Panel Defers to Hospitals On False-Labor Cases

BY JENNIFER SILVERMAN
Associate Editor, Practice Trends

WASHINGTON — Local laws and practice patterns should dictate which health care providers can certify false labor cases, according to a preliminary recommendation from the Emergency Medical Treatment and Labor Act Technical Advisory Group.

Currently, the EMTALA, which is now law, recognizes only physicians as qualified to certify false-labor cases. Agreeing with the recommendations of one of its subcommittees, the technical advisory group determined at its recent meeting that this requirement was "inconsistent with the scope of practice for nurse-midwives and other practitioners under state laws," and should therefore be eliminated.

Instead, hospital policies and procedures should dictate which personnel are capable of making such an assessment, said the panel, which advises the Department of Health and Human Services and the administrator of the Centers for Medicare and Medicaid Services (CMS) on issues related to EMTALA.

The changes proposed by the technical advisory group's subcommittee "would allow a hospital to take into account state law, federal law, local practice patterns, and scope of practice and make a decision that works for that hospital and its patients," Charlotte Yeh, M.D., a member of the technical advisory group, an emergency physician, and the CMS regional administrator for Region I in Boston, told this newspaper.

Deanne Williams, a certified nurse-midwife and executive director of the American College of Nurse-Midwives, called the action "a very important step towards eliminating a significant barrier to care that was mistakenly created by the EMTALA regulations."

Laws in every state permit nurse-midwives to determine if a woman is in false labor, she said. "We are very hopeful that this problem will be fixed quickly. As more hospitals create labor triage units, they will need teams of nurse-midwives and physicians to assure that pregnant women do not wait for hours to be discharged," she said.

Dr. Yeh noted that nurse-midwives would still have to contend with the individual hospitals and their definitions of qualified personnel, even if the physician requirement for false labor was eliminated.

"The [advisory group] also recognizes that a woman in labor could have emergency medical conditions other than labor that would not be within the scope of practice of a nurse-midwife," she said. "We would expect that a hospital, as part of its credentialing process, would take that into account when identifying who can perform medical screening examinations."

'Restricting a midwife's ability to discharge a patient who they have determined is not in labor merely takes physicians away from medical matters.'

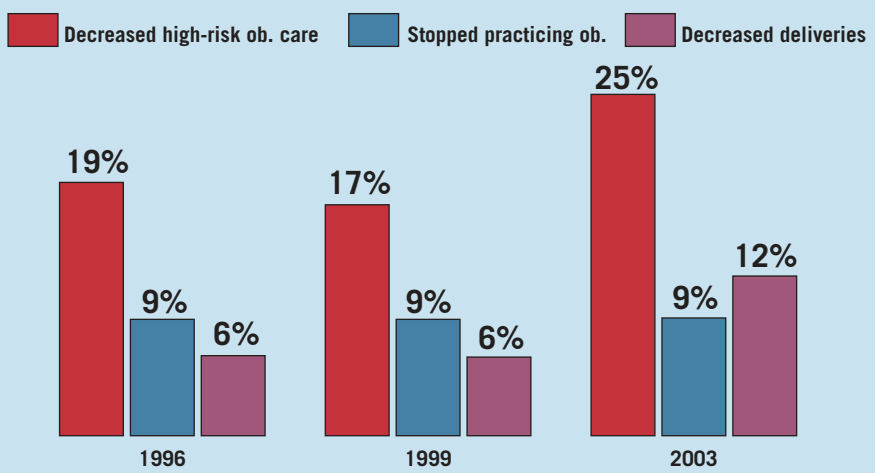
"One of the most common conditions treated by a certified nurse-midwife/certified midwife is the assessment of labor," Ms. Williams testified at a recent meeting of the technical advisory group. "Restricting a midwife's ability to discharge a patient who they have determined is not in labor merely takes physicians away from medical matters."

While the full advisory group ultimately voted to support the subcommittee's recommendation, it does not represent a final action, David Siegel, M.D., an emergency and internal medicine physician in Tampa, Fla., and the panel's chairman, said in an interview. The recommendation will be part of a larger package that the technical advisory group's new "action subcommittee" will deliver to the group and, subsequently, to CMS.

