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Regulatory and Operational Hot Button Issues

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I. Physician On-Call Panels.

A. Background. Hospitals require physician coverage to assist with the needs of patients presenting at their facilities. While traditionally physicians provided coverage as part of their routine support for hospital activities, patients and physician colleagues, hospitals are now frequently required to contract for physician availability.

B. EMTALA. The Emergency Medical Treatment and Active Labor Act (EMTALA)[1] requires a hospital to provide a medical screening examination to determine whether a patient has an emergency medical condition and, if so, to provide stabilizing treatment within its capabilities and capacities or to transfer the patient in an appropriate manner. While EMTALA does not expressly require particular staffing or on-call coverage for an emergency department, Interpretive Guidance[2] generally imposes a requirement that the hospital make available any specialty service that it offers through the on-call physicians. Coverage is not required 24-hours-a-day; CMS considers all relevant factors in determining whether a hospital's call program complies with EMTALA.

C. In addition to EMTALA compliance, hospitals struggle to adequately serve in-patient consultation needs for efficient patient care, potentially delaying necessary services and extending length of stay.

D. Regulatory Framework.

1. Stark Law[3]. The Stark Law generally prohibits referral of Medicare patients for designated health services if the referring physician has a financial relationship with the provider of services, unless the relationship falls within a statutory or regulatory exception. On-call arrangements most commonly qualify as personal services excepted from the Stark Law. To fall within the exception, the arrangement must meet the following requirements: (i) the arrangement is set out in writing, is signed by the parties, and specifies the services covered by the arrangement; (ii) the arrangement covers all of the services to be furnished by the physician (or an immediate family member of the physician) to the entity; (iii) the aggregate services contracted for do not exceed those that are reasonable and

[1] 42 USC 1395dd et seq.
[2] "Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases" dated 5-98
[3] 42 U.S.C. § 1395nn

necessary for the legitimate business purposes of the arrangement; (iv) the term of the arrangement is for at least 1 year; (v) the compensation to be paid over the term of the arrangement is set in advance, does not exceed fair market value, and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties; and (vi) the services to be furnished under the arrangement do not involve the counseling or promotion of a business arrangement or other activity that violates any state or federal law.[4]

2. Anti-Kickback Statute[5]. The Anti-Kickback Statute imposes criminal penalties for the solicitation, offer, payment or receipt of remuneration intended to induce the referral of business compensable by Medicare or Medicaid. On-call arrangement commonly do not meet the requirements of the personal services arrangements safe harbor regulation due to the failure to state aggregate compensation payable over the term of the arrangement in advance. The personal services and management contracts safe harbor provides protection for personal services contracts if all of the following seven standards are met: (i) the agreement is set out in writing and signed by the parties; (ii) the agreement covers and specifies all of the services to be provided; (iii) if the services are to be performed on a periodic, sporadic, or part-time basis, the agreement exactly specifies the schedule, length, and charge for the performance intervals; (iv) the agreement is for not less than one year; (v) the aggregate amount of compensation is set in advance, is consistent with fair market value in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made by Medicare, Medicaid, or other Federal health care programs; (vi) the services performed under the agreement do not involve the counseling or promotion of a business arrangement or other activity that violates any Federal or State law; and (vii) the aggregate services contracted for do not exceed those which are reasonably necessary to accomplish the commercially reasonable business purpose of the services.[6]

3. Advisory Opinions. The OIG has issued 3 advisory opinions related to physician on-call arrangements with hospitals.

   a. Advisory Opinion 07-10. This opinion favorably considered an on-call system established by a nonprofit medical center in collaboration with an ad hoc committee of its medical staff in response to a shortage of on-call coverage. Due to an uninsured care ratio of 1 in 4 patients presenting at the Emergency Department, malpractice coverage costs and other factors, physicians had declined to provide coverage for the Department and for inpatient follow-up consultations. Physicians were offered contracts for participation in the call rotation, along with requirements to cooperate with

[4] 42 C.F.R. § 411.357(d)
[5] 42 USC . § 1320a-7b.

[6] 42 CFT 1001.952(d)

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