New OIG Advisory Opinion on Payment for On-Call Coverage

In September 2007, the OIG issued an advisory opinion approving hospital payments of per diem fees to on-call physicians. Now, five years later, the OIG is re-visiting this issue in Advisory Opinion 12-15, and is scrutinizing these arrangements more closely. The agency gave a “green light” to the arrangement at issue, but demonstrated a great deal of suspicion regarding such payments. Hospitals and physicians should consider this a “yellow light” and proceed with caution.

This most recent advisory opinion concerns a hospital that offers each medical staff member (with limited exceptions) a one-year written contract to serve on its emergency department (“ED”) call coverage panel. In exchange for a per diem fee, the physician agrees to: be available and respond within specified time periods; provide inpatient and follow-up care for any ED patient admitted by the physician, without regard to ability to pay; and complete all related medical records in a timely manner. The physician bills, collects, and retains payment for any professional services rendered while providing call coverage.

The payment rate is set on a specialty-by-specialty basis. For each specialty, the hospital annually determines the total amount available to pay for call coverage based on the estimated number of ED patients who require such specialists’ services. That amount is divided by 365 to determine the specialty’s call coverage per diem fee. The hospital engages an independent consultant to perform a detailed analysis and, based on the consultant’s report, certifies to the OIG that the per diem fees are commercially reasonable and within fair market value for the services provided.

The hospital employs a uniform methodology across all specialties to evenly distribute call coverage among participating physicians and regularly monitors physicians’ adherence to their call coverage responsibilities. As part of the OIG’s request, the hospital presents a detailed justification for the payments, including its exposure to the Emergency Medical Treatment and Labor Act (“EMTALA”) liability due to specialists’ unwillingness to take call coverage absent the compensation
While agreeing it may be necessary in some circumstances to pay for call coverage, the OIG identified “substantial risk that improperly structured payments . . . could be used to disguise unlawful remuneration.” Specifically, the new advisory opinion identifies the following “problematic compensation structures that might disguise kickbacks, [which] could include:

• ‘Lost opportunity’ or similarly designed payments that do not reflect bona fide lost income.
• Payment structures that compensate physicians when no identifiable services are provided.
• Aggregate on-call payments that are disproportionately high compared to the physician’s regular medical practice income.
• Payment structures that compensate the on-call physician for professional services for which he or she receives separate reimbursement from insurers or patients, resulting in the physician essentially being paid twice for the same service.”

The OIG cautioned this list of prohibited arrangements is not exclusive, explaining that “each on-call coverage arrangement must be evaluated under the anti-kickback statute based on the totality of its facts and circumstances.”

The OIG’s analysis of the arrangement presented for review, however, shows that the agency approaches on-call and other hospital-physician compensation arrangements with a guilty-until-proven-innocent viewpoint. In this case, the hospital met its burden of proof by incorporating five safeguards into its arrangement:

• The hospital obtained an independent valuation regarding commercial reasonableness and fair market value of the compensation arrangement, and there was no obvious reason to challenge the validity of that expert opinion.
• The amount of the per diem fees for each specialty was determined in advance and applied equally to all physicians in that specialty.
• Contracting physicians were not otherwise compensated for the services provided, as the payment was not intended to reimburse them for direct patient care services. For example, the hospital specifically cited uncompensated care at approximately 19% of those patients being seen in the ED.
• With certain exceptions, each medical staff member was eligible to receive the per diem payment, provided he or she signed the standard agreement.
• The hospital absorbed all costs associated with the per diem payments and none accrued to federal health care programs.

Absent any of these safeguards, it is likely the OIG would have expressed greater concerns with the agreement. Hospitals and physicians, therefore, should build similar safeguards into their compensation arrangements.

Consistent with prior advisory opinions, the OIG once again emphasizes the critical importance of independent review and analysis to validate the terms of any financial arrangement between a hospital and members of its medical staff. The agency’s use of the terms “substantial risk,” “disguise[d] unlawful remuneration,” and “misused to entice physicians” demonstrates the significant compliance risks embedded within these agreements from the OIG’s perspective, and the value of seeking the objectivity and expertise of qualified independent review.

Your organization’s exposure to fraud and abuse risk is best managed through fair market value analysis and commercial reasonableness review. The skilled and experienced PYA valuation team can help your organization manage this risk.

For more information, please contact the experts listed below (800) 270-9629.