AMERICAN HEALTH CONSULTANTS®

ED Management®

The monthly update on Emergency Department Management

Vol. 11, No. 10

Inside

■ **Restraint regulations omit nurses 112**
Expect some disruption

■ **Joint Commission and HCFA regs are at odds 112**
Here are key differences

■ **Joint Commission task force studies restraints 113**
New standards on the way

■ **Update on the long-awaited HCFA documentation guidelines 114**
Find out the advisory panel's recommendations, hot off the press

■ **Committee suggests revisions to guidelines 115**
American College of Emergency Physicians provided input

■ **ED physicians may soon be unionized 117**
Here are pros and cons

October 1999

Warning: You already may be out of compliance with restraint regs

HCFA's new regs led to lawsuit but are still being enforced

You may be out of compliance with the Health Care Financing Administration's (HCFA) newly released restraint regulations that went into effect of as Aug. 2 and not even realize it, warn experts contacted by *ED Management.*

The regulations apply to physical restraints, chemical restraints, and seclusion. "There are several standards which are very difficult for EDs to comply with," says **Karen Milgate**, senior associate director for policy development at the Washington, DC-based American Hospital Association, which filed a lawsuit in response to the HCFA regulations.

HCFA changed its regulations in response to public reaction to news accounts of restraint-related deaths. "The primary issue was a series of newspaper articles in *The Hartford Courant*, which cited 142 deaths from seclusion or restraints over 10 years in facilities," says Milgate. "There was a huge outcry to do something. So HCFA thought they would go ahead and address this issue by putting out detailed regulations." **(See story on the differences between Joint Commission of Accreditation of Healthcare Organizations and HCFA standards, p. 112, and update on Joint Commission's upcoming revisions, p. 113.)**

Are you updated on upcoming regulations?

This special issue of *ED Management* containing cutting-edge updates on two federal regulations. Both will have a major impact on your ED's operations. On the clinical side, we report on the Health Care Financing Administration's (HCFA's) controversial new restraint regulations, which you may already be out of compliance with. On the financial front, there is also news: An advisory panel has published recommendations for HCFA's long-awaited documentation guidelines, which experts predict will be adopted in full. Don't miss reading this special issue of *ED Management*!

Executive Summary

The Health Care Financing Administration's (HCFA's) controversial new regulations for physical and chemical restraints and seclusion went into effect Aug. 2.

- Many EDs already are out of compliance with the new regulations.
- Behavioral health standards now will apply in some cases instead of medical/surgical standards.
- A physician is required to do a face-to-face evaluation within one hour when a patient is restrained.
- Because psychiatric departments don't always have physicians available, they may have to rely on ED physicians to perform evaluations.

The intentions were good, but the process was seriously flawed, suggests Milgate.

"They made it impossible to get effective public comment," she says. The standards were issued on July 2, 1999, and became effective 30 days later. "That's not enough time to even get the word out to the health care field, let alone enough time for hospitals to put in appropriate policies and procedures," says Milgate. **(For details on how to access the standards, see box, p. 111, top right column.)**

Toni Mitchell, MD, FACEP, a member of the Dallas-based American College for Emergency Physicians (ACEP) board of directors and chief consultant for acute care at the Veterans Health Administration in Washington, DC, says, "These came out with so little fanfare and so little notice. Generally, as a federal agency, HCFA gives us more notice about changes in regulations, and a chance to provide comment. But there was not an adequate comment period in this case."

As a result, some of the standards are very problematic to comply with, Milgate says. "There is less flexibility and the regulations are more specific, which is causing problems for EDs." The regulations also weren't field tested, which would have resulted in necessary changes being made, she says.

The controversial regulations have taken EDs by surprise. More than a dozen ED managers contacted by *ED Management* were unaware of the new regulations. Nonetheless, "Our surveyors are currently enforcing them," reports a spokesperson for HCFA, who under agency policy can't be identified.

Here are the key changes that will affect your ED:

1. **Behavioral health standards will apply in some cases instead of medical/surgical standards.**

Previously, only the less-stringent medical/surgical standards was used in the ED for restraint. The new standards make it difficult to decide which standard should be used — the behavioral health or medical/surgical. "There is some discussion in the preamble to the standards to help you figure it out, but there is still a lot of gray area," says Milgate.

Which standard applies is now based on the reason the restraints were applied, instead of the setting the patient is treated in. "So the behavioral health standards will apply if the patient is restrained because of their behavior," says Milgate.

You will have to decide which standard to use based on whether a patient is being restrained for behavioral management or a medical/surgical purpose, she explains. "This may cause problems for your ED, because the behavior health standards are very difficult to meet."

The behavior health standards were designed with psychiatric facilities in mind, not EDs, Milgate notes. "These standards are more stringent; for example, they require a face-to-face evaluation within one hour by a physician," she says.

Most patients meet restraint standards

However, the vast majority of restraints in the ED could be construed as medically necessary, Mitchell says. "The most common reasons for restraints are drug and alcohol abuse, but you must always presume there is something medically wrong with the patient," she stresses. "We have to rule out significant things like diabetic conditions and brain bleeds. So most patients would fall under the med/surg standards."

