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Structuring Call Coverage Agreements: Key Considerations and Provisions

Employee vs. Independent Contractor, Stark and AKS, Compensation Structures, and More

THURSDAY, SEPTEMBER 6, 2018

1pm Eastern | 12pm Central | 11am Mountain | 10am Pacific

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Structuring Call Coverage Agreements: Key Considerations and Provisions

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OVERVIEW

KIM STANGER

- Statutes, regulations and other laws
  - EMTALA
  - Employment classification
  - Fraud and abuse laws
  - 501(c)(3)
  - State laws
  - Telehealth

BOB WADE

- Structuring call coverage agreements
  - Restricted v. unrestricted call
  - Compensation methodologies and considerations
  - Commercial reasonableness
  - Documentation
  - Key terms

WRITTEN MATERIALS

- .Ppt slides
- EMTALA Interpretive Guidelines
- OIG Advisory Opinions
  - 12-15
  - 09-05
  - 07-10

LAWS GOVERNING CALL COVERAGE ARRANGEMENTS

EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT ("EMTALA")

- Hospital that participates in Medicare and has a dedicated emergency department must:
  - Provide appropriate medical screening examination.
  - If the patient has an emergency medical condition, the hospital must provide either stabilizing treatment or an appropriate transfer.
- Hospital with specialized capabilities must accept transfers.
- Hospitals may not delay exam or treatment to inquire about payment.
- Hospitals must maintain required signage and documentation, including on-call list.

(42 USC 1395dd; 42 CFR 489.24)

EMTALA PENALTIES

- Termination of Medicare provider agreement and exclusion from Medicare.
- Civil penalties
  - Hospitals:
    - Less than 100 beds: $25,000 per violation
    - 100+ beds: $50,000 per violation
  - Physicians: $50,000 per violation.
- Hospitals may be sued for damages.
  - Individuals who suffer personal harm.
  - Medical facilities that suffer financial loss.

(42 USC 1395dd(d); 42 CFR 1003.103(e))

EMTALA:
CONDITIONS OF PARTICIPATION

- Hospital must maintain "[a]n on-call list of physicians who are on the hospital's medical staff or who have privileges at the hospital, or who are on the staff or have privileges at another hospital participating in a formal community call plan … available to provide treatment necessary after the initial examination to stabilize individuals with emergency medical conditions who are receiving services required under §489.24 in accordance with the resources available to the hospital…"

(42 CFR 489.20(r))

- "[T]he on-call list requirement applies not only to hospitals with dedicated emergency departments, but also to hospitals subject to EMTALA requirements to accept appropriate transfers."

(State Operations Manual Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases (Rev. 60, 07-16-10) ("EMTALA Interpretive Guidelines")

EMTALA:
CONDITIONS OF PARTICIPATION

- Adequacy of call coverage
  - "Hospital administrators and the physicians who provide the on-call services have flexibility regarding how to configure an on-call coverage system…. It is crucial, however, that hospitals are aware of their responsibility to ensure that they are providing sufficient on-call services to meet the needs of their community in accordance with the resources they have available. CMS expects a hospital to strive to provide adequate specialty on-call coverage consistent with the services provided at the hospital and the resources the hospital has available. (73 FR 48662)."

(EMTALA Interpretive Guidelines)

EMTALA:
CONDITIONS OF PARTICIPATION

- Adequacy of call coverage
  - "CMS does not have specified requirements regarding how frequently on-call physicians are expected to be available to provide on-call coverage…."
  - "[I]n determining a hospital's on-call list compliance, CMS will consider all relevant factors in a case-specific manner, including the number of physicians on the medical staff/holding hospital privileges, other demands on these physicians, the frequency with which individuals with EMCs typically require the stabilizing services of the hospital's on-call physicians, and the provisions the hospital has made for situations in which a physician on-call is not available or is unable to respond due to circumstances beyond his/her control."

