

# **Physician Credentialing: Involving Hospital Staffing Issues, Being "On Call", and Insurance Interactions**

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## **Introduction**

The Children, Families, Health, and Human Services Committee (Committee) approached its study of Senate Joint Resolution No. 15 from a broad perspective, addressing access and delivery of health care in addition to specific issues related to economic credentialing and specialty hospitals.

As the SJR 15 study progresses, the complexity of the interactions involving hospitals, physicians, insurance companies, and patients becomes more obvious. This briefing paper outlines issues related to hospital staffing, being "on call"; and insurance credentialing. Key points are:

- the practice of medicine is evolving and not static, just as physicians' expectations for their work lives also are changing;
- federal laws put a burden on hospitals to provide 24/7 stabilization or transfer but there is no statutory requirement for physicians to provide that stabilization, which is why hospitals resort to call duties as part of granting medical staff privileges;
- some insurance providers have incentives to work with hospitals and physicians to avoid liability and be able to market "quality" assurance through their credentialing process; and
- hospitals in Montana are working in various ways to provide medical coverage.

## **Insurance Credentialing - Intertwined with Other Access and Delivery Issues**

At its September 2007 meeting, the Committee received a list of definitions that included credentialing, with a description of both economic credentialing and physician credentialing. The intended distinction was to distinguish economic credentialing, which typically addresses the investment or competitive employment interest of a physician seeking privileges at a hospital, from the broad term physician credentialing, which is a tool used by hospitals and insurers to assess the education and skill-set credentials of a physician.

Physician credentialing, as used by insurers, involves the following issues that intertwine with other issues related to the Committee's study of access and delivery of health care services:

- physician employment, including hospitals' use of hospitalists and contracts;
- hospital "call" requirements;

- efficiency in health care; and
- insurers' potential use of credentialing for network adequacy.

### **Hospital Staffing Issues and "Call" Requirements**

Hospitals in Montana range from the Billings Clinic, which is a large, multi-practice investor in a hospital, to a wholly physician-owned Great Falls Central Medical Hospital. In between are hospitals that extend medical staff or courtesy privileges to either independent physicians for the use of their facilities or to physicians employed by the hospital. At many hospitals in Montana, medical staff bylaws may limit full privileges to only those physicians who agree to be part of a rotating "call" to help the hospital meet federal requirements under Medicare and EMTALA (the Emergency Medical Treatment and Active Labor Act).

**A rationale for "call"**

That federal requirement says a "participating" hospital (i.e. one that accepts payments under the Medicare program regardless of whether the person seeking emergency treatment is a Medicare patient) that has an emergency room must screen a person requesting emergency care to determine the medical emergency, provide stabilization, and either treat or transfer to a facility with the capability of treating the condition. According to Dr. Jim Haley of St. Peter's Hospital, a hospital that offers a service, including a specialty service, must either provide screening/treatment for that service 24 hours a day, 7 days a week (24/7) through appropriate staffing or have arrangements in place to transfer a patient needing that specialty. The expectation of service falls on the physicians but the hospital faces the burden of providing the service. A website dedicated to frequently asked questions about EMTALA noted:

In truth, then, the requirements of EMTALA are imposed on the people who work within and on behalf of the hospital, but the hospital is the entity which must bear the loss if it is found that they have violated the statute.<sup>1</sup>

The website further clarified that Medicare eligibility rules require hospitals "to maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition."<sup>2</sup> The necessity of offering needed services at a hospital (or ambulatory surgical center in some cases) contributes to "call" requirements and the use of hospitalists, contract arrangements, or locum tenens physicians.

One way of responding to a hospital's need for physicians to be "on call" is to attach "call" requirements to privileges. Hospitals grant various types of privileges. In general, active medical staff privileges allow physicians to admit patients, exercise the full scope of their privileges, and vote on medical staff issues. A hospital may extend courtesy privileges to physicians who may be visiting or who anticipate using the hospital for only a limited number of procedures.

**Privileges**

These physicians would not have to participate in call or any of the mandatory meetings required of active medical staff with privileges. Some hospitals allow consulting staff to come in

and advise medical staff, but these consultants would not have admitting privileges or have to take call, according to Dr. Haley. For all other active medical staff, however, privileges entail responsibilities.

