

New Texas Medical Board Call Coverage Rules Causing Concern

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The Texas Medical Board (“TMB”) adopted new call coverage rules in the fall, that became effective on October 9, 2016. In the past, call coverage was arranged by physicians informally or collegially, but with no specific agency rules mandating any particular relationship structure or information sharing. These new rules change that historic practice, resulting in potentially significant changes to call coverage, especially for rural or solo physicians.

The Texas Ophthalmological Association has been contacted by members voicing various concerns about these new rules.

For example, one member who practices in rural Texas, wrote the following:

As the only ophthalmologist for over 100 miles...call coverage has always been a challenge for me for the 30 years of my solo practice. I will at times attempt reciprocal coverage but it is difficult since most of the ophthalmologists who cover for me will not have their patients drive 100 miles for coverage to see me...I do have coverage and they are EXCELLENT and communicate well, so my patients are always covered, but placing this type of restriction on them may cause them to stop covering for me. If these rules become too onerous then I might have to close my practice here and then there is no coverage anytime. No good deed goes unpunished!...

Unfortunately, this member’s concerns may be well-founded, as several of the minimum requirements may not be possible or plausible for some physicians.

The call coverage rules provide the following (emphasis added):

RULE §177.20. Call Coverage Minimum Requirements

(a) Generally.

(1) Physicians may provide medical services through a **call coverage agreement (CCA) to established patients** of a physician who requests the coverage. A covering physician who enters into a CCA is responsible for meeting the standard of care for patient care provided during such call coverage.

(2) The covering physician is **required to relay a report** to the physician who requested the coverage regarding the care provided. The covering physician may satisfy the report requirement described in this subsection by **updating the patient’s medical record, sending a written report, or providing the information to the physician who requested the coverage through other methods. The duty to provide the report is the sole, exclusive obligation of the covering physician**, and cannot be delegated to or satisfied by the patient or patient representative providing a report or otherwise recounting the encounter to the physician who requested coverage. The physician who requested the call coverage must make the report provided by the covering physician a part of the patient’s medical record.

(b) Call Coverage Models.

(1) **Non-Reciprocal Call Coverage Model.** For physicians who enter into a CCA **and are not of the same specialty or similar specialties, or do not require reciprocal medical call coverage services** for the covering physician’s patients through the CCA, the CCA **must be in writing and at a minimum include terms that:**

(A) establish a covering physician’s responsibility for meeting the standard of care in providing call coverage for the patients of the physician requesting coverage;

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(B) provide a list of all of the physicians that may provide the call coverage under the CCA;

(C) require that at the time of the service provided, the covering physician have access to the necessary medical records related to the patient who is being treated under the CCA;

(D) for non-emergency care provided for a diagnosis previously made by the physician who requested call coverage, require the covering physician to furnish a report to the physician requesting the call coverage within 7 days from the end of each call coverage period;

(E) for non-emergency care provided for an injury, illness, or disease not previously diagnosed by the physician who requested call coverage, require the covering physician to furnish a report to the physician who requested the call coverage within 72 hours from the end of each call coverage period; and

(F) for emergency care provided, require the covering physician to furnish a report to the physician who requested call coverage within an appropriate time period according to the circumstances of the emergency situation.

(2) Reciprocal Call Coverage Model.

(A) For physicians who enter a CCA and are of the same specialty or similar specialties and require reciprocal medical call coverage services for the covering physician's patients, the CCA may be oral or written.

(B) Terms of the CCA at a minimum must establish the covering physician's responsibility for meeting the standard of care for patient care provided during such call coverage and relaying a report to the physician who requested the coverage regarding such patient care provided within an appropriate amount of time from the conclusion of each call coverage period.

An area of concern with these rules arises with the rural physician who: 1) may not have another physician of the same specialty within a reasonable distance, and therefore seeks coverage from a qualified physician of a

different specialty; and/or 2) who may find a physician of the same or similar specialty at a somewhat larger community who is willing to cover the rural physician, but who would not be willing to reciprocate coverage and have his or her patients travel to a rural location for reciprocal coverage. In either of these scenarios, the "non-reciprocal call coverage model", of the rule (subsection (b)(1)) would apply, resulting in requirements that may not be feasible for the practice to comply with, and with which no covering physician would be willing to agree.