(EMTALA Interpretive Guidelines)

EMTALA:
CONDITIONS OF PARTICIPATION

- Availability of on-call physicians

  "[A] hospital must have written policies and procedures in place–

  (1) To respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control;

  (2) To provide that emergency services are available to meet the needs of individuals with emergency medical conditions if a hospital elects to

  (i) Permit on-call physicians to schedule elective surgery during the time they are on call

  (ii) Permit on-call physicians to have simultaneous on-call duties;

  (iii) Participate in a formal community call plan. Notwithstanding participation in a community call plan, hospitals are still required to perform medical screening examinations on individuals who present seeking treatment and to conduct appropriate transfers.

(42 CFR 489.24(j))

EMTALA:
CONDITIONS OF PARTICIPATION

- Hospital may, but is not required to:
  - Participate in a community call plan.
    - Subject to certain requirements
  - Allow simultaneous call coverage at other hospitals.
    - Must have policies/backup plan to address unavailability.
  - Allow elective surgery while physician is on-call
    - Must have policies/backup plans to address unavailability.
  - Not require call coverage for all physicians; may exempt certain physicians.
    - Beware selective call and adequacy of call coverage list.

(EMTALA Interpretive Guidelines)

EMTALA:
CONDITIONS OF PARTICIPATION

- Responding to call
  - Hospital and physician may be subject to penalties if the on-call physician fails to respond to call.
  - "A hospital must have written on-call policies and procedures and must clearly define the responsibilities of the on-call physician to respond, examine and treat patients with an EMC."
  - "[A] hospital would be well-advised to establish in its on-call policies and procedures specific guidelines-- e.g., the maximum number of minutes that may elapse between receipt of a request and the physician's appearance for what constitutes a reasonable response time, and to make sure that its on-call physicians and other staff are aware of these time-sensitive requirements."

(EMTALA Interpretive Guidelines)

SECURING ON-CALL COVERAGE

MEDICAL STAFF BYLAWS

- May require participation in call coverage.
  - May differ by specialty
  - Shared on equitable basis
  - Subject to waivers
- May require some level of follow-up care.
- Medical staff members subject to corrective action if fail to comply.

CALL COVERAGE CONTRACTS

- Employment contracts
- Independent contractor arrangements
  - Individuals
  - Groups
  - Facilities
  - Telemedicine

EMPLOYEES V. INDEPENDENT CONTRACTORS

EMPLOYMENT

- Right of control
- Employer must withhold taxes
- Employer vicariously liable
- Employment laws apply, e.g., discrimination, wage/hour , etc.

INDEPENDENT CONTRACTOR

- No right of control
  - See IRS 20 factor test
- Employer does not withhold taxes; contractor must pay
  - Unless IRS disagrees with classification

Employer not vicariously liable

  - Beware actual or apparent agency

- Not subject to employment laws

HTTPS://WWW.IRS.GOV/BUSINESSES/SMALL-BUSINESSES-SELF-EMPLOYED/INDEPENDENT-CONTRACTOR-SELF-EMPLOYED-OR-EMPLOYEE

Corporations
Partnerships
International Businesses
Small Businesses & Self-Employed

Small Business/Self-Employed Topics
- A-Z Index for Business
- EINs
- Forms & Pubs
- Industries/Professions
- Online Learning
- Operating a Business
- Self-Employed
- Starting a Business

Independent Contractor (Self-Employed) or Employee?

Español | 中文 | 한국어 | TiếngViệt | Русский

It is critical that business owners correctly determine whether the individuals providing services are employees or independent contractors.

Generally, you must withhold income taxes, withhold and pay Social Security and Medicare taxes, and pay unemployment tax on wages paid to an employee. You do not generally have to withhold or pay any taxes on payments to independent contractors.

Select the Scenario that Applies to You:

- **I am an independent contractor or in business for myself**
  If you are a business owner or contractor who provides services to other businesses, then you are generally considered self-employed. For more information on your tax obligations if you are self-employed (an independent contractor), see our Self-Employed Tax Center.
- **I hire or contract with individuals to provide services to my business**
  If you are a business owner hiring or contracting with other individuals to provide services, you must determine whether the individuals providing services are employees or independent contractors. Follow the rest of this page to find out more about this topic and what your responsibilities are.