### **Relationship Between "Call", Privileges, and Insurance**

One of the issues related to insurer and economic credentialing is that insurers and hospitals may seek to use privileges as a way to penalize physicians who do not take call. Physicians who do not want to take call, for whatever reasons, may have made arrangements with other practitioners for patients who need to be admitted to hospitals. Or they may rely on the emergency department to admit those patients. The former includes what are sometimes called "boutique" doctors, found in Washington, D.C., and other large cities, who may structure their practice to allow more time with patients and who may not be part of an insurance network. These physicians often charge more as a result. In Montana, some of the physicians who prefer not to take call try to contract with a hospital for hospitalist services or work with a specialist who agrees to handle hospitalization of that physician's patients. Or they may resort to an emergency room, where their patient becomes "unassigned".

For other physicians, the duty of being "on call" requires them to work with patients who enter the emergency room. The emergency room physician may call a patient's regular physician or whatever physician is accepting call for the regular physician or, if the patient is unable to list a physician, the "call" goes to the appropriate physician on call rotation. A physician accepting an "unassigned" patient then must follow that patient's care through the patient's time in the hospital. If the patient is uninsured, the on-call physician who accepted the assignment may very likely not receive any payment for services. Nor would the hospital receive any payment.

In some cases, hospitals pay stipends to physicians for their on-call service to compensate for the time spent. A 2005 report by the California HealthCare Foundation noted, "Depending on the type of hospital and its service-area demographics, unassigned patients range from 5% to 25% of all ED (emergency department) patients; 12% is the estimated average."<sup>3</sup> That report further noted that the time spent on unassigned patients costs physicians who still have to pay for medical malpractice insurance and have less time to devote to their paying patients. The report noted that only one-third of the uninsured or self-pay patients who are unassigned generally pay their emergency room bills.<sup>4</sup>

The type of practice in which a physician may engage also affects how "call" duties impact the physician. A community may have one or more of the following types of physicians, who respond to call as indicated in Table 1, below:

- the independent practitioner in a solo practice;

- independent practitioners in group practices;
- hospital-employed physicians;
- employed physicians who work only in the hospital, usually called hospitalists;
- contracted physicians, most typically radiologists, anesthesiologists, emergency room physicians, and pathologists;
- locum tenens physicians who serve as substitutes for a specified period; or
- a physician who does not accept call, as described above.

**Table 1: Types of Physicians, "Call" Duties, and Benefits/Constraints of Each Approach**

Type	"Call" Duties	Benefits/Constraints
<p>Independent practitioner in a solo practice. This is the traditional example of a doctor who sees patients in the office and continues to handle the patients' care when they are admitted to a hospital.</p>	<ul style="list-style-type: none"> <li>• Can get called to the hospital to cover his or her own patients at any time.</li> <li>• Is responsible for finding a same-type substitute if on vacation/unavailable to handle own patients.</li> <li>• May be required to take call on a rotating basis as part of medical staff privileges, depending on hospital's bylaws.</li> </ul>	<ul style="list-style-type: none"> <li>• Continuity of care is enhanced.</li> <li>• Autonomy</li> <li>• Physician responsible for buying malpractice insurance and employment of office staff.</li> <li>• The physician's daily office schedule and ability to see more patients may be affected by getting called to the hospital for a patient who lands in the emergency room or who is hospitalized and in need of immediate attention.</li> <li>• Risk of exhaustion, if handle night call and have to be in office early next day.</li> </ul>

<p>Independent practitioners in group practice, ranging from family practitioners to specialists like cardiologists, who handle call duties within their practice</p>	<ul style="list-style-type: none"> <li>• May arrange among themselves to share their practice's call among each "type" (e.g. internists) as well as any hospital-required call.</li> <li>• May arrange call either for certain periods (e.g. a week), providing day-time hospital contact or just after-hours and weekend call if each group member handles working hours "call".</li> <li>• May need to piece together other approaches for call duties if practice does not have depth within a specialty or "type".</li> </ul>	<ul style="list-style-type: none"> <li>• Continuity of care not as consistent as with solo practitioner but still within same practice, same availability of medical records.</li> <li>• Physician group responsible for buying malpractice insurance and employment of office staff.</li> <li>• Structure does not require 24/7 coverage by one person.</li> <li>• If one person handles call for a week, for example, both day and night, that person does not see patients or adjusts office visits - meaning income flow is diminished on a routine basis.</li> <li>• If individual group members handle call during the day, their schedule may be disrupted by running up to hospital.</li> </ul>
<p>Hospital-employed physicians whose main practice is outside the hospital</p>	<ul style="list-style-type: none"> <li>• May have hospital privileges but employment arrangement allows hospitalist to provide call duties.</li> </ul>	<ul style="list-style-type: none"> <li>• Offers economies of scale ranging from hospital purchasing of supplies to sharing in a group medical malpractice policy.</li> <li>• Allows physician to focus on outpatient work instead of being interrupted to go to the hospital if a patient lands in the emergency room or has an emergency situation at the hospital after being admitted.</li> <li>• Hospital may handle bill collection, which means that, as an employee, the physician gets paid..</li> </ul>

