

**WHY IS IT THAT I CAN GET PAID \$500 AN HOUR FOR MY EXPERT WITNESS FEE
BUT THE HOSPITAL REFUSES TO PAY ME \$500 AN HOUR FOR ER CALL
COVERAGE?**

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A physician's duty to undertake hospital emergency department call and whether or not the hospital is required to pay for such call coverage (and if so, how much) is a complicated and evolving matter with vast ethical, legal and medical implications. Typically, hospitals require physicians within certain specialties to share in some minimal amount of emergency department call coverage in order for the hospitals to meet certain federal and state quality of care requirements (e.g., EMTALA) and therefore mandate that these physicians provide some minimal call coverage in order to obtain and maintain medical staff privileges at the hospitals. However, over the years, in certain geographic areas, there has been a reduction in the willingness of physicians to provide such coverage, in part, due to an increase in the number of uninsured patients receiving their only care in emergency rooms, a shortage of certain specialty physicians, falling reimbursement for certain specialty physician services, and a perceived increase in the risk of lawsuits to the physician if the physician provides such coverage. In August 1992, the Office of Inspector General ("OIG") published a report on Specialty Coverage in Hospital Emergency Departments which found that "sixty-seven percent of hospitals report that they encounter difficulty ensuring coverage for at least one specialty service they offer in their emergency departments." The report also indicated that only about 10% of the hospitals encouraged specialty physicians to provide emergency care by offering them direct compensation for being on the on-call list. At the time, the OIG strongly encouraged physicians, hospital administrators and boards, consumers and advocacy groups, health insurers and government officials to get together and address the issue immediately. Unfortunately, approximately twenty years, we are still faced with the same issues.

When physicians request compensation for providing the additional emergency department call coverage requested by the hospital in order to offset the physicians' aforementioned financial concerns, legal issues arise. Such compensation may run afoul of numerous federal and state laws governing hospital-physician relationships including, but not limited to, the Federal Anti-Kickback Statute ("AKS") and Stark regulations. Moreover, non-profit hospitals also need to be aware of Internal Revenue Service regulations pertaining to private inurement and benefit issues to maintain their nonprofit status. The remainder of this article focuses on how such compensation may run afoul of the Federal Anti-Kickback Statute ("AKS").

The OIG has expressed concern that payments by hospitals for ER call coverage could be easily misused to entice physicians to join or remain on the hospital's staff or to generate additional business for the hospital in violation of the AKS. While the AKS bars the parties from making unlawful kickback payments in any form, it does not compel physicians to provide on-call services for free. As with any compensation relationship

between a hospital and a physician, compensation for ER call coverage must be at fair market value for actual and necessary services rendered based upon an arm's length transaction and cannot take into account, directly or indirectly, the value or volume of any past or future referrals or other business between the parties. On-call compensation will be scrutinized to ensure that it is not a vehicle to disguise improper payments for referrals. Although the OIG does not opine on whether a certain dollar amount is or is not at fair market value per se, it has published two instructive advisory opinions that should guide physicians and hospitals when deciding an appropriate on-call compensation arrangement.

On September 20, 2007, the OIG issued Advisory Opinion 07-10 which provides some guidance as to how to structure such compensation arrangements to avoid AKS violations. Included in the Advisory Opinion were statements by the OIG that warned against on call compensation arrangements: (1) based upon lost opportunity (i.e., payments that do not reflect bona fide/actual lost income to the physician); (2) where physicians are compensated and there are no identifiable services provided; (3) involving aggregate payments that are disproportionately high compared to the physician's regular practice income; and (4) wherein the physician receives separate reimbursement from insurers or patients in addition to the hospital's on call payment resulting in the physician being paid twice for the same services. The OIG approved the per diem payment arrangement to physicians who were willing to: (a) participate in an equal pro-rate share of on-call coverage; (b) provide follow-up in-patient care; (c) timely respond to calls; (d) appropriately document the services provided; (e) participate in quality programs; and (f) provide 1.5 days of uncompensated on-call coverage per month. The per diem rate was based upon (i) the physician's specialty; (ii) the severity of the illness typically seen by that specialty; (iii) the likelihood of having to respond to call or provide follow-up care; and (iv) whether the coverage was on a weekday or weekend (which resulted in a slightly higher fee).

On May 14, 2009, the OIG issued Advisory Opinion 09-05 which provided some additional guidance on how to structure an AKS compliant on-call compensation arrangement. The OIG approved an alleged FMV flat fee-for-service arrangement where, in order to be reimbursed for claims provided to indigent and uninsured patients treated at the hospital's ER, the physicians were required to: (a) participate in an on-call rotation; (b) provide follow-up in-patient care; (c) timely respond to calls; and (d) evaluate the patient in person. The flat fee schedule was determined based upon patient acuity levels, average length of stay, physician time commitment for each kind of service, and consideration of the fees paid by public, private and self payors for such services.

With the increasing desire to have specialists on call at hospitals, there will likely be more guidance issued in the future to address such matters.