OIG Opines On Propriety Of ED On-Call Coverage Arrangements

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Over the last several years, due in part to the growing financial burden on both physicians and hospitals related to the provision of uncompensated care to patients seeking medical care from hospitals’ emergency departments (EDs), hospitals have encountered increasing difficulty convincing their staff physicians to provide ED on-call coverage and corresponding follow-up care. Although some hospitals are still able to contain any on-call coverage controversy within the rubric of hospital administration-medical staff discussions, an increasing number of hospitals have begun to compensate physicians for ED on-call coverage services. As this phenomenon has grown, counsel for hospitals and physicians alike have struggled to find assurance that such financial arrangements comply with both the federal healthcare program anti-kickback statute[1] (the “Anti-Kickback Statute”) and the physician-self referral law, i.e., the Stark Law.[2] A lack of guidance from either the Centers for Medicare and Medicaid Services (CMS) or the Office of Inspector General (OIG) has augmented this uncertainty.

The Anti-Kickback Statute makes it illegal to knowingly and willfully offer, pay, solicit, or receive remuneration to induce the referral of any item or service payable by a federal healthcare program,[3] and has been broadly interpreted by courts to apply to situations where even one purpose is to provide compensation for referrals.[4] Separate and distinct from the Anti-Kickback Statute, the Stark Law prohibits a physician from referring a Medicare patient for the provision of certain designated health services to an entity with which the physician (or the physician’s immediate family member) has a financial relationship.[5] Both prohibitions allow for statutory and regulatory safe harbors and exceptions, largely due to the breadth of the statutes and the unlikelihood of the safe harbored and excepted arrangements to result in fraudulent or abusive conduct. With respect to ED on-call coverage arrangements, counsel have traditionally attempted to structure such arrangements in compliance with the Anti-Kickback Statute’s regulatory safe harbor for personal services and management contracts[6] and the Stark Law’s exceptions for either personal services arrangements or fair market value transactions.[7]

Recently, the OIG provided the industry with guidance and clarity regarding how ED on-call coverage arrangements may comply with the Anti-Kickback Statute. Specifically, on September 27, 2007, the OIG published Advisory Opinion No. 07-10, concluding that it would neither exclude from federal healthcare program participation nor impose civil monetary penalties and other administrative sanctions on a nonprofit medical center proposing to pay physicians to provide ED on-call coverage and otherwise uncompensated inpatient follow-up care for patients coming to the ED, despite the potential for the arrangement to violate the Anti-Kickback Statute.[8]
Need for the Compensation Arrangement

Similar to the experiences of many hospitals, the medical center requesting the advisory opinion (the “Hospital”) indicated to the OIG that the growing financial burdens of uncompensated care and malpractice insurance had caused the Hospital severe difficulty in finding physicians to provide ED on-call coverage and uncompensated inpatient follow-up care for patients coming to its ED.[9] As a result, the Hospital stated it was hindered in its ability to fulfill its mission of providing charitable care to the underinsured and uninsured population.[10] Consequently, the Hospital developed a proposed compensation arrangement for staff physicians in certain medical specialties to provide ED on-call coverage, respond to patient emergencies in the ED, and provide continuing inpatient care for uninsured patients (the “Arrangement”).[11]

The Compensation Arrangement

Under the Hospital’s proposed Arrangement, the staff physicians would be obligated to:
- Participate in a monthly on-call rotation schedule for his or her specialty;
- Provide inpatient follow-up care to the ED patients seen while on-call and admitted to the Hospital, until the patients’ discharge;
- Timely respond to calls from the ED and subject their response rates to Hospital review;
- Collaborate with the Hospital’s care management staff and participate in Hospital initiatives related to discharge planning, utilization, and review of observation patients (and be subject to suspension and/or termination for failing to so collaborate); and
- Timely document their services to all patients seen under the Arrangement.[12]

The Hospital proposed to pay the participating physicians a per diem rate for each day of on-call coverage, with the exception that each physician would be required to provide 1.5 days per month (18 days a year) of gratis on-call coverage.[13] The per diem rate would vary based on only two factors: (1) the physician’s specialty, and (2) whether the physician would remain on-call on a weekday or weekend day.[14] When seeking to determine the proposed per diem rates for each specialty, the Hospital would examine (a) the severity of the illness that physicians in a given specialty typically encounter when on-call; (b) each specialty’s likelihood of actually needing to respond while on-call; (c) the likelihood that the specialist would need to provide uncompensated care; and (d) the degree of inpatient care each specialty typically provides to patients admitted from the ED.[15]

Standard for Evaluating On-Call Coverage Arrangements, Generally

Acknowledging that hospitals increasingly are compensating physicians for on-call coverage in EDs, and further acknowledging that there are legitimate reasons for such arrangements (e.g., helping ensure the hospitals’ compliance with the Emergency Medical Treatment and Labor Act, the scarcity of certain physician specialties within
particular service areas, etc.), it is notable—first and foremost—that the OIG recognized
the need for hospitals to provide compensation to physicians for ED on-call coverage
services.[16]

However, the OIG also recognized that on-call coverage arrangements can create
significant risks of abuse and can be structured in a manner that violates the Anti-
Kickback Statute.[17] According to the OIG, on-call coverage arrangements can result in
physicians demanding compensation as a condition of doing business at a hospital, even
when neither the services provided nor external market factors, such as a physician
shortage, warrant it.[18] In addition, the OIG noted that (1) hospitals may use such
arrangements to entice physicians to join or remain on the medical staff or generate
additional business; and (2) physicians may use such arrangements to induce referrals
from the hospital (i.e., by offering to provide on-call coverage at below fair market value
rates).[19] Counsel for hospitals and physicians alike should note that the OIG
specifically identified the following as potentially improper aspects of on-call coverage
arrangements:

