

HEALTH LAW

Update

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On-Call Coverage Payments and OIG Advisory Opinion 09-05: Sometimes Positive Opinions Have Negative Implications

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The Office of Inspector General of the Department of Health and Human Services (OIG) recently issued Advisory Opinion 09-05, in which the OIG declined to impose sanctions for emergency department (ED) on-call compensation arrangements provided to physicians by a non-profit hospital. While as a general rule, advisory opinions in which the OIG declines to impose sanctions are viewed as "positive" opinions for the healthcare industry, sometimes the narrowness of the fact pattern that is the subject of the advisory opinion, or the OIG's commentary on the particular fact pattern, can create negative implications for other common industry arrangements that do not fit the particular fact pattern of the opinion. Advisory Opinion 09-05 presents just such a scenario.

The basic structure of the arrangement in Advisory Opinion 09-05 involved a hospital revising its on-call policy to allow physicians providing on-call coverage to the ED to submit claims to the hospital for services actually provided to indigent and uninsured patients presenting to the ED. The reimbursement was based on a pre-determined fee schedule (uniform across all specialties) and was available only if (a) the patient had no other insurance and eventually qualified for a state program providing payments for uncompensated services to the indigent and uninsured, and (b) the physician on-call provided actual patient care. The hospital submitting the request to the OIG certified that the payments were within fair market value and not related to referrals or business generated between the parties.¹

¹ This arrangement came close to satisfying, but did not meet, the personal services and management contracts safe harbor under the anti-kickback statute. That safe harbor requires that: 1) the agreement be in writing and signed by the parties, 2) it specify all services to be provided, 3) schedule, length and charge for services set in advance, 4) agreement length be at least one year, 5) the aggregate compensation be set in advance, be fair market value in arms length transaction and not take into account the volume or value of any referrals or other business generated between the parties, 6) the arrangement to be lawful, and 7) the aggregate services be reasonably necessary to accomplish the commercially reasonable business purpose for the services. 42 C.F.R. § 1001.952(d). Since the payment structure here was based on the number of patients treated, the aggregate compensation was not set in advance and therefore fell outside of the safe harbor.

The OIG found the proposed arrangement to be at low risk for fraud and abuse for a number of reasons, including those highlighted below. In articulating its reasons, the OIG – intentionally or unintentionally – cast a negative light on other call arrangements common in the industry today:

- One of the foremost reasons cited by the OIG for its decision not to impose sanctions was that the proposed arrangement would only allow payments for tangible services that physicians rendered pursuant to their on-call duties, such as surgical or endoscopy procedures. The language implies that on-call duties, in and of themselves, do not warrant compensation. This implication is reinforced by the fact that the OIG noted that, "unlike some on-call arrangements that pay regardless of actual emergency department calls, the Proposed Arrangement only reimburses physicians for time they actually spend providing services in the Emergency Department." Again, the implication is that merely being on-call is not a tangible service for which physicians can be compensated. This implication has a potentially huge negative effect, since many on-call arrangements in effect today compensate physicians with a per diem or hourly payment for being on-call and ready to come to a hospital's ED to provide needed services.
- Another reason cited by the OIG in declining to impose sanctions was that "physicians will only be able to seek payment for services rendered to uninsured patients [who ultimately qualify for the state-supported uncompensated care program]." While OIG's concern was to "eliminate the risk that a physician could be paid twice for the same service" by collecting under the proposed arrangement and then from a patient's insurer, the OIG's comments again seem to indicate that actual patient care services are the only compensable on-call services and that there are no other on-call duties that are independently compensable.

Perhaps most concerning is the fact that the OIG's commentary in 09-05 is conceptually at odds with a previous Advisory Opinion, 07-10, in which the OIG declined to impose sanctions on a per diem payment for physicians who agreed to "provide ED on-call coverage, respond to patient emergencies in the ED, and provide inpatient care for uninsured patients." This earlier opinion appeared to recognize that on-call coverage is a compensable service separate and distinct from providing actual patient care. In fact, the OIG stated in 07-10: "The per diem rate paid to physicians appears tailored to reflect the burden on a physician **and the likelihood that a physician in a particular specialty will actually be required to respond while on call** ...[emphasis supplied]." Thus, contrary to the implications of 09-05, the OIG recognized in 07-10 that on-call "coverage" is compensable and is not necessarily coincident with providing patient care services to patients as a result of being on call.

Adding to the inconsistency, the OIG declared in 09-05 that the anti-kickback statute "neither compels hospitals to pay for on-call services, nor compels physicians to provide on-call services without compensation." This comment appears to be at odds with other statements made by the OIG in 09-05 and in 07-10.

The on-call compensation model in 09-05 is different than the one in 07-10 and is significantly different from many current compensation systems that pay per day or annually for on-call services. While the OIG's recognition in 09-05 of the challenges that hospitals face trying to provide patient care and meet EMTALA requirements is reassuring, the larger implication from

Advisory Opinion 09-05 regarding the permissible structuring of on-call payment, and that fact that 09-05 is conceptually at odds with an earlier important on-call advisory opinion, may cause many hospitals to revisit compensation structures that they thought were safe from enforcement scrutiny. If you have any questions regarding this Health Law Update, please contact any attorney in our Healthcare Practice Group listed below.

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