department, but does not require individual physicians to provide that call coverage.**

Under the federal Emergency Medical Treatment and Active Labor Act (“EMTLA”; also called the Patient Anti-Dumping Statute), Medicare-participating hospitals must provide persons coming to the emergency department with an appropriate medical screening exam, and stabilizing treatment for any emergency medical condition revealed by the exam, before discharging or transferring the patient.<sup>6</sup> EMTALA requires Hospitals must provide these services without regard to payor source (or lack thereof), and “regardless of diagnosis (e.g., labor, AIDS), financial status (e.g., uninsured, Medicaid), race, and color, national origin (e.g. Hispanic or Native American surnames), and/or disability, etc.”<sup>7</sup>

EMTALA also requires that the hospital have a list of physicians who are on-call for duty after the medical screening exam to provide further evaluation and/or provide treatment necessary to stabilize an individual with an emergency medical condition.<sup>8</sup> A hospital must provide adequate medical personnel to meet its emergency needs by using on-call physicians to either staff or to augment its emergency department, during which time the capabilities of its emergency department includes the services of its on-call physicians. The on-call list identifies and ensures that the emergency department is prospectively aware of which physicians, including specialists and subspecialists, are available to provide care.

**A. CMS Will Review “All Relevant Factors” To Determine How Much Specialty Call Coverage a Hospital Must Provide.**

*1. CMS does not use a “Rule of 3’s”.*

CMS does not require any physician to be on-call at all times, and EMTALA does not state how frequently physicians are expected to be available to provide on-call coverage.<sup>9</sup> CMS has stated there is no pre-determined ratio for determining how much call coverage a hospital is required to provide in a particular specialty. Before CMS’ 2003 revisions to the EMTALA regulations, it was widely believed that CMS used a “rule of 3”; hospitals must provide "full" call coverage (24 hours a day, 365 days a year) for a specialty with three or more practitioners. CMS, however, specifically repudiated a "rule of 3" in 2003, declining to create a “safe harbor” for the appropriate amount of call under EMTALA.<sup>10</sup> Instead, CMS stated that hospitals should have flexibility in determining the appropriate amount of call,<sup>11</sup> and that it will “consider all relevant factors

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<sup>6</sup> 42 U.S.C. §1395dd

<sup>7</sup> Medicare State Operations Manual, Appendix V, Responsibilities of Medicare Participating Hospitals in Emergency Cases, Section 489.24.

<sup>8</sup> 42 C.F.R. §489.20(r)(2)

<sup>9</sup> 68 Fed. Reg. 53,251; See CMS Memorandum to regional offices and State Survey Agencies, May 13, 2004, regarding the revised EMTALA Interpretive Guidelines (“CMS Memorandum”), p. 21.

<sup>10</sup> 68 Fed. Reg. 52,251; CMS Memorandum dated June 13, 2002.

<sup>11</sup> 68 Fed. Reg. 53,224.

in determining whether a hospital has met its obligations for providing call coverage, including:

- the number of physicians on staff,
  - other demands on these physicians,
  - the frequency with which the hospital's patients typically require services of on-call physicians,
  - the provisions the hospital has made for situations in which a physician in the specialty is not available (vacations, conferences, days off) or the on-call physician is unable to respond.”<sup>12</sup>
2. *It is up to hospitals and physicians to decide what level of call coverage is adequate.*

Under EMTALA, hospitals are ultimately responsible for ensuring adequate call coverage, not individual physicians.<sup>13, 14</sup> CMS specifically addressed its expectation of how frequently a medical staff member expected to provide call coverage, in a Memorandum, dated June 13, 2002, stating that:

Medicare does not set requirements on how frequently a hospital's medical staff of on-call physicians is expected to provide on-call coverage. Hospitals are expected to provide services based upon the availability of physicians required to be on-call. We are aware that practice demands in treating other patients, conferences, vacations, and days off must be incorporated into the availability of staff. *We are also aware that there are some hospitals that have limited financial means to maintain on-call coverage all of the time. CMS allows hospitals flexibility to comply with EMTALA obligations by maintaining a level of on-call coverage that is within their capability.* (emphasis added)<sup>15</sup>

CMS has also emphasized that it has not set a “full coverage” requirement, as that it might establish an “unrealistically high standard that not all hospitals could meet”,<sup>16</sup> and that:

[W]e do not believe it would be practical or equitable to attempt to adopt more prescriptive rules on such matters as the number of hours per week physicians must be on-call or the numbers of physicians needed to fulfill on-call responsibilities at particular hospitals....[T]hese are local decisions

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<sup>12</sup> 68 Fed. Reg. 53,251 (2003); CMS Memorandum, June 13, 2002.

<sup>13</sup> 68 Fed. Reg. 53,250; See CMS Memorandum to regional offices and State Survey Agencies, dated May 13, 2004, regarding the revised EMTALA Interpretive Guidelines, p. 20-21; CMS Manual, §489.24(j).

<sup>14</sup> “Hospitals have an EMTALA obligation to provide on-call coverage for patients in need of specialized treatment if the hospital has the capacity to treat the individual...On-call coverage should be provided for within reason depending upon the number of physicians in a specialty.” CMS Memorandum, p. 21; Manual.

<sup>15</sup> CMS Memorandum; 68 Fed. Reg. 53,251, C.

<sup>16</sup> 68 Fed. Reg. 53,252

that can be made reasonably only at the individual hospital level through coordination between the hospitals and their [medical staff].”<sup>17</sup>

This has been interpreted as requiring those specialties with many physicians and/or high patient volume to be “well-represented” in the call coverage schedule.<sup>18</sup> Those with fewer physicians and/or low patient volume may be represented in proportionately lower amounts. Gaps in the on-call coverage may be permitted, but back-up arrangements must be made and documented in writing for any gaps. CMS recognized, however, that, “[g]iven the wide variation in the size, staffing, and capabilities of the institutions that participate in Medicare as hospitals, we do not believe it is feasible for us to mandate any particular minimum level of on-call coverage that must be maintained....”<sup>19</sup>

Wyoming physicians should understand, however, that they may have call coverage obligations under their hospital’s medical staff bylaws, rules or policies, or under employment or call coverage agreements. Those obligations are still enforceable even though EMTALA does not impose them. Moreover, serious penalties can be also assessed against individual physicians under EMTALA if a physician is scheduled to provide emergency department call coverage under the medical staff bylaws, and does not respond.<sup>20</sup> If the physician fails to a request to provide stabilizing treatment, and the patient is transferred to another facility, the physician’s name and address included with the patient’s medical records sent to the receiving facility.<sup>21</sup> Therefore, Wyoming physician may still have hospital call coverage obligations, and should take those seriously even if do not arise under federal or state law.

### **III. Conclusion**

Physician call coverage obligations are not going away. Patients will probably always need assistance at odd hours that are not convenient or desirable for physicians. Few physicians would argue that they were not aware of those burdens when they made the decision to pursue a career in medicine. But it is important to understand what burdens are legal, and what burdens are chosen, so that Wyoming physicians can make an educated decision with respect to how much of that burden they are willing to shoulder.

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<sup>17</sup> Fed. Reg. at 53,253.

<sup>18</sup> *On-call Obligations under EMTALA*, Physician’s Digest News, July 2006.

<sup>19</sup> Fed. Reg. at 53,253.

<sup>20</sup> Civil penalties of not more than \$50,000, per violation, may be assessed directly against a physician for certain EMTALA violations, and the physician faces potential exclusion from participating in federal health care programs. 42 U.S.C. §1395dd(d).

<sup>21</sup> 42 C.F.R. §489.24(e)(2)(B)(iii)