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Paying for Call Coverage

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Hospitals increasingly pay physicians and other practitioners to participate in call coverage for emergency services. Last week, the Office of Inspector General ("OIG") issued Advisory Opinion No. 12-15, which reminds providers of fraud and abuse parameters applicable to call coverage agreements.

Permissible Arrangements. Federal law does not require compensation for call coverage, nor does it prohibit paying for call so long as the compensation is not offered to improperly induce referrals for federal healthcare program business. The OIG recognizes that paying for call may be necessary to obtain services that may otherwise be unavailable because of, *e.g.*, the lack of specialty services in an area or local physicians' reluctance to take call because of practice demands, time commitments, or the probability of rendering uncompensated care. The key is to ensure that any call compensation paid (1) represents fair market value for actual and necessary services, (2) does not take into account the volume or value of referrals or other business generated between the parties, and (3) was not intended to maintain or generate future referrals from the physician for non-emergency patients. Common payment structures include hourly or "per diem" payments to be available for call, payment for time or services actually provided in response to call in exchange for assignment of the physician's professional fees, *etc.*

Problematic Arrangements. Call compensation that exceeds fair market value or pays physicians for unnecessary or illusory services may amount to illegal kickbacks and/or Stark law violations. According to the OIG, suspect arrangements include:

- "lost opportunity" or similarly designed payments that do not reflect bona fide lost income;
- payment structures that compensate physicians even though 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 physicians for professional services for which the physician receives separate payments from patients or third party payors, thereby resulting in duplicate payment for the same services; or
- payments made in response to threats that the physician will refuse to continue to use the hospital or refer non-emergency patients to the hospital unless call payments are provided.

Regulatory Compliance. Whatever its terms, the arrangement must be structured to satisfy Stark and Anti-Kickback Statute ("AKS") technical requirements. For example, if the compensation is to be paid to a

physician who is not employed by the hospital, the arrangement must satisfy the following:

- The agreement must be documented in a written contract fully executed by the parties before any payments are made.
- The compensation must represent fair market value for legitimate, needed services actually provided, and not offered to maintain, induce or reward the physician's referrals to the hospital.
- The compensation must not vary with the volume or value of referrals or other business generated by the physician except for services personally performed by the physician.
- The compensation formula must be set in advance and be objectively verifiable.
- Compensation-related terms may not change during the first year of the arrangement. If the agreement is terminated within a year, the parties may not enter a new agreement with different compensation terms within that year.
- To avoid unintentional lapses, it is usually wise to include an auto-renewal or "evergreen" clause so that the agreement automatically renews unless terminated by the parties.

(*See* 42 C.F.R. §§ 411.357(d) and (l), and 1001.952(d)). Most call coverage arrangements will not satisfy an applicable AKS safe harbor because, e.g., the aggregate compensation is not set in advance. It is important that the parties consider and document the legitimate reasons for the call coverage arrangement, e.g., the hospital's need for the contracted services, the financial or professional burden on physicians absent call compensation, and the physician's reluctance to provide needed coverage absent call compensation that reflects fair market value for services actually provided.

For questions regarding this update, please contact
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