

Neonatal care codes labeled too inclusive

AAP seeking to revise work values

AAP officials quickly are moving to develop physician work values for the three new neonatal critical care codes included in the 1993 Physician's Current Procedural Terminology (CPT).

The Academy is pursuing this as part of its role as a standing member of the AMA/Specialty Society RVS Update Committee (RUC). The RUC provides a forum for national medical specialty societies to develop recommendations for the physician work component of Medicare's resource-based relative value scale (RBRVS).

A March 24 meeting has been planned during the AAP Spring Session in Chicago. Representatives from the Academy, Society for Critical Care Medicine (SCCM) and American Medical Association plan to address

this issue. They say that they hope to develop a survey instrument which can be used to gather physician work value data on the three codes from a sample of neonatologists and critical care physicians and develop patient vignettes for the three codes which can be used as part of the survey.

If a survey instrument is developed, it will then be administered to a sample group of neonatologists. The resulting work value data will be analyzed and submitted to the RUC for review at an upcoming meeting. AAP Section on Perinatal Pediatrics and Committee on Fetus and Newborn representatives also are scheduled to attend, as is COPAM Chairman Roger Suchyta, M.D., the Academy's Specialty Adviser to the CPT Advisory Committee. Timothy

Costich, M.D., the Academy's alternate to the RUC, will also be joining the meeting.

AMA Director of Department of Payment Systems, Sandra Sherman, scheduled to attend the meeting, has previously indicated her enthusiasm for the coalition between the Academy and the AMA to recommend relative work values for the three codes.

Although the focus of this meeting is on developing physician work values for the three neonatal critical care codes, Dr. Costich pointed out that the structure of the codes themselves must be examined.

"It covers too broad a range of services and too broad a range of clinical situations," he said. "The problem with this on a practical level is most

neonatologists don't know how to use it and don't know if they're going to get paid for it because insurance companies would probably prefer not to."

If the codes are unworkable, the next step will be to reach an agreement with the SCCM and the AMA CPT Editorial Panel to revise the codes by April so that they can be included in the 1994 CPT book.

Dr. Costich said previously there was no urgency to provide work values for the codes since they are not Medicare covered services. The current RBRVS only applies to Medicare. However, since several states are either using the RBRVS or are planning to use it for their Medicaid programs, the AAP officials say an added push to develop the work values is needed.

Pediatricians and the Law

Emergency staff have responsibilities for private patients

by JAN BERGER, M.D., FAAP AND
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Editor's note: This article is the first in a series about providing quality care in and avoiding medical liability associated with emergency room visits. This month's article deals with the relationship between in the private, primary care physician and physicians in the emergency room.

Drs. Berger and Selbst are members of the AAP Committee on Medical Liability.

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The private patient who is sent to the emergency department (ED) for evaluation can cause special legal problems for the staff in the ED, and the patient's private physician.

In some cases, the private physician expects to meet the child in the ED and provide the acute care himself or herself, without the aid of the ED staff.

This is often a reasonable approach, but the ED staff should realize that it has some responsibility



Emergency room staff face legal questions.

for the patient once he or she arrives in the ED.

Physicians and hospitals have been sued when patients deteriorated in the ED while waiting for the private doctor to arrive.

Therefore, remember that even if the private doctor plans to care for the child, the ED staff should triage all children who present for care.

If the child needs prompt attention, the emergency physician should examine the child and ad-

minister necessary treatment while waiting for the private physician to arrive.

In the absence of the private physician, patients should be registered as ED patients, an appropriate ED record should be generated, and care should be documented in the usual way.

Sick children should wait in the ED treatment area, not the waiting area, for the private doctor to arrive, and nursing staff should monitor the patient like any other ED patient.

Explain to the child's parents that the involvement of the emergency physician is in the child's best interests.

Certainly, if they refuse care, this should be clearly documented.

After the child has been appropriately examined and stabilized, the private physician should be called and notified of the child's condition.

Care of the patient may be transferred to the private doctor when he or she arrives in the ED.

The medical record should be clearly documented to indicate this transfer of care, and medical staff bylaws should delineate how such transfer of responsibility takes place.

Some private patients who are referred to the ED may expect to be seen immediately, rather than wait for care like other patients who arrived unexpectedly.

This creates more of an ethical dilemma for the ED staff than a legal issue.

Most EDs have specific policies about handling such referred patients.

It seems best to triage the private patients and allow the seriousness of the child's condition to determine when the child will be seen.


However, the ED staff should keep in mind that the private physician most likely sent the child to the ED because he or she feels that the child is more ill than others in the practice.

Thus, in many cases, a higher priority should be given to such private patients.

This is an important ethical issue for the ED staff, who wish to please the private doctor and the private patient without being unfair to children who are not fortunate enough to have their own personal physician.

Next month: Resolving differences.

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