Related Topics
- Businesses with Employees
- Hiring Employees
- Know Who You're Hiring - Independent Contractor (Self-employed) vs. Employee

Forms & Instructions
- Form SS-8, Determination of Worker Status for Purposes of Federal Employment Taxes and Income Tax Withholding

IRS FACTORS FOR DETERMINING EMPLOYEE V. CONTRACTOR

- **Behavioral**
  - Type and degree of instruction given
  - Evaluate how work performed or just end result
  - Instruction as to how work is performed
- **Financial**
  - Wage/salary or payment of flat fee for job
  - Investment in equipment used
  - Unreimbursed expenses
  - Opportunity for profit or loss
  - Worker may perform services elsewhere in the market
- **Type of Relationship**
  - Terms of written contract
  - Payment of employee benefits
  - Services provided as key activity of the business
  - Permanency of relationship

Right of Control

ANTI-KICKBACK STATUTE

- Cannot knowingly and willfully offer, pay, solicit or receive remuneration to induce referrals for items or services covered by government program unless transaction fits within a regulatory safe harbor.

(42 USC 1320a-7b(b))

- "One purpose test"
  - Anti-Kickback Statute applies if <u>one</u> purpose of the remuneration is to induce referrals. (*U.S. v.Greber*, 760 F.2d 68 (3d Cir. 1985)).
  - Difficult to disprove.
- Ignorance of the law is no excuse.

ANTI-KICKBACK STATUTE PENALTIES

- Penalties
  - 5 years in prison
  - $25,000 criminal fine
  - $50,000 penalty
  - 3x damages
  - Exclusion from Medicare/Medicaid

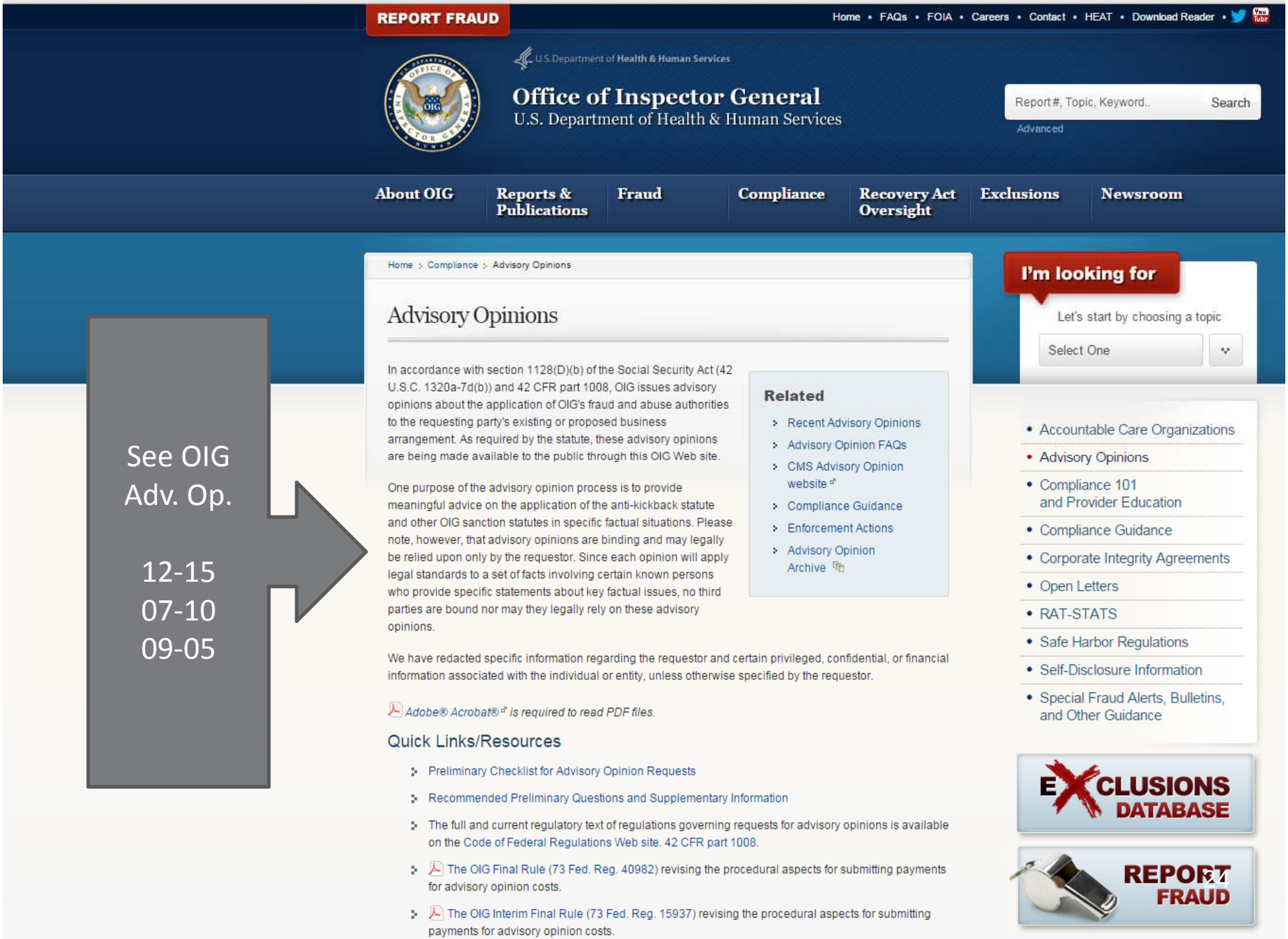
(42 USC 1320a-7b(b); 42 CFR 1003.102)