Occasionally, patients may have a long psychiatric history and have stopped taking their medications. "Under the new regulations, those patients would fall under the behavioral health standards, but that scenario is very uncommon in the ED," says Mitchell.

Still, the fact that HCFA would apply the behavioral health standard in the ED setting is surprising, says Mitchell. "The application of psychiatric standards in

COMING IN FUTURE MONTHS

- New strategies for pediatric pain management
- Resolve conflicts with other departments
- How to synchronize timepieces in your ED
- Prove the ED's value to administrators

a general medical hospital is not appropriate, because the nature of what we do is rapid assessment and determination," she says. "Then the patient would be admitted to the psychiatric unit, where the behavioral health standards would apply."

It's rare to have a patient's complete psychiatric history in the ED, Mitchell stresses. "And even if you do, that might not be the explanation why they need to be restrained," she says. "So you would still have to evaluate for an underlying medical condition. Because if we miss something, it can be a catastrophe for the patient."

2. **A face-to-face evaluation by a physician is required within one hour if behavioral health standards are used.**

The behavior health standards require a physician to perform a face-to-face evaluation within an hour when a patient is restrained. "That may be difficult to comply with if your ED is very busy and you don't have the necessary staff," Milgate notes.

The face-to-face evaluation by a physician is considered unnecessary by experts, she says. "The clinical field is united in suggesting it's unnecessary in all cases." Also, nurses feel it's an insult to suggest they don't have the ability to do the face-to-face evaluation and then discuss it with the physician afterward, she explains. "That's what has been done traditionally."

Previously, nurses could initiate the restraint, then get in touch with a physician as soon as possible to obtain a written order. "The face-to-face evaluation by the physician wasn't required, although it probably occurred when the nurse and physician were talking about writing the order," says Milgate. "Also, before, there was no specific time frame for the evaluation to take place."

Clarification needed

Many restraints aren't used for a full hour, Milgate notes. "Particularly with seclusions, there may be just simply time out for a few minutes," she says. "This new standard makes it more onerous to apply restraints and seclusions, so one concern is that this will discourage appropriate use of restraints."

The regulations also don't specify what the physician needs to evaluate within the one-hour time frame, notes **Margaret Van Amringe**, Joint Commission vice president of external affairs. "It's not clear what are they evaluating: Is it the need for restraint in first place, the continued need for that restraint, or whether the patient is having any distress while in that restraint?" she asks. "Clarification from HCFA is needed on this point."

Where to find HCFA's new restraint regulations

The new restraint regulations are available in the July 2, 1999, *Federal Register.* The *Federal Register* is available at many libraries. For copies of the July 2 *Federal Register,* send your request to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954. Specify the date of the issue and enclose a check or money order payable to the superintendent of documents, or enclose your Visa or Mastercard number and expiration date. Credit card orders also may be placed by calling the order desk at (202) 512-1800 or by faxing to (202) 512-2250. The cost for each copy is $8.

This document also is available from the *Federal Register* on-line database through GOP Access, a service of the U.S. Government Printing Office. The superintendent of documents home page address is www.access.gop.gov/nara.index.html. ■

Sources

- **Karen Milgate**, American Hospital Association, 325 Seventh St. N.W., Washington, DC 20004. Phone: (202) 626-4628. Fax: (202) 626 4626. E-mail: kmilgat1@ aha.org. Web: www.aha.org
- **Toni Mitchell**, MD, FACEP, Veterans Health Administration, Mail Stop 111, 810 Vermont Ave. N.W., Washington, DC 20420. Phone: (202) 273-8530. Fax: (202) 273-9126. E-mail: toni.mitchell@mail.va.gov.

3. **Because psychiatric departments don't always have physicians available, they may have to rely on ED physicians.**

"For hospitals that are intent on doing that, they may be asking ED physicians to leave less stable patients to come and do this evaluation," says Milgate. "So that's another challenge ED physicians may have which could increase their workload." **(See story about the regulation's impact on nursing, p. 112.)**

If staff at a psychiatric hospital cannot find a physician at the point of restraint to do a face-to-face evaluation, they may wind up transferring that patient to the ED. "They will have two choices: Either they are out of compliance with Medicare rules or will send the patient somewhere else, which would be the ED," says Milgate. "So your ED may have more patients to deal with."

However, EDs should find it easier to comply with regulations involving psychiatric patients and restraint due to the Emergency Medical Treatment and Active Labor Act (EMTALA) regulations.

"We've been on the leading edge of making changes in restraint ever since 1991 when EMTALA came out," notes Mitchell. "It became clear that psychiatric patients were covered under EMTALA, so we've already had to make a number of changes to comply with that."

EMTALA requires a medical screening exam to determine if a patient has a medical emergency, she says.

"Early on, we had to recognize psychiatric patients as emergencies and evaluate them upon arrival. Part of that evaluation means providing the appropriate environment for them, whether that meant physical or chemical restraints, or seclusion," Mitchell explains. ■

HCFA rules leave nurses out of picture

Because newly released restraint regulations from the Health Care Financing Administration (HCFA) in Baltimore don't allow the use of medical staff protocols, it hinders the collaborative working relationship between ED nurses and physicians, says **Toni Mitchell**, MD, FACEP. Mitchell is a member of the Dallas-based American College for Emergency Physicians (ACEP) board of directors and chief consultant for acute care at the Veterans Health Administration in Washington, DC.

