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May 2004

Number 11

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This newsletter is written in response to numerous questions the Loss Prevention Department has received from policyholders.

Sharing office space

Q: Another physician and I share a small office suite. We have a mutual waiting room; the receptionist answers the phone and makes appointments for all patients; we each have our own medical assistants; we do not see one another's patients; and our patients' charts are totally separate. A colleague recently told us we were asking for trouble with this arrangement. What is she talking about?

A: Your colleague was probably referring to a legal concept called "ostensible agency" or "ostensible partnership." When two solo practitioners share physical space such as an office or suite, a telephone number, reception area, and staff, it creates the illusion that those physicians have a legally binding relationship such as a partnership, and therefore share the responsibility of professional liability (i.e., they are vicariously liable for one another). When a patient goes to an attorney with the intent of suing his or her physician, the attorney may use a "scatter-gun" approach in filing the lawsuit, and name all physicians that might possibly be involved in the patient's care. This often includes the unsuspecting and uninvolved suite-mate who appears to be the primary defendant's business partner if there is no evidence to the contrary. It is likely that the suite-mate in this situation will ultimately be extricated from the lawsuit, if she or he had no involvement with the patient, and because s/he has no responsibility for the suite-mate's practice of medicine. However, it could take considerable time, money and energy to accomplish that end, a price most physicians prefer not to pay.

It is relatively easy to avoid this predicament by taking the following steps:

Ensure that **all** visible indicators identify each physician as "Sole (or Solo) Practitioner" (e.g., signs on and in the building; signs on the office door; telephone white pages and Yellow

Pages listings; separate letterhead, etc.). Even if you already use “LLC” after your name, patients may not know that this means “limited liability company,” and that it means you do not share risk with your suite-mate.

Identify each physician’s practice as “solo” in both physicians’ patient information brochures, and other individual practice literature. *(You may request sample patient information brochures from the Loss Prevention Department, or find them on MIEC’s website [publications](#).)*

Install separate telephone lines, so each physician’s practice is perceived as a solo practice when patients and potential patients call. (In the alternative, receptionists answering on a shared line could answer the telephone with a greeting such as, “Good morning. This is Sherry. Are you calling Dr. Young’s or Dr. Chinn’s office?”)

Each physician should keep his/her charts separate from the suite-mate’s charts. Even if suite-mates occasionally see one another’s patients while on-call for the other, care should be taken to document the event for the primary treating physician, and retain a copy for the note’s author. *(You may request an “On-call Physician’s Report Form” from the Loss Prevention Department, or find it on MIEC’s website [publications](#).)*

If there is a contract or other written agreement regarding space sharing, make certain that the document clearly indicates that the physicians are not engaged in a partnership, joint venture or other business relationship which could lead to liability. Any written agreement should clearly indicate that the parties are space sharing only and will not assume any liability for the actions of each other. Informal, undocumented business relationships can lead to trouble in a variety of ways. On the other hand, space sharing agreement which clearly makes the case that the physicians are operating independently of each other can be very helpful if a patient’s attorney includes both physicians in a lawsuit for medical malpractice.

Avoid the temptation to utilize a name which might suggest a group practice. If in solo practice, do not select a name like “Vista Family Group;” also be wary of sharing space with a group or a physician who utilizes a business name suggesting a group practice. Any description which suggests something other than solo practice can mislead others, to your detriment.

Psychiatric medication management

Q: My partner and I are psychiatrists who increasingly find ourselves doing less psychotherapy and more medication management while nonphysician therapists provide weekly therapy for our patients. Since there are some risks to the medications we prescribe and because we don't schedule medication-management-only patients at the frequent intervals required for psychotherapy, how can we protect ourselves from liability risks?

A: There are a number of ways you can protect yourself and your patients in this now-common circumstance:

Obtain either a baseline medical history or clearance from a primary care physician (PCP) as part of your initial evaluation, before you begin a medication regimen, to avoid medical contraindications to the prescription of psychotropic medications (including ruling out medical etiology of symptoms).