The nonreciprocal model requires: 1) a written agreement containing a list of physicians who may provide call coverage and a written statement of the covering physician's responsibility for meeting the standard of care; 2) access to necessary medical records related to the patient being treated; 3) a report to be provided by the covering physician within 72 hours to 7 days after the call coverage period, depending on the type of care provided (i.e. emergency, non-emergency, new diagnosis, etc.).

Access to Medical Records — Logistical and Potential HIPAA Concerns

The written agreement for non-reciprocal call coverage must **require that at the time of the service provided, the covering physician have access to the necessary medical records related to the patient who is being treated under the CCA.**

This may prove to be impossible for some rural sole practitioners. For example, if a physician does not have an electronic medical record ("EMR"), how will access to medical records be provided? If a physician does have an EMR, will there be unlimited access to all patient records, since it is not always possible to know in advance which patients will require coverage? Perhaps there will be at least one staff member available in the physician's office to share the limited medical records with the covering physician, but if these records are voluminous, the manner of sharing the information and the portion to share (all or recent, etc.) will be an issue to determine.

In any of the scenarios of making the medical records available, the physicians must ensure that patient privacy is protected, and that federal and state privacy laws (i.e., HIPAA, HITECH) are followed in the sharing of this information. As it would appear that a covering physician could be a "business associate"² under the HIPAA rules and regulations, the physician

²A "business associate" is a person or entity, other than a member of the workforce of a covered entity, who performs functions or activities on behalf of, or provides certain services to, a covered entity that involve access by the business associate to protected health information. A "business associate" also is a subcontractor that creates, receives, maintains, or transmits protected health information on behalf of another business associate.

and covering physician may be required to enter into a Business Associate Agreement (“BAA”). The HIPAA Rules generally require that covered entities and business associates enter into contracts with their business associates to ensure that the business associates will appropriately safeguard protected health information, but there are some exceptions for the treatment of patients. Regardless of whether a BAA is specifically required for a call coverage arrangement, it may be a useful tool to consider, in order to ensure that proper privacy protections are in place and that there is an appropriate risk allocation and breach notification protocol in the event of a breach.

It is also interesting that the TMB requires access to medical records for a covering physician in a non-reciprocal arrangement, but not for physicians in a reciprocal arrangement—if access to medical records for the patients under one coverage arrangement is not required for reasonable call coverage, then why would the same or similar medical care/coverage require such access under a different coverage arrangement? Indeed, the requirement is being imposed upon the physician who is least likely to be able to comply with such medical records access, i.e. the rural solo physician.

Liability of Covering Physician

Regardless of whether the call coverage arrangement is reciprocal or non-reciprocal, the potential liability for a covering physician may be increased. This liability may be affected by: 1) increasing potential professional liability by entering into the CCA (whether oral or written); 2) potentially increasing HIPAA and other state and federal privacy regulations, by having access to the medical records of the practice he or she is covering; and 3) by being required to timely report the coverage encounters.

Duty of Care—Physician Patient Relationship.

The existence of a duty of care to patient is required to establish professional liability. Texas courts have recognized the existence of a duty only when the physician was *party to a contract for the benefit of the patient*, or had taken an active step in treating the patient. See, e.g., *St. John v. Pope*, 901 S.W.2d 420 (Tex. 1995); *Wax v. Johnson*, 42 S.W.3d 168, 172 (Tex.App.-Houston [1st Dist.] 2001, pet. denied).

Although Texas Supreme Court in the *St. John* case noted that “Creation of the physician-patient relationship does not require the formalities of a contract” and that, “The fact that a physician does not deal directly with a patient does not necessarily preclude the existence of a physician-patient relationship,” the Court held that ***there was no physician patient relationship between a patient***

and a hospital’s on-call internist who recommended that an emergency room patient be referred to another hospital where the physician’s affidavit stated ***he never agreed*** to treat the patient. The Court then wrote, “If any agreement existed which divested [the physician] of the discretion to choose whether to treat a patient, it was incumbent on [the patient] to present it in order to preclude summary judgment for the doctor.” Texas courts have followed *St. John*, and have held that ***a duty exists only when a physician was a party to a contract for the benefit of the patient or had taken an active step in treating the patient***. See, e.g., *Hand v. Tavera*, 864 S.W.2d 678 (Tex.Ap.--San Antonio 1983, no writ) and *Dougherty v. Gifford*, 826 S.W.2d 668 (Tex.App—Texarkana 1992, no writ). For example, courts have held that a duty existed when a patient medical plan’s designated doctor was consulted when the patient was at the emergency room, and that it existed between a patient and pathologist with whom the patient’s physician contracted to perform laboratory work for benefit of the patient.