"The regulations essentially left nurses and psychiatric social workers completely out of this," she notes. "This is completely inconsistent with how HMOs deliver mental health care today."

New rules hinder decision making

Previously, nurses were able to make the initial assessment and tell the physician that a patient needed chemical or physical restraint, she notes. The regulations diminish the nursing role in the clinical decision-making process, Mitchell emphasizes. "They can't do anything other than tell the physician the patient needs to be seen right now."

Nurses are not able to perform what is covered under their clinical practice, she says. "So there may be some disruption of established relationships and styles of practice," Mitchell warns. ■

Joint Commission, HCFA restraint regs are at odds

Know four key differences

There are several key differences between the Joint Commission on Accreditation of Healthcare Organizations standards for restraint and the new Health Care Financing Administration (HCFA) requirements, reports **Margaret Van Amringe**, Joint Commission vice president of external affairs.

If a hospital is accredited by the Joint Commission, then it is deemed to meet the Medicare requirements, explains Van Amringe. "Eighty-five percent of hospitals are accredited, and these only get an accreditation survey, not a HCFA survey."

However, HCFA's restraint regulations apply to all hospitals that participate in the Medicare and Medicaid programs. "HCFA does a random survey of 5% of hospitals, to make sure that the [Joint Commission] surveys are valid," she notes.

The 15% of hospitals that are not accredited are surveyed by HCFA, which contracts with state survey agents.

"However, if there is a complaint, HCFA has the option of surveying the hospital directly itself to see if the complaint is substantiated. Or they can ask the [Joint Commission] to go in," says Van Amringe.

But it's possible to be accredited by the Joint Commission and still not meet HCFA's new stringent requirements. "That's why it's important for us to have some agreement with HCFA about the restraint

Executive Summary

The restraint standards from the Joint Commission on Accreditation of Healthcare Organizations and restraint regulations from the Health Care Financing Administration (HCFA) differ in key areas.

- HCFA requires a physician or other licensed practitioner to perform a face-to-face evaluation within one hour, while the Joint Commission requires the evaluation within 12 hours.
- HCFA doesn't permit the use of physician-developed protocols for restraints, while the Joint Commission allows protocols to be used.
- HCFA requires that restraints can be used only in emergency situations, unless it's documented that all other types of interventions have failed, while the Joint Commission permits restraint use for some behavioral management situations.

Copies of Joint Commission manual available

Copies of the Joint Commission on Accreditation of Healthcare Organization's *Comprehensive Accreditation Manual for Hospitals* are available for $325 for a printed manual and $595 for CD-ROM format, plus $17.95 for shipping and handling.

For additional information, contact the Joint Commission on Accreditation of Healthcare Organizations, One Renaissance Blvd., Oakbrook Terrace, IL 60181. Telephone: (630) 792-5000. Fax: (630) 792-5177. If you need clarification about the restraint standards, contact the Joint Commission Department of Standards by e-mail at standards@jcaho.org. Web: www.jcaho.org/standards.htm.

At press time, the new proposed restraint standards were to be posted on the Web. ■

Source

- **Margaret Van Amringe**, Vice President of External Affairs, Joint Commission on Accreditation of Healthcare Organizations, One Renaissance Blvd., Oakbrook Terrace, IL 60181. Phone: (630) 792-5000. Fax: (630) 792-5177. E-mail: mvanamringe@jcaho.org.

standards," she stresses. **(See box, top of page, for details on ordering the Joint Commission standard. See brief on the Joint commission's upcoming revised standards, at right.)**

Some of the areas where the Joint Commission is not consistent with the new HCFA regulations may change when the Joint Commission comes out with new standards, reports Van Amringe. "We were already deeply in the process of drafting new changes to our standards, when HCFA came out with theirs," she says.

Here are how the Joint Commission and HCFA standards compare:

❑ **Behavioral vs. medical/surgical standards.**

HCFA: Requires a physician or other licensed practitioner to perform a face-to-face evaluation within one hour of the time restraints are applied.

Joint Commission: Requires the physician to see the restrained patient as soon as possible, but no later than 12 hours after restraints are applied.

❑ **Use of restraints for medical/surgical patients.**

HCFA: Each order for restraints must be done by a physician. The standards do not permit the use of physician-developed protocols.

Joint Commission: Protocols may be used, which means that medical staff can approve how restraints are used for routine purposes.

❑ **Deaths caused by restraints.**

HCFA: All deaths due to restraints are required to be reported to HCFA.

Joint Commission: There is no requirement to report restraint-related deaths to the Joint Commission. However, under the Joint Commission's sentinel event policy, a death related to restraints must be recorded, along with proof that a root cause analysis has been performed, and made available on site for review during a survey.

❑ **Appropriate use of restraints.**

HCFA: Restraints can be used only in emergency situations, unless it's documented that all other types of interventions have failed.

Joint Commission: Restraints are encouraged to be used only as a last resort, but it's not specified that they may be used only in emergency circumstances. Restraint use is permitted for some behavioral management situations. ■

Update on Joint Commission regs

New standards expected by March

In the coming months, the new restraint regulations from the Health Care Financing Administration (HCFA) will not be the only changes you'll have to contend with. The Joint Commission on Accreditation of Healthcare Organizations' restraint standards also will change within the next year, says **Margaret Van Amringe**, vice president of Joint Commission external affairs.