Clarify with the patient – in writing – the three-way relationship that will exist between you, the patient and the nonphysician therapist. This may include, for example, information such as: The nonphysician (MFT, LCSW, psychologist, etc.) will be responsible for the patient's overall mental health care; the psychiatrist will manage medications; the therapist is the first person to call if there is a problem unless it is specifically related to the medication; the psychiatrist and the therapist collaborate, but the psychiatrist does not supervise the therapist; and, the psychiatrist and the therapist will communicate with one another to coordinate care. Invite the patient to ask questions about the tandem therapy at any time. This information can be incorporated into a patient information brochure, or in a brief written agreement between the psychiatrist, nonphysician therapist, and the patient. (*Call the Loss Prevention Department for samples of either.*)

Establish and maintain as-needed communication guidelines with the patient's nonphysician therapist, if at all possible. Discuss with the co-treater mutual issues you believe are essential for the patient's medication treatment. Develop agreements about who is responsible for what aspects of care, what you need to know and when you need to know it, and what to do in emergencies. If you ask the patient to sign a written agreement about the collaborative care, ensure that the nonphysician therapist receives a copy.

Educate patients about the medications you prescribe and, to the extent that it is clinically appropriate, the reasons you prescribe them. Provide written information about the medication you prescribe: Why you prescribed it, the possible side effects, how to take it, the expected result, when to call you about medication reactions, and how to obtain refills in a way that ensures continuity. Include clear guidelines about the frequency in which the patient must be seen, and the intervals at which lab work must be done in order to ensure that the medication is at an acceptably therapeutic level.

Include in progress notes the indications for medications; comments on their efficacy and indications for continued use; test results of drugs that must be monitored; and the details of dose, amount, directions, refills, and changes.

All refills must be monitored carefully and properly documented. Front office staff should not have the authority to authorize refills, and a separate part of the patient's records should be dedicated to tracking refills and medication management. Documentation of refills should reflect physician authorization. You may wish to use a Medication Control Record (MCR) to monitor the pattern of a patient's medication treatment. (*You may request a sample MCR from the Loss Prevention Department, or find it on MIEC website [publications](#)*).

Remember to include in patients' charts:

1. patients' consent to treatment;
2. the content of significant communication – including telephone calls – between you and the patient, the co-treater, other doctors, and managed care plans;
3. all patient education, oral and written;
4. unambiguous referral information; and
5. patients' noncompliant behavior or refusal to follow your medical advice. If your treatment plan deviates from the usual standard, document the rationale for your decision.

In general, your documentation should justify the medication you prescribe, support the fees you charge, and distinguish between your responsibility and that of the patient and the co-treater.

EMTALA changes

Q: What should I know about the latest changes to the Emergency Medical Treatment and Active Labor Act (EMTALA) regulations?

A: Emergency physicians, and specialists who serve on on-call panels for hospital emergency departments, should be aware of the EMTALA regulation changes that went into effect in November 2003. There are a number of changes to the regulations, not all of which are easily understood. Keep in mind that the Center for Medicare and Medicaid Services (CMS) does not clearly define all of the changes, and clarifications of existing regulations are sometimes made in future interpretive guidelines or court rulings. Unfortunately, those often occur after implementation. Some of the current and most salient changes include:

