# Awaiting Further Guidance from CMS, Hospitals Seeking to Craft On-Call Physician Compensation Policies May Look to OIG Advisory Opinion for Guidance

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In a recent opinion issued by the Health and Human Services (HHS) Office of Inspector General (OIG) on May 14, 2009, Advisory Opinion No. 09-05 [.pdf], the OIG concluded that there are circumstances under which a hospital may compensate physicians for taking on-call coverage in the emergency department without running afoul of the federal Anti-Kickback statute. The OIG's advisory opinion enters a space that has not yet been filled with guidance from the Centers for Medicare & Medicaid Services (CMS). Although OIG Advisory Opinions are written to apply only to the party that requested the opinion, hospitals should be aware of this recent development as it relates to requirements under Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. §1395dd, and its regulations, at 42 C.F.R. 489.24.

**CMS Guidance on On-Call Physician Services Under EMTALA**

Under EMTALA, Medicare-participating hospitals that have an emergency department have certain obligations to any individual who "comes to the emergency department." 42 U.S.C. § 1395dd(a). First, if a "request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening within the capability of the hospital's emergency department . . . to determine whether or not an emergency medical condition. . . exists." Id. Second, "[i]f . . . the hospital determines that the individual has an emergency medical condition, the hospital must provide either-- (A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or (B) for transfer of the individual to another medical facility[.]" Id. at §1395dd(b).

Thus, under EMTALA, the "staff and facilities available" to the hospital are relevant to determining the extent of the hospital's EMTALA obligations. Traditionally, hospitals have expected physicians with admitting privileges at the hospital to accept an obligation to be "on call" to provide care to patients needing treatment in the physician's area of specialty; these on-call physicians are then within the hospital's "staff and facilities." As laid out in statute and CMS regulations, hospitals are required to maintain a list of on-call physicians. 42 U.S.C. § 1395cc(a)(1)(I)(iii) (requiring hospitals "maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition"); 42 C.F.R. 489.20(r)(2).

CMS has issued only limited additional guidance on hospital on-call physician policies in the context of EMTALA. In 2003, CMS issued a Final Rule on EMTALA that included some guidance on on-call. Beyond recognizing the statutory requirement that Medicare-participating hospitals maintain a list of on-call physicians, CMS stated in the 2003 rule that it does not dictate the design of the on-call physician policies. It does not, for example, dictate how many hours physicians must be on-call or whether waivers from performing on-call duties can be granted to senior medical staff. 68 Fed. Reg. 53221, at 53250-51 (Sept. 9, 2003). CMS stated in the Final Rule, rather, that with respect to on-call physicians' services, "we believe that a hospital is responsible for maintaining an on-call list in a manner that best meets the needs of its patients as long as the exemption does not affect patient care adversely. Thus, CMS allows hospitals flexibility in the utilization of their emergency personnel." Id.

In CMS's Proposed Rule on the Hospital Inpatient Prospective Payment Systems for FY2008, CMS went a step further in proposing a way in which hospitals may satisfy their physician on-call list requirement. In the FY2008 Proposed Rule, CMS proposed that hospitals may comply with the on-call list requirement by participating in a formal "community call" plan so long as the plan includes certain elements. 73 Fed. Reg. 23528 at 23671 (Apr. 30, 2008). The formal plan would be required to have the following elements:

- Permits a specific hospital in a region to be designated as the on-call facility for a period of time, or for a specific service, or both.
- Includes a clear delineation of on-call coverage responsibilities;
- Defines the specific geographic area to which the plan applies;
- Is signed by a representative of each hospital participating in the plan;
- Ensures that any EMS system protocol formally includes information on community on-call arrangements;
- Participating hospitals engage in an analysis of the specialty on-call needs of the community for which the plan is effective;
- Plan would include a statement specifying that even if an individual arrives at a hospital that is not designated as the on-call hospital, that hospital still has an EMTALA obligation to provide a medical screening examination and stabilizing treatment within its capability, and hospitals must abide by the EMTALA regulations on appropriate transfers; and
- Participating hospitals conduct an annual reassessment of the plan.

CMS finalized the community on-call provision, as proposed, in its Final Rule issued on August 19, 2008, with only one modification. [1] 73 Fed. Reg. 48434, at 48667 (Aug. 19, 2008).

**May 2009 OIG Advisory Opinion**

After the 2003 EMTALA rule was issued, many hospitals complained to CMS that its statements had made it more difficult to establish an on-call roster. In addition, many physicians used the advent of the 2003 rule to request that hospitals compensate them for agreeing to be on call. Hospitals were skeptical of doing so, however, due to concerns over the

federal anti-kickback and physician self-referral statutes. Given that on-call physicians are clearly in a position to refer patients to the hospital at which they are on call, and given that a compensation arrangement can be a prohibited financial relationship, hospitals were concerned about agreeing to physician requests for compensation.