- Anti-Kickback violation = False Claims Act violation
  - Lower standard of proof
  - Subject to False Claims Act penalties
  - Subject to qui tam suit.

(42 USC 1320a-7a(a)(7))

- OIG Self-Disclosure Protocol: minimum $50,000 settlement.

https://oig.hhs.gov/compliance/advisory-opinions/index.asp



See OIG Adv. Op.

12-15
07-10
09-05

ETHICS IN PATIENT REFERRALS ACT ("STARK")

- If a physician (or their family member) has a financial relationship with an entity:
  - The physician may not refer patients to that entity for designated health services, and
  - The entity may not bill Medicare or Medicaid for such designated health services ("DHS")

  unless arrangement structured to fit within a regulatory exception.

(42 CFR 411.353)

STARK PENALTIES

- No payment for services provided per improper referral.
- Repayment of payments improperly received within 60 days.
- Civil penalties.
  - $15,000 per claim submitted
  - $100,000 per scheme

(42 CFR 411.353, 1001.102(a)(5), and 1001.103(b))

- Stark violation may also =
  - False Claims Act violation
    - Repayment
    - Penalties
    - Qui tam lawsuit
    - Exclusion from Medicare/Medicaid
  - Anti-Kickback Statute violation
    - Felony
    - Penalties
    - Exclusion from Medicare/Medicaid

STARK:
"UNDER ARRANGEMENT" PROBLEMS

- Stark applies to referrals to both:
  - Entity that bills for the service (e.g., hospital)
    - Use employment, personal services, or fair market value safe harbors.
  - Entity that performs the service (e.g., group providing call coverage)
    - Typical group safe harbors don't apply.
    - Rural provider exception may apply.
      - May limit on-call physician's ability to refer services performed at hospital to other group practice members.

(See 42 CFR 411.351 and 411.353)

STARK AND AKS:
EMPLOYMENT SAFE HARBORS

Stark (Physicians)

- Compensation must be:
  - Consistent with fair market value ("FMV") of services.
  - Does not take into account the volume or value of referrals for DHS
    - Does not apply to services personally performed by referring physician.
  - Commercially reasonable even if no referrals made.

(42 CFR 411.357(c))

Anti-Kickback

- Compensation paid to bona fide employees for furnishing items or services payable by Medicare/Medicaid.

(42 CFR 1001.952(i))

- Safe harbor may not apply to excess payments for referrals instead of "furnishing items or services". (OIG Letter dated 12/22/92 fn.2)

STARK AND AKS: EMPLOYMENT SAFE HARBORS

Stark (Physicians)

Writing specifies compensation.

Compensation formula is:

- Set in advance.
- Consistent with FMV.
- Does not take into account the volume or value of services or other business generated by the physician.

Arrangement is commercially reasonable and furthers legitimate business purpose.