In December 1998, the Joint Commission created a Restraints Use Task Force to explore the use of restraint, seclusion, and therapeutic holding. A major focus is the amount of time allowed to pass before a physician evaluates a restrained patient.

"This is one of the areas we decided to field-test. We will require something more stringent than the current standards, which allow 12 hours to go by," says Van Amringe.

The new Joint Commission standards will be field-tested this fall and are expected to come out by March 2000. ■

Here are key revisions to documentation guidelines

Overall, proposed documentation guidelines from the Baltimore-based Health Care Financing Administration (HCFA) will be easier to comply with than the current rules, reports **Mason Smith**, MD, FACEP, president and CEO of Lynx Medical Systems, a Bellevue-WA-based consulting firm specializing in coding and reimbursement for emergency medicine.

The total amount of documentation required is essentially unchanged, says Smith. "For example, a Level 5 service still requires documentation of approximately 35 elements."

The difference is there is less review of systems, and medical decision making has been simplified, he reports. Here are eight key changes in the proposed documentation guidelines:

1. **The definition of the extended history of the present illness (HPI) has changed.** The new guidelines define this as including four discreet elements of the history of the present illness. "In the original version, it was defined as at least one element in four of eight categories of the HPI," Smith notes. "What that means is that I can meet the requirements for an extended HPI with fewer than four categories included. That is actually a fairly common occurrence."

2. **For a comprehensive history, only five organ systems are required to be reviewed, not 10.** The organ systems can be considered covered by HPI questions, but an element cannot be counted twice, so elements count as review of systems or HPI, but not both, says Smith. Under current rules, you can count one element twice. "You now have more stringent requirements, because you needed four separate categories and 10 systems," he explains. "So you now can have a complete history of illness and a comprehensive review of systems, with a total of nine elements, as opposed to a minimum of 10 under the existing rules."

3. **The number of physical exam elements has changed.** Instead of using organ systems, the exam elements now include individual components of those systems. "So instead of using the neurology system, there is individual credit given for each element of the neurologic examination, including each of the cranial nerves, instead of at a system level," Smith explains.

A minimum of six data elements are required for an expanded examination. "Anything less than that falls into lowest category," he says. From seven through 11 elements is an expanded exam, from 12 through 17 elements is a detailed exam, and 18 or more is now a comprehensive exam.

A complete neurologic examination of cranial nerve counts as nine elements, but you have to record them individually, not as a system, he says. "It's actually not too difficult, it just requires a more detailed approach to documentation. It does lend itself to structured records."

4. **Medical decision making is reduced from three calculations to a single table.** "The basic thrust of it remains the same, but there are some differences," says Smith. "Emergency hospitalization is recognized as high-complexity medical decision making, but routine hospitalization is considered a moderate level. We expect that anyone admitted from the ED will be considered emergency hospitalization."

5. **The number of prescription drug management levels was decreased.** There will be only three levels now: low, moderate, and high," he says. "Currently there is a fourth level, called 'straightforward,' which was combined with low."

6. **Elements have been added to the history requirements.** There was concern that HCFA's guidelines might be adopted by other payers, whose covered members could include pediatric patients. Examination components were added to the examination to account for that possibility, says **Peter Sawchuk**, MD, JD, MBA, representative from the American College of Emergency Physicians to the American Medical Association advisory committee that developed the recommendations.

For example, measuring head circumference is very unusual in an adult visit, so this element was added for pediatric patients. "This element of the exam could be used to substantiate the level of exam," says Sawchuk. "HCFA is appropriately focused on adult examination,

Executive Summary

ED reimbursement experts say the new documentation guidelines proposed by the Health Care Financing Administration will be easier to comply with.

- For a comprehensive history, only five organ systems are required to be reviewed, not 10.
- Instead of organ systems, the number of physical exam elements now includes individual components of those systems.
- It will be easier to identify the level of history if the patient is unable to give an adequate history.

Sources

- **Peter Sawchuk**, MD, JD, MBA, c/o Eidos Healthcare Resources, 168 Lake End Road, Greenpond, NJ 07435. Phone/fax: (973) 208-1226. E-mail: plsawchuk @aol.com.
- **Mason Smith**, MD, FACEP, Lynx Medical Systems, 15325 S.E. 30th Place, Suite 200, Bellevue, WA 98007. Phone: (425) 641-4451. Fax: (425) 562-4860. Web: www.lynxmed.com.

and if these guidelines are adopted by other payers with pediatric patients, and they didn't address this issue, then ED physicians would have difficulty meeting the requirements for pediatric patients."

7. **It will be more difficult for ED physicians to designate patients at high risk.** The current guidelines are based on three areas: the diagnosis or management options based on the presenting problem, the data obtained and reviewed, and the patient's risk.

"That risk is based upon a risk table that has been published," says Sawchuk. "Under the new guidelines, the first two will essentially no longer be there. So it will be structured almost entirely on the risk table."