In May of this year, the HHS OIG issued an Advisory Opinion that analyzed the question of whether the hospital requesting the Advisory Opinion ("Hospital") can pay physicians for their on-call services, according to the Hospital's Proposed Arrangement, or whether such an arrangement would violate the anti-kickback statute, under 42 U.S.C. §§ 1320a-7(b)(7), 1320a-7a(a)(7) and 1320a-7b(b)(1). Under the Hospital's Proposed Arrangement, the Hospital would amend its Hospital By-laws to "allow participating physicians to submit claims to Requestor for payment for services rendered to certain indigent and uninsured patients presenting to the Hospital's Emergency Department." OIG Adv. Op. 09-05, page 3. Specifically, the on-call physicians will be compensated for care of only "Eligible Patients," defined as individuals who (1) have no sponsoring insurance plan (which includes Medicare, Medicaid, Workers Compensation, any private commercial insurance, a hospice program, and/or motor vehicle accident or a home owner's insurance policy (when an event occurs applicable to that policy coverage), and (2) eventually qualify for the State program, as determined independently by the State. Id.

The OIG, acknowledging that hospitals "increasingly are compensating physicians for on-call coverage for hospital emergency rooms," and that "legitimate reasons exist for such arrangements in many circumstances, including compliance with EMTALA obligations; scarcity of certain physicians within a hospital's service areas; or access to sufficient and proximate trauma services for local patients," went on to explain the concerns that are raised by such compensation arrangements. Id., at 7. The OIG's concerns include that there is potential to create "considerable risk that physicians may demand such compensation as a condition of doing business at a hospital, even when neither the services provided nor any external market factor (e.g., a physician shortage) support such compensation" and that the on-call coverage payments "could be misused to entice physicians to join or remain on the hospital's staff or to generate additional business for the hospital." Id. In explaining the key to determining whether such compensation arrangements are permissible, the OIG cited its Supplemental Compliance Program Guidance for Hospitals regarding the need for compensation to reflect fair market value. 70 Fed. Reg. 4858, at 4866 (Jan. 31, 2005). The Advisory Opinion states that

with respect to compensation for on-call coverage, the key inquiry is whether the compensation is: (i) fair market value in an arm's-length transaction for actual and necessary items or services; and (ii) not determined in any manner that takes into account the volume or value of referrals or other business generated between the parties. Adv. Op. 09-05, at 7.

The OIG additionally stated that it "should be possible for parties to structure on-call payment arrangements that are consistent with this standard and therefore pose minimal risk under the statute. . . [and] in many cases, it should be possible to structure on-call coverage compensation to satisfy the personal services safe harbor at 42 C.F.R. §1001.952(d)." Id. at 7-8. That said, the OIG went on to note examples of ways in which payments for on-call coverage could be used improperly,

and stated that any "on-call coverage arrangement must be evaluated under the anti-kickback statute based on the totality of its facts and circumstances." Id.

Upon analyzing the Hospital's Proposed Arrangement for on-call physician compensation under the facts given for this case, the OIG concluded that the Proposed Arrangement would not cause the OIG to impose administrative sections against the Hospital under the anti-kickback statute. The reasons for the OIG to come to this conclusion included: (1) the Hospital's payment amounts are "within the range of fair market value for services rendered, without regard to referrals or other business generated between the parties…;" (2) the Hospital has "a legitimate rationale for revising its on-call coverage policy"; (3) the Proposed Arrangement has features to "further minimize the risk of fraud and abuse"; and (4) the Proposed Arrangement "appears to be an equitable mechanism for the Hospital to compensate physicians who actually provide care that the Hospital must furnish to be eligible for [state program redacted] funding." Id. at 9-10.

**Conclusion**

Since the 2003 Guidance from CMS, hospitals have been seeking ways to meet their EMTALA obligations and design their on-call physician policies in ways that best meet the needs of their patients. The May 2009 OIG Advisory Opinion appears to move a step forward in answering how hospitals may permissibly do this. However, the Advisory Opinion is limited to the facts of its case, which notably includes the fact that the on-call physicians will be compensated for care of only certain indigent and uninsured individuals, as described above. This leaves a major question still unanswered: can hospitals compensate their on-call physicians for services performed for the care of insured patients? In the coming months, CMS or the OIG may have an opportunity to answer this question.

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1. The one modification in the Final Rule was that it deleted the proposed requirement [for the community plan-- that it include:] "Evidence of engagement of the hospitals participating in the community call plan in an analysis of the specialty on-call needs of the community for which the plan is effective." 73 Fed. Reg. 48667 (Aug. 19, 2008).