Compensation may not be changed within 1 year.

(42 CFR 411.357(d) or (l))

Anti-Kickback

Writing signed by parties.

Aggregate compensation is:

- Set in advance.
- Consistent with FMV.
- Does not take into account the volume or value of referrals for federal program business.

Aggregate services do not exceed reasonably necessary to accomplish commercially reasonable business purpose.

(42 CFR 1001.952(d))

STARK AND AKS: INDIRECT COMPENSATION ARRANGEMENTS

STARK (PHYSICIANS)

- Indirect compensation arrangement
  - Written agreement
  - FMV
  - Not based on referrals
  - Does not violate AKS

(42 CFR 411.357(p)

- Stark definition for indirect compensation arrangements
  - Closest compensation arrangement does not vary with referrals

(42 CFR 411.354(c)(2))

ANTI-KICKBACK STATUTE

- No similar safe harbor

Remember:
Physician "stands in the shoes" of his physician group. (See 42 CFR 411.354(c)(3))

STARK AND AKS: OB MALPRACTICE SUBSIDY

STARK (PHYSICIANS)

- Physician's practice located in rural area, HPSA, or demonstrated need per advisory opinion
- 75% of physician's OB patients reside in MUA or are MUP.
- Written agreement.
- Not conditioned on referrals.
- Compensation not based on referrals.
- Physician allowed to establish privileges elsewhere.
- Payment to insurer.
- Physician does not discriminate against federal program patients.
- Does not violate AKS.

(42 CFR 411.357(r))

ANTI-KICKBACK STATUTE

- OB practice in HPSA.
- Written agreement.
- At least 75% of provider's OB patients are in HPSA, MUA, or part of MUP.
- Not conditioned on referrals.
- Provider allowed to establish privileges elsewhere.
- Compensation not based on referrals.
- Provider does not discriminate against federal program patients.
- Bona fide malpractice policy.

(42 CFR 1001.952(o))

STARK:
REQUIRING REFERRALS

Under Stark, may condition compensation on referrals to provider if:

- *Bona fide* employment or personal services arrangement;
- Compensation is set in advance for term of arrangement;
- Referral requirement is set out in writing and signed by parties;
- Referral requirement does not apply if:
  - Patient prefers another provider,
  - Insurer determines provider, or
  - Physician believes referral is not in patient's best medical interest;
- Required referrals relate solely to physician's services covered by scope of employment or personal services arrangement; and
- Referral requirement reasonably necessary to effectuate legitimate business purpose of the compensation arrangement.

(42 CFR 411.354(d)(4))

CIVIL MONETARY PENALTIES LAW

Prohibits certain specified conduct, e.g.:

- Submitting false or fraudulent claims, misrepresenting facts relevant to services, or engaging in other fraudulent practices.
- Violating Anti-Kickback Statute or Stark law.
- Violating EMTALA.
- Failing to report and repay an overpayment.
- Failing to grant timely access.
- Misusing “HHS”, “CMS”, “Medicare”, “Medicaid”, etc.
- Failing to report adverse action against providers.
- Offering inducements to program beneficiaries.
- Offering inducements to physicians to limit medically necessary services.
- Submitting claims for services ordered by, or contracting with, an excluded entity.

(42 USC 1320a-7a; 42 CFR 1003.200-1100)

PAYMENT TO LIMIT SERVICES

- Hospital or CAH cannot knowingly make a payment, directly or indirectly, to a physician as an inducement to reduce or limit medically necessary services provided to Medicare or Medicaid beneficiaries who are under the direct care of the physician.
  - May include many "gainsharing" programs.
  - MACRA amendments ease the prohibition.
- Penalties:
  - $2000 for each individual with respect to whom payment made.
  - Any other penalty allowed by law.

(42 USC 1320a-7a(b)(1), as amended by MACRA; 81 FR 88370)

501(C)(3) TAX EXEMPT STATUS: PRIVATE BENEFIT/INUREMENT

- To qualify for tax exemption, no part of an organization's net earnings shall inure in whole or part to the benefit of private individuals.
  - Applies to "insiders", i.e., those with power exercise control or influence over the organization.
  - May extend to physicians employed by organization.
- Penalties
  - Loss of tax exempt status
  - Intermediate sanctions, including managers who participate in excess benefit transaction.
    - 10% of the excess benefit
    - $10,000 per transaction

MEDICARE REIMBURSEMENT

- Critical access hospitals may not claim per diem call coverage reimbursement on cost report if provider is allowed to take call at other facilities or perform elective procedures while on call.