EMTALA was enacted in 1986 to ensure public access to emergency services regardless of ability to pay. The Medicare Modernization Act of 2003 required the Department of Health and Human Services to establish a technical advisory group to review EMTALA regulations. The group is required by law to meet at least twice a year. ■

DATA WATCH

More Ob.Gyns. Cut Services in Response to Liability Risk



Note: Based on a national survey of an average of 1,822 ob.gyns. per year conducted over the preceding 3-4 years.
Source: American College of Obstetricians and Gynecologists

KEVIN FOLEY, RESEARCH

Panel Decides Not to Link On-Call Service to Medicare

BY JENNIFER SILVERMAN
Associate Editor, Practice Trends

WASHINGTON — On-call services should not be a condition for participating in Medicare, a federal advisory panel on the Emergency Medical Treatment and Labor Act has recommended.

While most panel members panned the idea of an on-call/Medicare link, they were divided over whether to turn their disapproval into a formal recommendation to the Centers for Medicare and Medicaid Services.

Ultimately, the measure to recommend that CMS not link on-call participation with Medicare participation was approved in a close vote (7-6 with one abstention).

The technical advisory group advises the Department of Health and Human Services and the administrator of the Centers for Medicare and Medicaid Services on issues related to the Emergency Medical Treatment and Labor Act (EMTALA).

Hospitals cannot force physicians to be on call, although individual hospital policies may require on-call services as a condition of privileges. To address the shortage of on-call physicians, hospital associations had floated a proposal to the technical advisory group to link on-call participation to Medicare participation or hospital privileges.

Technical advisory group members who voted against making a formal recommendation to CMS at this point said they "were concerned about angering or offending the hospital associations who brought the idea to begin with," said Carol Bayer, M.D., a panel member and vice president for medical affairs at East Jefferson General Hospital in Metairie, La.

If such a link were enacted, however, "physicians would quit Medicare in droves," Dr. Bayer told this newspaper. Participating in Medicare means "you abide by the rules and have to accept the payments, but it has never been linked to anything like this before."

Some panel members, such as Charlotte Yeh, M.D., an emergency physician and CMS regional administrator for Region I in Boston, thought the issue deserved further review by the technical advisory group's on-call subcommittee before making a recommendation to CMS.

"Given the multiple factors affecting availability of on call, and the importance of solutions that both meet patient care needs and yet are practical enough for both hospitals and physicians, taking the time for analysis will result in a stronger position," she said.

But James Nepola, M.D., an orthopedic trauma surgeon in Iowa City, and author of the recommendation, thought there was enough evidence to oppose a link between Medicare and on call. "We've had testimony, we've had studies, and we've had surveys on both sides of this issue. Cultural changes are taking place in medicine right now that don't bode well for emergency medicine, Dr. Nepola said. "Young physicians are moving as quickly as they can to study fields that do not require emergency work at all. They are moving toward boutique practices, which I abhor."

For that reason, the technical advisory group should take affirmative actions "so that physicians can go in without this problem before them," Dr. Nepola said. The panel should also be addressing physician concerns such as liability reform and adequate resources and compensation for on-call services. "We need to move toward solutions like warnings for hospitals, not big penalties, and get rid of things that are not going to work."

Physician and hospitals groups offered their own views about the Medicare/on-call link at the technical advisory group's June meeting. Requiring on-call services as a condition of participating in Medicare "would far exceed the scope of the EMTALA statute," the American College of Surgeons argued in written testimony.

It is also contrary to the regulations and the interpretive guidelines, which state that each hospital must maintain an on-call list of physicians on its medical staff in a manner that best meets the needs of the hospital's patients, the ACS stated.

Many neurosurgeons are already being required to provide continuous call 24 hours a day, 7 days a week, 365 days per year, the American Association of Neurological Surgeons and the Congress of Neurological Surgeons testified, reporting from a survey of more than 1,000 members.

"Despite the fact that EMTALA does not mandate continuous emergency call, hospitals are nevertheless imposing this requirement on nearly one-third of neurosurgeons," the groups testified.

Going beyond Medicare, the neurosurgeons requested that CMS adopt a rule that would prohibit hospitals from requiring around-the-clock call of physicians.

In its own surveys, the American Hospital Association illustrated a continued struggle to recruit specialists for on-call services. Nearly one-third of the hospitals surveyed reported paying physicians for specialty coverage, and 40% of the community hospitals had to place their emergency departments on diversion for some period of time, said Kathleen DeVine, chief executive officer of Saint Anthony Hospital in Chicago, who testified on behalf of the AHA.

"If CMS wants to deal with any more specificity around on-call coverage, then physicians, those whom hospitals rely on to provide on-call care, must be brought to the table," she said. "Hospitals cannot do it alone." ■