<p>Hospital-employed physicians who work only in the hospital, usually called hospitalists. Typically these are internists but may include specialists. They have no "office" patients but take over the care of patients for other physicians whose patients are admitted to a hospital. Once the patient is discharged, the patient's care goes back to the regular physician.</p>	<ul style="list-style-type: none"> <li>• Do not take "call" per se because their work hours consist of being in the hospital. Through the hospital, they may accept "call" from other physicians outside the hospital, whether those employed by the hospital or under another arrangement.</li> </ul>	<ul style="list-style-type: none"> <li>• Work hours are consistent.</li> <li>• Hospital covers malpractice insurance.</li> <li>• Hospital may subsidize the coverage offered by hospitalists because the limited supply of hospitalists nationwide does not adequately cover a 24/7 year-round need.</li> <li>• Some hospitals use a hospitalist service, which means the hospitalists may not stay in the community for as long as other physicians, depending on contract needs elsewhere.</li> <li>• Continuity of care is interrupted except that in contract situations, a hospitalist who works with a physician can typically obtain necessary records. A 2007 <i>New England Journal of Medicine</i> report found no impact on quality of care along with shorter patient stays.<sup>5</sup></li> <li>• Hospital handles bill collection.</li> </ul>
<p>Contracted physicians, typically a radiologist, anesthesiologist, emergency room physician, or pathologist. These physicians provide a service to a hospitalized patient or emergency room client but do not see patients on an outpatient basis.</p>	<ul style="list-style-type: none"> <li>• May take call in the same way that an independent physician in solo or a group practice takes call. (see above)</li> </ul>	<ul style="list-style-type: none"> <li>• These physicians provide a service to a hospitalized patient or emergency room patient.</li> <li>• Some of these physicians do not participate in the same insurance networks as the hospital does, which leads to separate billing and occasional disputes. This has been part of the hospital economic credentialing discussion</li> </ul>
<p>Locum tenens physicians who serve as substitutes for a specified period. Hired either by a physician who has an outpatient practice or by a hospital. In Montana they typically bridge staffing shortages in specialties or, in rural areas, they offer a sole practitioner a vacation.</p>	<ul style="list-style-type: none"> <li>• Usually takes call in the same way as the person for whom the locum tenens physician is substituting.</li> </ul>	<ul style="list-style-type: none"> <li>• Costly for the physician or hospital who hires the locum tenens.</li> <li>• Continuity of care inconsistent.</li> <li>• Only option for some rural areas or for some specialties.</li> </ul>

Independent practitioners who do not accept call	<ul style="list-style-type: none"> <li>• Either make arrangements with other practitioners for their patients who need to be admitted to hospitals or rely on the emergency department to admit those patients;</li> </ul>	<ul style="list-style-type: none"> <li>• Freed from call requirements but run risk of not getting hospital privileges or being on certain insurers' preferred provider lists.</li> <li>• If don't have hospital privileges, may have more trouble getting malpractice insurance.</li> <li>• May have difficult time finding replacement coverage. This is especially true of specialists.</li> </ul>
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### Insurance Credentialing of Physicians

Preferred Provider Organizations arrange panels of providers who agree to discount their costs in exchange for being part of the insurance health plan network. By credentialing physicians in the plan, an insurer verifies the physician's educational credentials and determines whether there are any complaints against the physician. An insurer also might require a certain number of continuing medical education credits, which state law does not require of physicians. The reasons for insurer credentialing, according to an article for Physician's News Digest, include:

- risk management;
- protection from lawsuits under the Health Care Quality Improvement Act; and
- better marketing options.<sup>6</sup>

Risk management relates to a theory of "negligent credentialing" in which an insurer that includes a physician in its network presumably may be liable if that physician is unqualified and the health plan beneficiary suffered as a result. As one way of buttressing their credentialing, insurers may seek verification that a hospital, too, has credentialed that physician and offered privileges. Another reason for an insurer to require hospital privileges, or a plan of care that indicates how a patient can be hospitalized and cared for in a hospital, is for network adequacy of care. In this regard, a 1995 attorney general's opinion differentiated between health maintenance organizations (which incorporate network adequacy under 33-31-111, referencing chapter 36) and preferred provider organizations, which requires competitive bidding among providers.<sup>7</sup> Requirements for network adequacy, as described in Title 33, chapter 36, for managed care organizations include the following, as provided in 33-36-201:

33-36-201 (1)...covered persons must have access to emergency care 24 hours a day, 7 days a week. A health carrier providing a managed care plan shall use reasonable criteria to determine sufficiency. The criteria may include but are not limited to:

- (a) a ratio of specialty care providers to covered persons;
- (b) a ratio of primary care providers to covered persons;
- (c) geographic accessibility;
- (d) waiting times for appointments with participating providers;

(e) hours of operation; or

(f) the volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.