This approach is problematic for the ED, he says. "For example, in the data obtained and reviewed, one of the designators of high risk would be evaluations of diagnostic results that takes 20 minutes or more," he explains. "This is problematic in the ED setting because there is a premium on doing things quickly. Since ED physicians address a number of patients within the same time frame, it makes it difficult."

There are items that ED physicians might not be able to utilize as indicators of risk, simply because of the way they practice medicine. "It limits the options for ED physicians to appropriately indicate medical decision making under the new proposal," Sawchuk says.

8. **It will be easier to identify the level of history appropriately if the patient is unable to give an adequate history.** Currently, appropriate reimbursement in this situation is possible only for patients of the highest severity, so ED physicians can identify a Level 5 service.

"Currently, it's very difficult to obtain the required level of history for a patient who can't give a history but is not of high severity," says Sawchuk. "But there are now ways of addressing that on the record, so it allows more leeway for submitting a less-than-required history." ■

Documentation guidelines: AMA tips hat to final draft

The long-awaited documentation guidelines from the Baltimore-based Health Care Financing Administration (HCFA) still have not been finalized, but recommendations recently published by an advisory panel are likely to be close to the final version, say experts interviewed by *ED Management.*

Currently, you can choose between HCFA's 1995 or 1997 documentation guidelines.

"HCFA has stated that if an audit occurs, whichever guideline is most advantageous to the provider will be used in any assessment," explains **Peter Sawchuk**, MD, JD, MBA. He is chair of the Dallas-based American College of Emergency Physicians (ACEP) panel on coding and nomenclature committee and is ACEP's representative on the American Medical Association (AMA) advisory committee in Washington, DC, that developed the recommendations sent to HCFA. "In most cases, that will be the 1995 guidelines, since the 1997 guidelines are not very useful for most emergency medicine practices," Sawchuk says.

Emergency medicine made its mark

ACEP gave significant input on the recommendations for the new guidelines, says **Mason Smith**, MD, FACEP, president and CEO of Lynx Medical Systems, a Bellevue-WA-based consulting firm specializing in coding and reimbursement for emergency medicine.

The structure of the medical decision making components was largely driven by emergency medicine, Smith says. "We actually created the approach adopted

Executive Summary

The long-awaited documentation guidelines from the Health Care Financing Administration (HCFA) still have not been finalized, but recommendations recently published by an advisory panel are likely to be close to the final version.

- Currently, you can choose between HCFA's 1995 or 1997 documentation guidelines, whichever is more advantageous.
- The American College of Emergency Physicians gave significant input to the recommendations, including the approach to physical exams.
- The major area of controversy involves whether there should be counting of specific elements of the exam.

for the physical exam," he notes. "So we had a substantial impact in how the physical exam should be approached and how medical decision making should be measured."

In June, the AMA advisory panel submitted its recommendations to change HCFA's original guidelines, with input from ACEP. HCFA is reviewing those suggestions, Sawchuk says. "They could decide to adopt them as is, modify them, or not adopt them at all," he says. "Everybody's waiting to hear HCFA's response."

"Most emergency physicians perform an exam consistent with HCFA's expectation, but few document it."

However, in a controversial move, the AMA published its recommendations on its Web site (www.ama-assn.org) before getting HCFA's response. The decision to publish revisions before getting approval from HCFA is unprecedented, says Smith.

"So this creates a very interesting quandary for ED physicians," he explains. "The issue is, if the AMA has published these guidelines as their official interpretation of the code, is that in fact the official interpretation?"

Guidelines may be official by early 2000

HCFA has stated that the 1995 or 1997 guidelines are still the only ones it recognizes for audit purposes. "But the reality is, there are substantial changes proposed by the AMA editorial panel, which are likely to be adopted by HCFA," Smith says.

Although HCFA has not responded to the panel's recommendations officially, they likely will be adopted in full, he predicts. "It is significant that one member of the panel is a HCFA representative."

The earliest projected implementation date is January 2000, so it could occur with the next CPT publication, Smith says. HCFA is likely to decide on the final regulations before it implements ambulatory patient classifications (APCs, the basis of the outpatient prospective payment system which is slated to be implemented in July 2000), he says. "So we should have final guidelines sometime between January and March of 2000."

(See story on HCFA's switch to APCs for outpatient reimbursement in the August 1999 issue of *ED Management,* p. 1.)

The new documentation guidelines also will affect hospital pay under the new APC guidelines. "So when this goes forward there will be double the effect," Smith says.

One key controversial area remains: Should counting specific elements of the exam be part of the final guidelines or not?

The 1997 guidelines required explicit, detailed counting of elements in the physical exam and history before a certain level of coding could be submitted. "The new guidelines have made it much more flexible," says **Charlotte Yeh**, MD, FACEP, medical director for Medicare policy at the National Heritage Insurance Co. in Hingham, MA. "But the question is whether it's sufficiently flexible to meet the needs of the provider community."

Yeh thinks HCFA is willing to allow for some flexibility. "But some element of counting will probably remain, whereas the AMA approach is no counting whatsoever," she says. "It will take time and effort to find the right middle ground."

'This is a very positive change'

The overall impact on emergency medicine will be positive, Smith predicts.

"The new guidelines are more rational overall," he says. "Most emergency physicians perform an exam consistent with HCFA's expectation, but few document it. This is a very positive change, because they are refocusing on the history of the present illness and physical examination, and that's what emergency physicians excel at."

