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### We Get Letters

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

#### **When a specialist is asked to provide primary care**

**Q:** *When patients come to me for consultation, occasionally we get along so well that they want me to treat them for their chronic problems such as hypertension and diabetes, or even their common colds. How do I help them understand that even though I provide consultation, and condition-specific temporary treatment, I don't do primary care?*

**A:** Clear communication is the starting point for all doctor-patient relationships, and in this case, it must also include a finishing point. As many patients fail to differentiate between specialties, it is up to physicians to educate them. Fortunately, this can be done effectively in different ways throughout a patient's care.

Specialists can simplify their lives by printing up a [Consultant's Introduction Card](#) — a brief description of themselves and their practice, including a map to direct patients to their office, and give a stack of these cards to colleagues to dispense to patients upon referral. This gives the referring physician an opportunity to introduce you, and gives patients a frame of reference for who, what, and where you are before making their appointment to see you.

Once patients make an appointment with you, give them a [Patient Information Brochure](#). This patient relations tool (1) acquaints patients with the nature of your specialty and its limits; (2) familiarizes them with you and your practice policies; (3) sets the stage for the doctor-patient relationship; (4) anticipates questions before they are asked; (5) advises patients what is expected of them; (6) gives patients something to take home with them to remind them of the good care you gave them, and (7) gives them answers to questions they may have forgotten to ask while in the office.

When you return a patient to the referring physician's care, you can include in your customary consultant's letter a statement similar to: "I return Mr. Blank to your care, and trust that if you want me to see him in the future, you will make another referral." You may copy the patient with the letter, therefore making the return to the referring physician clear to all concerned. Another means of ensuring that the patient understands that he or she is being returned to the referring physician's care is to inform the patient orally at the last visit that your "mission" has been fulfilled, say good-bye and wish the patient well as he or she returns to the referring physician's care. Document that the patient knows that your relationship is ended and will not be resumed unless a subsequent referral is made.

### **Getting specialists to report to referring physicians**

**Q:** *Sometimes I have to practically beg specialists to whom I've referred a patient for consultation to send me a written report of their examination, assessment and recommendation. Isn't there something wrong with this picture?*

**A:** The referral to a consultant is to assist the referring physician in the care and treatment of the patient. The consultant is paid for his or her services on the basis of providing expert advice, and in many cases, specialty-specific treatment. The absence of a written report of the assessment, advice, and treatment, minimizes the value of the consultation, limits the referring physician's ability to treat the patient optimally, creates the potential for contradictory and incompatible care, and leaves a gaping hole in the documentation that memorializes the patient's care. In the absence of effective communication, patients are vulnerable to injury and physicians are vulnerable to allegations of medical negligence.

The importance of communication between co-treating colleagues is as essential to good medical care as the relationship between physician and patient. To protect the patient, the referring physician, **and** the specialist, referrals should be in writing, for which MIEC's Loss Prevention Department has a handy form.<sup>1</sup> Responses from specialists should be prompt and in writing. A "quick and dirty" informal response on an NCR (no carbon required) template is an option for specialists who want to fulfill their obligations, but require more time to dictate the formal consultation letter.<sup>1</sup>

Much depends on community standards, but a culture of responsibility begins with the ability of physicians to negotiate what co-treating physicians will do to maximize patient safety and to communicate cooperatively. One-on-one conversations between referring physicians and specialists are the most effective means of obtaining colleagues' cooperation. One of MIEC's medical consultants advises, "If you don't hear from the consultant, call! If you get no response, call again, and if the staff says the doctor is with a

patient, ask that the consultant be called to the phone. If the doctor remains recalcitrant, send a registered letter. If all else fails, depending on the urgency of the matter, send a registered letter or appeal to the QA panel of the mutual third party payer. If it is an option, refer the patient elsewhere.”

In some communities, it may be necessary to seek assistance from the medical staff at the local hospital to encourage specialists’ timely responses. Some physicians would be well served to enlist the aid of the county medical society to open dialogue about colleagues’ expectations of consultation referrals from both sides of the equation. MIEC’s consultant warns that the more people are involved, however, the more time intensive the solution becomes, but until the issue is resolved, patients and physicians are vulnerable to unfortunate, and avoidable, consequences.

### **More on triplicate prescriptions for California physicians**

**Q:** *(California only) It’s almost January 1, 2005. I read MIEC’s [New Law Alert #12](#), May 2004. What else do I need to know about the new required controlled substance tamper-resistant prescription forms? Where can I find a list of approved security printers?*