1. EMTALA applies to individuals who present to a “dedicated emergency department of a hospital” and request examination or treatment for a medical condition or when a request for such examination or treatment is made on the behalf of the individual by another. The definition of “dedicated emergency department” (DED) is broad and includes more than the hospital’s emergency room. EMTALA applies to other departments such as urgent care centers, labor and delivery, and psychiatric units. It includes “any area of a hospital which provides services to at least one-third of the ambulatory individuals who present for care without appointments.” In addition, if an individual is within the hospital and suddenly experiences a medical emergency that requires immediate care, EMTALA applies. Therefore, an EMTALA situation can arise almost anywhere on the hospital campus or property.
2. As previously stated, EMTALA applies to people who present to a DED and request examination or treatment. If the request is for medical care that does not appear to be emergent, “... the hospital is required to perform a medical screening exam to determine whether the individual does or does not have an emergency medical condition. The examination may be limited to establishing that the patient is not asking for emergency care and brief questioning by a qualified medical person sufficient to establish that no emergency condition exists.” EMTALA also applies if someone appears and does not request treatment, but a prudent observer recognizes that the person's appearance and/or behavior indicates that the individual needs examination or treatment for a medical condition.
3. Once a patient has been screened in the ED and is found to require hospitalization to stabilize an emergency medical condition, the hospital has satisfied its EMTALA obligations. When the patient is then admitted in good faith for inpatient care, EMTALA obligations no longer apply.
4. Hospitals that have a dedicated emergency department are required to maintain an on-call list of physicians that “best meets the needs of the hospital’s patients” and is determined by the hospital’s available resources, including on-call physician availability.
5. Several changes have been made regarding on-call coverage, including some deference to the needs and abilities of individual hospitals. There is no requirement under EMTALA for full-time on-call coverage by every specialty or a predetermined ratio used to identify how much on-call coverage should be provided based on the number of physicians on staff for a particular specialty. At the same time, CMS can consider whatever relevant factors it chooses, including the number of physicians on staff, other demands on physicians, and provisions made by a hospital regarding non-availability of specialty

physicians. Hospitals must have written policies and procedures regarding the times a specialty is not available or the on-call physician cannot respond to a request for care due to circumstances beyond his or her control. The hospital must also have written policies and procedures to provide emergency services which meet the needs of its emergency medical patients if the hospital elects to permit on-call physicians to schedule elective surgery when they are on-call or who have simultaneous on-call duties for two or more hospitals. Surgeons must not, however, use elective surgery scheduling to avoid fulfilling EMTALA's on-call obligations.

6. On-call physicians may be on-call to more than one hospital simultaneously, if the hospital elects to permit this practice.
7. On-call physicians are not required to be continually on-call (twenty-four hours per day, seven days per week, 365 days per year) even if the hospital lacks access to a representative of their specialty when they are off-call.
8. Hospitals may exempt senior physicians from the call schedule, if the hospital on-call plan meets the needs of patients, and if the absence of the senior physician does not adversely impact patient care.
9. A physician exempted from on-call duties may not continue to be on-call for his/her own or colleagues' private patients. Being on-call for private patients is evidence of the physician's ability to take call, so to then refuse to be on the hospital's on-call panel would be considered discriminatory and a violation of EMTALA. It would be a clear violation of EMTALA for a physician to refuse to be listed on the on-call roster but to take call selectively for some, but not all, patients. Physicians who come to the hospital to see their own patients are not necessarily considered on-call provided, that they are not listed on the coverage roster as the on-call physician for that time period.
10. On-call physicians who fail or refuse to appear when contacted to provide emergency care are in violation of EMTALA.
11. It is the responsibility of the physician who examines a patient in the emergency department to determine when an on-call specialist must come to the hospital. Any disagreement between the treating and on-call physicians regarding the need to come to the hospital must be resolved by deferring to the medical judgment of the emergency physician or other practitioner who has personally examined the individual and is currently treating the individual.
12. EMTALA no longer applies to hospital-owned ambulances if the ambulance is operated under community-wide EMS protocols that direct it to transport the individual to a hospital other than the hospital

that owns the ambulance or if the ambulance is operated at the direction of a physician who is not employed or otherwise affiliated with the hospital that owns the ambulance.

For a complete copy of the 44-page Final Rules, or for more detailed explanations of the changes, contact the Centers for Medicare and Medicaid Services (CMS).

How to reach MIEC

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Oakland Office: 510/428-9411
Honolulu Office: 808/545-7231
Boise Office: 208/344-6378
Outside: 800/227-4527

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