It's important to remember that the HCFA documentation guidelines are still in limbo, Yeh cautions. "HCFA intends to take its time before issuing any final guidelines. They have publicly stated that are interested in doing pilot studies before issuing guidelines."

HCFA is being cautious to ensure the guidelines are feasible, she explains. "They need to take a considered approach, to ensure they are workable and satisfy both the need for HCFA to determine proper documentation and, at the same time, not be overburdensome to providers."

Become familiar with the draft guidelines to prepare for implementation, Yeh recommends. "In the meantime, be sure you are familiar with the current guidelines, so you can decide which version best represents the evaluation of the services performed."

The revised guidelines are moving in the right direction, she says. "There are certainly improvements over the 1997 guidelines. Those made it very hard to fulfill the highest level of coding requirements because they were so detailed and not very reflective of the actual practice of emergency medicine." ■

ED docs may unionize — Here are pros and cons

Job security or poor public image

In a landmark move, the Chicago-based American Medical Association (AMA) has proposed forming a unionlike organization for employed physicians.

The AMA is creating a board of directors for the negotiating organization, reports **Mark Bair**, MD, FACEP, chair-elect of the AMA Young Physicians Section, also based in Chicago. After the board is created, the organization will begin taking form.

"In emergency medicine, there are a lot of employed physicians, so there is a definite market for a union. Also, there are a fair number of abuses of emergency physicians," says **Robert McNamara**, MD, FAAEM. McNamara is president of the American Academy of Emergency Medicine in Milwaukee and chief of emergency medicine at Temple University Hospital in Philadelphia.

Several small unions now exist

ED physicians often are treated poorly by their employers, McNamara notes. "To have a difficult business environment is added stress to an already stressful specialty. I understand [that] the realities of what rank-and-file physicians are going through may dictate that we have to unionize," he says.

There already are several unions with physicians and residents as members, but they are much smaller than the AMA organization would be. The Dallas-based American College of Emergency Physicians (ACEP) does not have a specific policy on unions, but it does recognize that physicians need more clout in advocating for patients with health plans, explains **John Moorhead**, MD, FACEP, current president of ACEP. **(See story on potential impact with managed care groups, p. 118.)**

There are a number of pros and cons of a union, according to experts interviewed by *ED Management* **(see story on potential greater access to financial records, p. 119)**:

❑ **Pro: Lack of due process will be addressed.**

The typical ED contract says you can be terminated with or without cause, says McNamara. "So as ED physicians, we've got our own effective gag clause, because if we speak up about closed books or patient care issues, we run the risk of losing our contract."

One study documented that 15% of board certified ED physicians have been terminated without due process, notes McNamara.[1] "That's an appalling number," he says.

❑ **Pro: Patient care may be improved.**

There are financial concerns involved with forming a union, but 99% of the issue is patient care, says McNamara. "Doctors feel they are being kept from making the right decisions for patients for corporate reasons," he says. "This is not a pocketbook issue, because most doctors feel they are adequately compensated."

The union will be a patient-driven organization, emphasizes Bair. "The issues they're hoping to combat are inappropriate managed care pressures, inappropriate transfers that are forced, and lack of access to EDs resulting in patients not receiving care."

A union that improves working conditions for practicing physicians also might deliver a higher quality of care for patients, Moorhead notes. "Likewise, better working conditions for residents might improve their education," he adds.

❑ **Con: Strikes are not an option.**

"Physicians don't want to strike, and that would go double for emergency medicine, McNamara stresses. "So the most powerful tool of a union is theoretically taken out of our hands. That has left some people skeptical as to whether we could succeed."

Without the threat of a strike, unions are essentially powerless, says **Todd Taylor**, MD, FACEP, an attending emergency physician at Good Samaritan Regional Medical Center in Phoenix. "While I am not in favor of physician unions, I do not believe they should enter into such an organization under the premise that a strike is never appropriate," he explains. "To do so will cut such a union off at the knees or force it to eventually break its promise."

Executive Summary

The American Medical Association has proposed forming a unionlike organization for employed physicians.

- Research shows most ED contracts state that physicians can be terminated with or without cause, which could prevent physicians from speaking up about patient care issues.
- ED experts say ED physicians often are not given access to financial information to determine if bills are appropriately coded, which increases liability risks.
- Some ED experts argue that the public perception of unions and striking could hurt emergency physicians' status as a profession.

Look at what has happened in other countries with physicians and nurse unions, he says. "Virtually all have had strikes or work slowdowns from time to time."

❑ Con: The status of emergency medicine as a profession could be damaged.

The concept of unions and striking also could hurt emergency physicians' status as a profession, warns McNamara. "I would hate to see physicians go down that pathway and reduce their professionalism," he says. "If the AMA does it, hopefully they will do it right and will retain the professional aspects of emergency medicine."

Physicians are concerned about what has happened with other professions that have unionized, such as teachers. "The status of teachers has fallen dramatically because of their unions," he notes. "That erosion of professionalism has raised concerns that this could happen to physicians."

❑ Con: Physician unions are essentially untested in America.

"There is no clear evidence that without significant participation that they can ever be effective," notes Taylor. "In fact, members may suffer not only from significant dues payments but from being shut out of certain markets."