- payments for “lost opportunity” that do not reflect *bona fide* lost income;
- payments to physicians when no identifiable services are provided;
- disproportionately higher aggregate on-call payments compared to the physician’s regular
  medical practice income; and
- structures that pay for services for which the physician is paid twice, i.e., that allow the
  physician to receive separate reimbursement from insurers and/or patients for the same
  services.[20]

Regardless, the OIG concluded that on-call coverage arrangements can be structured in a
manner that satisfies the Anti-Kickback Statute’s safe harbor for personal services and
management contracts.[21] However, the OIG noted that this safe harbor would be
inapplicable to the Hospital’s proposed Arrangement because the Arrangement would
result in varying monthly payments to physicians and therefore would not meet the
requirement that the aggregate amount of compensation be set in advance.[22]

**The OIG’s Analysis of the Hospital's Proposed On-Call Coverage Arrangement**

With respect to the Arrangement, the OIG relied on the Hospital’s certification that (a)
the payment rates would be fair market value for services provided and would not
account for either party’s referrals or other business generated, and (b) the services were
actually needed and provided.[23] With respect to the fair market value nature of the
daily stipends, it is notable that the OIG specifically pointed out that the Hospital had
retained an independent healthcare industry consultant to provide advice on the
reasonableness of the per diem rates, and further that, in providing its advice, the
consultant had reviewed both publicly available data and proprietary data concerning
practices and pay rates at dozens of medical facilities.[24] Putting these certifications
aside, the OIG determined that the risk of fraud and abuse was minimized not only as a
The OIG took further comfort that substantial services would be provided, documented, quantified, and accounted for because the Arrangement required the physicians to:

- Continue to provide inpatient follow-up care until the patient’s discharge;
- Provide 18 days per year of uncompensated on-call services;
- Assume responsibility for recording their services in medical records; and
- Cooperate with the Hospital’s care, risk management, and performance improvement efforts.\[26\]

Moreover, the OIG also considered significant the fact that the Hospital legitimately needed physicians to provide ED on-call coverage and uncompensated care, as the Hospital had been transferring ED patients to other medical facilities for care.\[27\]

Finally, the OIG focused on the Arrangement’s following safeguards as further minimizing the risk of fraud and abuse:

- The Hospital would offer the Arrangement to all physicians on its medical staff and in the relevant specialties;
- The Hospital would establish an ED on-call coverage schedule that would divide the monthly on-call obligations in each specialty as equally as possible among the physicians;
- The physicians would be required to provide inpatient follow-up care to any ED patient seen while on-call and admitted to the Hospital;
- The physicians would be required to document their services in medical records; and
- The costs would be absorbed by the Hospital; no costs would accrue to any federal healthcare program.\[28\]

**Analysis and Conclusion**

While Advisory Opinion 07-10 is important because it provides overdue and substantial guidance on hospitals’ ability to offer (and physicians’ ability to accept) payment for ED on-call coverage services, some questions remain unanswered and new questions have been raised. For instance:
To what extent must a hospital be able to document its difficulty in procuring professional ED on-call coverage as well as uncompensated inpatient follow-up care?

To what extent must an ED on-call coverage arrangement require a physician to provide further, uncompensated inpatient follow-up care to patients first attended to in the ED through the patients’ discharge?

How much additional risk of Anti-Kickback Statute liability is present when an ED on-call coverage program does not require physicians to provide any gratis coverage?

What if a hospital offers the same daily rate to all physicians seeking to provide ED on-call coverage, regardless of specialty? If it is advisable to establish a fair market value daily rate for multiple specialties, how many specialties is sufficient?

What would the OIG consider to be payment for “no identifiable services”? Would this encompass daily stipends paid to physicians scheduled to take on-call but who were never called? Would payments to physicians offering secondary or backup on-call coverage be considered excessive? What about payments to physicians scheduled to take call but who do not respond to a call—or do not timely respond?

When the OIG states that a physician must not “receive separate reimbursement from insurers and/or patients for the same services,” does the OIG mean to prohibit a physician from billing and collecting for services rendered to any patient attended to while on call? Certain patients? When paying for on-call coverage services, is a hospital paying the physician (a) to remain available, (b) to render professional services, or (c) both?

What if certain specialty on-call coverage has traditionally been one part of a global arrangement with a physician group practice? Must the hospital now offer other, non-group physicians the opportunity to provide on-call coverage?

Nonetheless, counsel for hospitals and physicians may view the opinion as providing a roadmap to an ED on-call coverage arrangement with minimal risk of Anti-Kickback Statute liability, despite the OIG’s legally questionable and begrudging assertion that “[t]his advisory opinion may not be introduced into evidence in any matter involving an entity or individual that is not a requestor of this opinion.”[29]

Of course, hospitals and physicians must also bear in mind that advisory opinions are legally binding only on the requesting entity, and further that Advisory Opinion 07-10 does not speak to the application of the Stark Law. Therefore, any ED on-call coverage arrangement between a hospital and a physician must satisfy a Stark Law exception for direct compensation arrangements, without regard to OIG Advisory Opinion 07-10.

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[10] Id.
[12] Id. at 3.
[13] Id.
[14] Id. at 4.
[15] Id.
[16] See id. at 6.
[17] See id.
[18] Id.
[19] See id. at 6, 7.
[21] Id.
[22] Id. at 8.
[23] See id.
[26] See id. at 8.
[27] Id. at 9.
[28] Id. at 8, 9.
[29] Id. at 10.