(2) Whenever a health carrier has an insufficient number or type of participating providers to provide a covered benefit, the health carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the covered benefit were obtained from participating providers or shall make other arrangements acceptable to the department.

(3) The health carrier shall establish and maintain adequate provider networks to ensure reasonable proximity of participating providers to the businesses or personal residences of covered persons. In determining whether a health carrier has complied with this requirement, consideration must be given to the relative availability of health care providers in the service area under consideration.

The statutes for preferred provider organizations make no reference to network adequacy but 33-22-1705(2) states:

(2) A health care insurer may not require hospital staff privileges as criteria for designation as a preferred provider in a preferred provider agreement.

Insurers determine a physician's credentials in a variety of ways, including checks with the Board of Medical Examiners to determine if the physician's license is in good standing, with the National Practitioners Data Bank, and by requiring physicians to fill out various forms or background checks. By undertaking the credentialing of physicians an insurer may qualify as a "health care entity", if it provides health care services as a managed care organization or health maintenance organization. As a health care entity, the insurer has access to the National Practitioner Data Bank and also to immunity from liability under the Health Care Quality Improvement Act. The Physician's News Digest article on managed care credentialing of physicians notes that once entitled to immunity under the Health Care Quality Improvement Act, a managed care organization has to report certain adverse actions to the National Practitioner Data Bank, which can impact a physician's right to continue practicing.

**Determining credentials and getting liability immunity**

Insurers also may credential in order to improve their marketing to consumers interested in quality care. Credentialing gives the foundation for marketing claims of a quality panel of providers.

### **SJR 15 Considerations**

The broad study statement in Senate Joint Resolution 15 is to address access and delivery issues in Montana. The Children, Families, Health, and Human Services Committee has undertaken this study from the perspective of consumer-directed health care, including choice. Issues that relate to choice under credentialing include:



- availability of physicians;
- cost of insurance; and
- adequacy of hospital coverage.

Physician availability may be affected by how hospitals handle call arrangements. Restrictive call requirements, for example, can be a reason behind physicians moving to a hospital that has fewer restrictions or becoming a hospital-employed physicians. Hospitals that employ hospitalists may get caught in the middle of call issues, encouraging some physicians (by contracting the hospitalists for call) and discouraging others (by not contracting hospitalists for their call).

Various physicians have commented that reactions to call depends somewhat on the age of the physician. Older physicians accept the traditional Marcus Welby, M.D., model of an independent practitioner who was on call 24/7 all year. The middle-aged practitioners may prefer the group practice model that allows some autonomy combined with some time off while others in the group cover call. Younger physicians reportedly favor the hospital-employed physician model because of regular hours, more of a home life, and fewer call demands.

As the health care scene changes for practitioners, legislators are asked to consider whether public support is necessary. A 2003 working group in California suggested, among other solutions to call problems, legislative changes :

- to guarantee round-the-clock emergency coverage in hospitals, either by helping hospitals to subsidize coverage of "call"; providing public assistance for the patients who have no insurance and who cost both physicians and hospitals; or requiring mandatory call for physicians who are licensed in the state; or
- to provide malpractice insurance or other liability protection for physicians assigned to treat unassigned patients.

In terms of insurance costs, efficiencies may be gained by standardizing credentialing forms or the credentialing process. In the Physician's News Digest article, the certified public accountant author suggested:

...the entire credentialing process could be made easier if there were required standardization among the format used by insurers. This would allow physicians to maintain a database of all of their information in a standardized format and send the same information and application to each managed care organization....This one decision could drastically curtail the long hours spent by physicians completing credentialing applications and compiling information.<sup>8</sup>

Inefficiencies and costs also may increase if a hospital shares "call" coverage through agreements with other hospitals, primarily because of shortages of specialists. If Hospital A does not have a certain specialist on call and receives an emergency patient in need of that specialty, the hospital most likely will transfer that patient to a specialist in the next nearest hospital, which may be 60 miles or more away or out of state. Transfer costs add to the cost of health care for the consumer.