Reference

1. Plantz S, Kreplick L, Panacek E, et. al. A national survey of board-certified emergency physicians: Quality of care and practice structure issues. *Amer J Emerg Med* 1998; 10:1-4. ■

Sources

- **Mark Bair**, MD, FACEP, 9164 S. Wedgefield Drive, Sandy, UT 84093. Phone: (801) 714-6570. Fax: (801) 942-4671. E-mail: mark4success@prodigy.net.
- **Robert McNamara**, MD, FAAEM, Temple University Hospital, Division of Emergency Medicine, Broad and Ontario streets, Jones Hall, 10th Floor, Philadelphia, PA 19140. Phone: (215) 707-8400. E-mail: rmcnamar @unix.temple.edu.
- **John Moorhead**, MD, FACEP, Oregon Health Sciences University, Department of Emergency Medicine, 4138 S.W. Hamilton Terrace, Portland, OR 57201. Phone: (503) 227-5130. Fax: (503) 241-4837. E-mail: moorhead@ohsu.edu.
- **Todd Taylor**, MD, FACEP, 1323 E. El Parquet Drive, Tempe, AZ 85282-2649. Phone: (480) 731-4665. Fax: (480) 731-4727. E-mail: tbt@compuserve.com.

Would a union increase clout with managed care?

The power to say 'no'

A physicians' union could combat increasing frustration with managed care organizations, says **Mark Bair**, MD, FACEP, chair-elect of the Young Physicians Section of the American Medical Association in Chicago.

"For an individual physician group to fight against a large HMO is very ineffective," he argues. "This will bring in the power of a national organization with a complete staff of legal and medical advisors, with that kind of backing and knowledge base."

For example, if an HMO contract was violating the Emergency Medical Treatment and Active Labor Act (EMTALA), the national organization could respond with federally based lawyers, says Bair. "The kind of connections they have include the ability to interact with the OIG [Office of Inspector General] and HCFA [Health Care Financing Administration], so you are bringing that power to bear with managed care."

The union will eliminate the need for ED groups to battle managed care organizations (MCOs) at the local level, notes Bair. "For instance, you may be in the middle of negotiating your contract, and the hospital is putting pressure on you to sign, and the MCO is asking you to accept inappropriate patient transfers. If you go to your ACEP [American College of Emergency Physicians] chapter and other avenues, and their help is inadequate, you now have another alternative to turn to."

If physicians were organized, they could collectively refuse to adhere to a managed care policy that was detrimental to patient care, says **Robert McNamara**, MD, FAAEM, president of the American Academy of Emergency Medicine in Milwaukee and chief of emergency medicine at Temple University Hospital in Philadelphia.

"The sheer numbers would be useful," McNamara says. "For example, if the HMO said you could only use certain drugs on our formulary, the physicians could say no, we will not change our prescriptions."

Others insist that instead of unionizing, ED physicians should find alternative solutions to deal with managed care.

"Decline poor managed care contracts, fight for unpaid revenue, submit grievances routinely to keep managed care 'honest,' report unethical behavior of managed care physicians or medical directors to the appropriate authorities, and [take advantage of] a

number of other opportunities," urges **Todd Taylor**, MD, FACEP, an attending emergency physician at Good Samaritan Regional Medical Center in Phoenix. "Complaining to your colleagues is simply not enough."

It's a mistake to assume all managed care is "bad" and needs a union to fight against it, Taylor says. Many physician groups, particularly emergency physician groups, have been able to thrive in heavily penetrated managed care environments, he says. "Understanding managed care needs and working toward common goals can be profitable. It doesn't always have to be a fight."

Other resources can help

ED physicians may be unaware of options currently available to them to combat problems with managed care, notes Bair.

"For instance, doctors have the opportunity to bring contracts to the AMA to be legally reviewed and given feedback as to whether they should sign or not," he says. "If they have problems with the contract or it's not appropriate, there is also some help available from the AMA legal staff." **(See source box, below, for contact information.)**

The theory is to use the union as a last resort when nothing else works, says Bair. "For example, if an MCO contract includes EMTALA [Emergency Medical Treatment and Active Labor Act] violations, the idea is to first work at the local level and look at any type of help they'd get," he explains. "If none of that is effective, the national organization would take over from there and try to help."

However, there are many issues that emergency medicine physicians have not adequately addressed that could improve their work situations, McNamara cautions. "We really need to try those avenues before going down the union pathway. We believe that emergency physicians can solve their problems in many circumstances just by using what's already on the books, without going through a union."

(Editor's note: In next month's issue, two guest columnists will present a point/counterpoint on physician unions.) ■

Source

- **American Medical Association**, 515 N. State St., Chicago, IL 60610. Phone: (312) 464-5000. Fax: (312) 464-4184. Web: www.ama-assn.org.

ED docs may gain more access to financial info

ED physicians don't obtain access to financial records to see what is being billed for or paid on their behalf, despite the fact that this puts them at risk, says **Robert McNamara**, MD, FAAEM, president of the American Academy of Emergency Medicine in Milwaukee and chief of emergency medicine at Temple University Hospital in Philadelphia.

Physicians should be able to determine if bills are being appropriately coded, he says. The ED is the only specialty that has allowed this lack of access, McNamara says.

