AMERICAN MEDICAL ASSOCIATION PRIVATE PRACTICE PHYSICIAN SECTION

Resolution: 2
(June 2022)

Introduced by: Matt Gold, MD

Subject: Maintaining an Open and Equitable Hospital Work Environment for Specialists

Referred to: PPPS Reference Committee
(xxxx, MD, Chair)

WHEREAS, AMA objectives include the betterment of patient care; and

WHEREAS, AMA objectives include the satisfaction and sustainability of physicians in the practice of medicine; and

WHEREAS, Maintaining access to a larger number of specialty physicians in the inpatient setting maintains and expands patient access to appropriate care as well as increases care integration; and

WHEREAS, Assuring access to inpatient hospital consultations by independent physicians promotes inclusive work environments and increases physicians' financial sustainability within the healthcare environment as well as advancing professional growth and satisfaction; and

WHEREAS, AMA advocacy of increased physician engagement and diversity and increased engagement and collaboration with key stakeholder groups demonstrates AMA dedication to action in matters of practical import to the physician within the healthcare system; and

WHEREAS, The implementation of the position of inpatient hospital physician ("hospitalist") programs was intended to streamline inpatient general management and was generally accepted by physicians in outpatient general practice who concentrate on outpatient care; and

WHEREAS, Policy on this topic focuses on definition of the role of the hospitalist. Though it speaks to teamwork and communication between hospitalist and outpatient general physicians, existing policy does not directly address the dislocations of the community/independent specialist by virtue of an expanding specialty hospitalist system, yet access to specialists is imperative; and

WHEREAS, Specialty physicians in community/independent practice more often incorporate consultations on hospitalized patients as part of a practice than general medicine physicians, with economic benefit and an opportunity for gaining new patients for outpatient follow up which also contributes to continuity of care; and

WHEREAS, Access of hospitalized patients to a variety of specialists in a field with different skills, talents, and intangibles, in the opinion of many, benefits the general hospitalists as well as the hospitalized patient and contributes to continuity of care into the outpatient setting; and

WHEREAS, Hospitals traditionally have required physicians on the medical staff to participate in coverage to consult on hospitalized patients as a condition of having hospital privileges; and

WHEREAS, Introduction of specialty hospitalists, in many instances, severely constrains access to inpatient consultation by community/independent specialists and limits access of patients to the variety of independent specialists available. When this change is introduced unilaterally by the hospital/healthcare organization, it is accompanied by preferential publicity and promotion of the specialty hospitalist at the expense of the community/independent specialist, sometimes nearly excluding them from practice in the hospital; and

WHEREAS, For a community/independent specialist, even limited coverage of inpatient care, including telephone contacts for clinical advice, carries potential liability for which professional liability insurance must still be procured; and

WHEREAS, Lower inpatient volume for the community/independent specialist may complicate future reappointment to the medical staff, not the mention the economic loss to the physicians; and

WHEREAS, Prejudicial financial arrangements for the specialty hospitalist compared with fee-for-service opportunities without retainer for the community/independent specialist as the new model may create a competitive advantage for the hospital system as well as the hospitalist; therefore be it

RESOLVED, That our American Medical Association takes the position that there should be equal promotion of, and access to inpatient consults for, credentialed and privileged community /independent specialty physicians as for hospital-employed specialty physicians (New HOD Policy); and be it further

RESOLVED, That our AMA advocate that hospitals engage community/independent specialty physicians available on the medical staff for observation, inpatient, and emergency department coverage and that the parties negotiate mutually satisfactory payment terms and service agreements for such service (Directive to Take Action).

Fiscal Note: Not yet determined

Received: 3/13/22

RELEVANT AMA POLICY

Billing Procedures for Emergency Care (H-130.978)

(1) Our AMA urges physicians rendering emergency care to ensure that the services they provide are accurately and completely described and coded on the appropriate claim forms. (2) In the interest of high quality care, patients who seek medical attention on an emergency basis should have the benefit of an immediate evaluation of any indicated diagnostic studies. The physician who provides such evaluation is entitled to adequate compensation for his or her services. When such evaluations are provided as an integral part of and in conjunction with other routine services rendered by the emergency physician, ideally an inclusive charge, commensurate with the services provided, should be made. Where the carrier collapses or eliminates CPT-4 coding for payment purposes, the physician may be left with no realistic alternative other than to itemize. Such an itemized bill should not be higher than the amount which would be paid if the appropriate inclusive charge were recognized. The interpretation of diagnostic procedures by a consulting specialist, as a separate and independent service provided the emergency patient, is equally important to good patient care. Physicians who provide such interpretations are also entitled to adequate compensation for their services. (3) Our AMA encourages state and local organizations representing the specialty of emergency medicine to work with both private and public payers in their area to implement payment practices and coding procedures which assure that payment to physicians rendering emergency care adequately reflects the extent of services provided.

Citation: CMS Rep. J, I-86; Reaffirmed: Res. 118, I-95; Reaffirmed: A-00; Reaffirmed: BOT Rep. 6, I-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed in lieu of Res. 808, I-15