For the hospital, other costs include that of hospitalists, particularly when unassigned patients do not pay up. One advantage to the hospital of using hospitalists, however, is that they can receive facility-based Medicare reimbursements in contrast to the lesser reimbursements that Medicare pays an independent practitioner. The Centers for Medicare and Medicaid Services apparently is considering reimbursement changes to encourage more combined physician and hospital reimbursements. Another cost to some hospitals is if they pay stipends to physicians who are on call. A 2008 Medical Group Management Association article noted that, of 180 medical groups informally surveyed, a little more than 25% received compensation for call duty. Of those who received payment, nearly 50% were compensated by shift and 12.7% were paid by the hour.<sup>9</sup>

One strategy mentioned by the California HealthCare Foundation for hospitals to address costs of on-call coverage is by contracting with outside organizations. The idea is for the outside organization to handle collections, recruit the on-call physicians, and compensate physicians for unassigned patients. The organization serves as a buffer between the physicians and the hospital, which owns the accounts receivable and may have to make up the shortfall but does not have the headache of dealing with call.<sup>10</sup>

## **Summary**

Solutions to access care and delivery are complex in Montana and involve addressing how insurers, physicians, and hospitals interact. The consumer may often not know why coverage is unavailable, why costs are high, and even where best to seek medical care. Information from the SJR 15 may help to point out some of the answers to those "whys".

## **Endnotes**

1. From emtala.com, Frequently Asked Questions. <http://www.emtala.com/faq.htm>

2. Ibid., quoting 42 U.S.C. §1395cc(a)(1)(I)(iii). The website further says:

The obligation of a physician to serve on a call schedule is legally based on state law governing contracts, derived from the agreements attendant to medical staff membership, rather than an obligation placed on the physician by Federal law.

As noted above, Section 1395dd(d)(1)(C) imposes a penalty on a physician who fails to respond to an emergency situation when he is assigned as the on-call physician. This is the only obligation placed on physicians governing the obligation to respond to an emergency situation. This provision does not require that a particular physician or particular specialty provide coverage on a call basis.

With a couple of exceptions, the statute and regulations impose all of their obligations on hospitals. This area is no exception. The expectations of CMS and of the courts in construing EMTALA are directed at hospitals. Hospitals are left to their own devices as to how to ensure compliance by members of their medical staffs.

How are hospitals expected to structure the coverage requirement? The [Interpretive Guidelines document](#) (PDF format) includes a general statement to the effect that any specialty service that a hospital offers should be available through on-call physicians covering that service. But that general statement is overly broad. It does nothing to distinguish between specialists -- who really cares if a dermatologist is not immediately available to see a patient? -- and to address the particular needs of small rural hospitals and other facilities where the number of available specialists is limited.

Prior to 2003, CMS reportedly used an undocumented informal 3-physician "rule of thumb" which requires a hospital to ensure that it has 24 hour on-call coverage for any specialty for which it has three or more physicians. If fewer than three were on staff, then full-time coverage was not required. Under this rule, a hospital which has only one or two specialists in a given area could have less than full coverage for that specialty without being considered to be in violation of EMTALA requirements.

The 2003 regulations expressly decline to follow a numerical approach, instead stating that CMS will consider "all relevant factors" in determining whether a hospital is in compliance with EMTALA requirements in maintaining its call list. The new regulations do not require 24-hour coverage for under-represented specialties when that is not feasible, they permit physicians to serve on call at more than one hospital simultaneously, and they permit the ER to direct the patient to the specialist, such as to his office or another hospital where he is working, to see and examine the patient. The regulations require that hospitals develop protocols for handling specialty needs when its specialists are not available on call.

3. California HealthCare Foundation, Issue Brief, "On-Call Physicians at California Emergency Departments: Problems and Potential Solutions", January 2005., p. 3.

4. *Ibid.*

5. Peter Lindenauer, et al., "Outcomes of Care by Hospitalists, General Internists, and Family Physicians", *New England Journal of Medicine*, 357: 2589-600, December 20, 2007.

6. Jerry S. Sobelman, "Managed Care Credentialing of Physicians," *Physician's News Digest*, June 2001. Available at <http://www.physiciansnews.com/business/601sobelman.html>

7. The Attorney General opinion, 46 A.G. Op. 9 (1995) weighed in on the competitive bidding requirement for preferred provider organizations (PPOs) and noted that Health Maintenance Organizations (HMOs

8. Sobelman, *op. cit.*

9. Lisa Schneck, "Call of the Riled: Physician call schedules: How administrators find solutions", MGMA Connexion, April 2008, p. 35.

10. California HealthCare Foundation, *op. cit.*, p. 9.

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