"The AMA [American Medical Association] stance is that it's ludicrous that physicians don't see what is paid on their behalf," he notes.

This situation not only happens at contract group levels, but also with single group levels when one

ED Management® (ISSN 1044-9167) is published monthly by American Health Consultants®, 3525 Piedmont Road, N.E., Six Piedmont Center, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA. POSTMASTER: Send address changes to **ED Management**®, P.O. Box 740059, Atlanta, GA 30374-9815.

ED Management® is approved for approximately 18 nursing contact hours. This offering is sponsored by American Health Consultants®, which is accredited as a provider of continuing education in nursing by the American Nurses' Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, Provider Number CEP 10864, for approximately 18 contact hours. American Health Consultants® is accredited by the Accreditation Council for Continuing Medical Education to sponsor CME for physicians. American Health Consultants® designates this continuing medical education activity for 18 credit hours in Category 1 of the Physicians' Recognition Award of the American Medical Association. This activity was planned and produced in accordance with ACCME Essentials. **ED Management**® is also approved by the American College of Emergency Physicians for 18 hours of ACEP Category 1 credit. Physician members of American Health Consultants® 1999 Continuing Medical Education Council: Stephen A. Brunton, MD; Dan L. Longo, MD; Ken Noller, MD; Gregory Wise, MD and Fred Kauffman, MD, FACEP.

Subscriber Information
Customer Service: (800) 688-2421 or fax (800) 284-3291 (customerservice@ahcpub.com). **Hours of operation:** 8:30 a.m.-6 p.m. M-Th; 8:30 a.m.-4:30 p.m. F, EST. Subscription rates: U.S.A., one year (12 issues), $399. With 18 Category 1 CME hours, $449. For 21 ANA hours, $449. Outside U.S., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $319 per year; 10 or more additional copies, $239 per year. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. Back issues, when available, are $67 each. (GST registration number R128870672.)

Editor: Staci Bonner.
Group Publisher: Brenda Mooney, (404) 262-5403, (brenda.mooney@medec.com).
Executive Editor: Park Morgan, (404) 262-5460, (park.morgan@medec.com).
Managing Editor: Joy Daughtery Dickinson, (912) 377-8044, (joy.dickinson@medec.com).
Production Editor: Terri McIntosh.

Editorial Questions

For questions or comments, call Joy Daughtery Dickinson, (912) 377-8044

physician owns a contract, says McNamara. "It's exceedingly common that the rank-and-file ED physician doesn't have any idea how bills are being sent out or how bills are being coded. They get paid an hourly rate, and in most circumstances have no idea that they could be losing 25 to 30% of their fees."

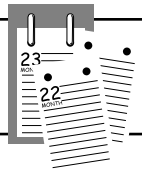
The other problem in emergency medicine is the concept of fee-splitting, he says. "If they could get access to what is being billed and paid on their behalf, they could see if it's consistent with fair market value," he explains. "I think all of us would be willing to pay fair market value for management services. The trouble is, we don't know what we're paying. And in many circumstances when we do find out, it's excessive, and we feel we're being exploited." ■

CE objectives

After reading this issue of *ED Management*, the continuing education participant should be able to:

1. Discuss and apply new information about various approaches to ED management. (See *ED docs may unionize — Here are pros and cons.*)
2. Explain developments in the regulatory arena and how they apply to the ED setting. (See *Joint Commission, HCFA restraint regs are at odds; Warning: You may already be out of compliance with restraint regs;* and *HCFA rules leave nurses out of picture.*)
3. Share acquired knowledge of these developments and advances with employees. ■

CALENDAR



• **Oct. 2: Emergency Observation Medicine, Cambridge, MA.** Sponsored by Harvard Medical School, Brigham and Women's Hospital, and Massachusetts General Hospital, all in Boston. For more details, contact: Harvard MED-CME, P.O. Box 825, Boston, MA 02117-0825. Phone: (617) 432-1525.

• **Oct. 3-6: Emergency Medicine into the 21st Century, Cambridge, MA.** Sponsored by Harvard Medical School, Brigham and Women's Hospital, and Massachusetts General Hospital, all in Boston. For more details, contact: Harvard MED-CME, P.O. Box 825, Boston, MA 02117-0825. Phone: (617) 432-1525.

• **Oct. 4-8: Medicolegal Death Investigator Training Course, St. Louis.** Sponsored by St. Louis University School of Medicine. For more details, contact: Julie Wiedemann, St. Louis University School of Medicine, Forensic Pathology, 1402 S. Grand Blvd., St. Louis, MO 63104-1028. Phone: (314) 268-5970.

• **Oct. 4-8: Primary Training in Hyperbaric Medicine, Columbia, SC.** Sponsored by National Baromedical Services. For more details, contact: Tina Fernell, National Baromedical Services, 5 Richland Medical Park, Columbia SC 29203. Phone: (803) 434-7101.

• **Oct. 21: Emergency Management of AMI/ Stroke 1999, Shrewsbury, MA.** Sponsored by the University of Massachusetts Medical School. For more details, contact: Continuing Medical Education Office, University of Massachusetts Medical School, 222 Maple Ave., Shrewsbury, MA 01545. Phone: (508) 856-3041. ■