**A:** The following should answer your remaining questions about the new law:

- All **written\*** controlled substance prescriptions (Schedules II-V) must be on tamper-resistant security prescription forms as of January 1, 2005. (\*These are prescriptions *written* in the physician’s office, *signed* by the prescriber and *given* to a patient to be taken to a pharmacy for filling.)
- Schedule III through V prescriptions **may** be faxed to pharmacies. Faxed prescriptions, however, must be written on an **ordinary** prescription form, because the new form cannot be faxed or copied. If faxed or copied, the word “VOID” automatically appears on the reproduced form.
- Schedule III through V prescriptions may be orally or electronically transmitted to the pharmacy. The pharmacist or other person authorized to fill the prescription must reduce the prescription to hard copy for filing purposes.
- Information may be entered on a controlled substance prescription by a prescriber’s agent. However, all controlled substance prescriptions must be signed and dated by the prescriber.
- Prescribers who **dispense** Schedule II drugs (as of July 1, 2004) and Schedule III drugs (by January 1, 2005) must report those prescriptions to California’s Department of Justice (DOJ). The means by which this can be accomplished will be posted on the DOJ website when the information is available.
- Physicians who want to obtain a patient’s Schedule II controlled

substance prescription history, if the physician suspects drug abuse, may request a “Patient Activity Report (PAR)” from California’s DOJ. All physicians who are authorized to obtain triplicate prescription forms may download the PAR request form from the Medical Board of California’s website under “Services for Licensees;” submit the completed form by fax to the DOJ at 916/227-5079, or mail it to California Department of Justice, PO Box 160447, Sacramento, CA 95816.

- For a list of approved security printers from whom to purchase the new forms, go to the Board of Pharmacy’s website at [www.pharmacy.ca.gov](http://www.pharmacy.ca.gov). If you have additional questions regarding the new forms, send an email to [Security Printer@dca.ca.gov](mailto:SecurityPrinter@dca.ca.gov).

(For a review of other details related to the new controlled substance prescription form law, refer to MIEC’s [New Law Alert #12](#), May 2004.)

### **California physicians who want to volunteer after retirement**

**Q:** (*California only*) *I’ve been retired since August 1, 2004, but I’d like to volunteer at a local student health center. Can I do that?*

**A:** Yes, but not as a “retired” physician. Effective July 1, 2004, physicians with “retired” license status can no longer practice medicine in the state of California. If you want to volunteer, you must apply for a “volunteer” license. A holder of a “volunteer” license is exempt from annual licensing fees unless his/her medical license is currently delinquent. If delinquent, the applicant must pay all accrued renewal fees, delinquent fee, and penalty fee when submitting the application for a volunteer license. You also must fulfill continuing medical education (CME) requirements, unless the Medical Board of California (MBC) grants you a waiver. If you receive any money at all for the services you provide, you must maintain an “active” license, pay licensing fees, and fulfill CME requirements. [*Business & Professions Code §§2439 and 2442*]

*Some “good news:”* “Retired” physicians with CME waivers, who decide to reactivate their license or apply for a volunteer license, need not “make up” CME units. However, they will be required to take the appropriate number of units in the future. *Some “bad news:”* The law requires that all retired doctors switching to “active” status pay full licensing fees at the time they change their license status. Because the state does not have a mechanism to prorate licensing fees, another full fee may need to be paid on the physicians’ regular renewal dates.

For more information about a volunteer license and waived CME requirements, contact the MBC’s Division of Licensing at 916/263-2382 or go to the website [www.medbd.ca.gov](http://www.medbd.ca.gov).

## Clarification re EMTALA changes

**Q:** *What else should I know about the latest changes to the Emergency Medical Treatment and Active Labor Act (EMTALA) regulations? Specifically, if I'm exempt from the emergency department call roster, can I see my patients or my colleague's patients who have been admitted to the hospital?*

**A:** “The Social Security Act requires that hospitals have a list of physicians who are on-call for duty after the initial patient examination in order to provide treatment necessary to stabilize an individual with an emergency medical condition. Each hospital has the discretion to maintain the ED on-call list in a manner to best meet the needs of its patients. Hospitals have some flexibility in the utilization of their emergency personnel, which includes on-call coverage. Allowing a senior physician exemption from the ED on-call list is not necessarily a violation of EMTALA, depending on the circumstances. A determination about whether a hospital is in compliance with regulations will be based on facts of the individual case. The Center of Medicare and Medicaid Services of the DHHS will consider ‘all relevant factors’ including the number of physicians on staff, other demands on these physicians, the frequency with which the hospital’s patients typically require services of on-call physicians, and the provisions the hospital has made for situations in which a physician in the specialty is not available or the on-call physician is unable to respond due to circumstances beyond his or her control.

At the same time, being exempt from the ED’s on-call roster does not disqualify a physician from continuing to practice at a particular hospital. It is generally accepted that it would be an EMTALA violation for a physician to refuse to be listed on the ED on-call roster but to selectively take call for some, but not all, patients. For example, a physician who remained on-call for insured patients but refused on-call requests for the uninsured would be in violation of EMTALA.

A physician can see his or her own hospitalized patients or his/her own patients who come to the ED, if the physician is requested to do so. Under those circumstances, a physician would not necessarily be viewed as on-call to the ED. The flexibility of the hospital to maintain an on-call roster contemplates situations where a senior physician could be exempt from the ED’s on-call panel and yet continue to maintain staff privileges and see his or her own patients (or his/her group’s patients) at the hospital.” [*Provided by Thomas J. Donnelly, Esq., Donnelly & Nelson, Walnut Creek, CA*]

We thank Gene Cleaver, MD, Loss Prevention Committee Chairperson, for his review and advice for this edition of *We Get Letters*.

1For a prototype of this or other forms, call MIEC’s Loss Prevention Department, or go to [www.miec.com](http://www.miec.com), Loss Prevention section.

## How to reach MIEC

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