Therefore, although this area of the law is very fact specific, it appears that complying with the new call coverage rules and establishing a formal agreement with the covering physician will likely create a duty and thereby increase potential liability for the covering physician.

HIPAA Obligations. Similarly, the covering physician may have increased liability and exposure under HIPAA, and other federal and state privacy rules and regulations (the extent of which is beyond the scope of this article). Such increased liability would exist because the covering physician would have access to the medical records of the physician’s office being covered, as required by the new TMB rules (for non-reciprocal coverage) and in accordance with the Business Associate Agreement the physicians may execute.

HIPAA imposes direct responsibility on the business associate. HHS clarified its interpretation of the law: “A business associate is directly liable under the HIPAA Rules and subject to civil and, in some cases, criminal penalties for making uses and disclosures of protected health information that are not authorized by its contract or required by law. A business associate also is directly liable and subject to civil penalties for failing to safeguard electronic protected health information in accordance with the HIPAA Security Rule.” <https://www.hhs.gov/hipaa/for-professionals/covered-entities/sample-business-associate-agreement-provisions/index.html>.

However, there are situations in which a Business Associate Agreement may not be required, for example a hospital is not required to have a business associate

contract with the specialist to whom it refers a patient and transmits the patient's medical chart for treatment purposes. See HHS guidance for more information: <https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/business-associates/index.html?language=es>. Regardless of whether or not a BAA is specifically required under a nonreciprocal arrangement under the specific circumstances of that CCA, the sharing of protected health information and the potential for breaches to occur in that access or transmission should be considered. For example, if the covering physician does not properly secure the access to protected health information, and if there is a breach, or if the practice has a breach while the covering physician has access, the responsibilities for breach notification, indemnification of associated costs, etc., could depend on whether there is a BAA. Additionally, a BAA would contain requirements that the business associate maintain appropriate policies and procedures to protect protected health information. Proper protection of patient health information should be addressed with anybody who will have access to a physician's medical records. Furthermore, cyber liability coverage should be considered by the physician; likewise, it should be encouraged (if not required) of anybody with whom the physician will have an agreement that allows access to medical records.

Reporting by Covering Physician. The new call coverage rules require the covering physician to relay a report to the physician who requested the coverage regarding such patient care provided; if the coverage was reciprocal, then the report must be within an "appropriate amount of time" from the conclusion of each call coverage period. But if it is nonreciprocal, then the rule requires a report as quickly as 72 hours after the coverage period ends (for non-emergency care provided for an injury, illness, or disease not previously diagnosed by the physician who requested call coverage, 7 days for non-emergency care provided for a diagnosis previously made by the physician who requested call coverage), or for emergency services, "within an appropriate time period according to the circumstances of the emergency situation."

Clearly, access to medical records will be important for non-reciprocal coverage, because the timeframe within which a report is required will depend on whether the physician for which coverage was provided had previously diagnosed the condition. There is no time limitation on how far back that diagnosis could have been made, and there is no clarity on whether it is for a new occurrence of a prior diagnosis (i.e. an entirely new episode of an infection that had previously been resolved).

Summary

The new call coverage rules may affect a covering physician's willingness to enter into a CCA, because the covering physician's liability is potentially increased by virtue of the agreement, and because the providing formal reports within a certain time period may be too burdensome. If a physician is nonetheless able to find a willing covering physician for a nonreciprocal agreement, the physician must address the issue of access to the physician's patients' medical records and ensuring that patient privacy is sufficiently protected in accordance with state and federal privacy laws.

As noted herein, there may be a disproportionate detrimental effect on the small town or rural solo physician. Perhaps hiring a locum tenens, if available, will be an option (albeit potentially expensive) utilized by these physicians for a family vacation or longer absences from the practice; but being away for a shorter period of time, such as attending a CME, a grandchild's graduation or wedding, or addressing a personal illness, may be more challenging.

Texas Ophthalmological Association is making efforts to work with the TMB to address or clarify some of these concerns. But the TMB did vote to pend all rulemaking until the legislative session has completed, out of respect for the legislature. Therefore, at this time the new call coverage rules must be complied with as written.