(See Provider Reimbursement Manual § 2109)

- "Critical Access Hospitals (CAHs) should be aware that if they reimburse physicians for being on-call, there are Medicare payment policy regulations, outside the scope of EMTALA requirements, that the CAH might want to consider before making a decision to permit on-call physicians to schedule elective procedures."

(EMTALA Interpretive Guidelines)

STATE LAW ISSUES

- Self-referral laws ("mini-Stark")
- Anti-kickback statutes
- Corporate practice of medicine
  - Limits employment of physicians by corporation
- Hospital licensing statutes
  - Call coverage requirements
  - Credentialing
- Scope of provider-patient relationship
  - Extending relationship beyond call coverage
- Ostensible or apparent authority
  - Extending hospital liability for acts of contractors
- Malpractice standard of care
- Others?

TELEHEALTH COVERAGE ARRANGEMENTS

- Licensure
  - Generally must be licensed in state where patient receives treatment.
- State telehealth laws
  - Limits on remote prescribing
  - Standard of care
  - Consent
  - Documentation
- Credentialing
  - CMS allows credentialing by proxy if conditions limited.
  - Does not apply if provider renders services in person.
- Privacy and security
- Reimbursement

ON-CALL COMPENSATION ARRANGEMENT DEFINED

When commercially reasonable factors exist to compensate a physician to provide either restricted or unrestricted call coverage, fair market value (FMV) compensation paid to a physician to be immediately available by phone or pager for consultation or to personally come to the hospital to treat a patient at the request of the hospital

The FMV compensation is paid for the hospital's access to the physician requiring the physician to remain in close proximity to the hospital and be physically and mentally capable of providing direct patient care (including refraining from drinking alcohol or taking any medication that would inhibit the physician's ability to treat patients)

MARKET TRENDS

Approximately 60% of health care organizations provide call pay to at least some physicians[1]

- Trend is increasing utilization of call coverage compensation

[1] Data abstracted from SullivanCotter's *2016 Physician Compensation and Productivity Survey*

MARKET TRENDS

- Call coverage is either restricted or unrestricted:
  - Restricted call coverage means that the physician is required to remain on the premises
  - Unrestricted call coverage means that the physician is not required to remain on the premises but must be on-site within a specified time frame (typically 30 minutes)
    - Most physicians provide unrestricted call coverage
    - Specialties that compensation for restricted call coverage include:
      - Anesthesia
      - Critical Care/Intensivist
      - OB/GYN
      - Trauma Surgery

The rates paid for restricted call are higher than the rates paid for unrestricted call

MARKET TRENDS

For restricted call, can an entity pay the clinical hourly rate as opposed to benchmarked restricted call hourly rate?

MARKET TRENDS

- There are two types of call coverage:
  - General emergency department call coverage (most common)
  - Trauma call coverage

	Neurosurgery *		
Type of Call	25th Percentile	50th Percentile	75th Percentile
General ED	$ 33.33	$ 59.54	$ 100.00
Trauma Call	$ 41.67	$ 75.00	$ 116.67
Level I Trauma Center	$ 52.59	$ 75.00	$ 129.17

Trauma call rates are typically higher than the rates paid for general emergency department call

* Examples

MARKET TRENDS

- **Telephonic call coverage is an emerging practice**:
  - The physician providing telephonic call is not required to come on-site when called; but must be available by cell for telephone consultation
- **Compensation for call coverage is paid as**:
  - Stipend or hourly rate for coverage
    - For example: $1,000 per day for 24 hours of coverage
- **Compensation for actual services provided when called in**
  - For example:
    - $150 per hour for actual services provided
    - Guarantee of 100% of the Medicare rate for services provided
    - $45.00 per wRVU
- **Compensation for both call coverage and services provided when called in**

Each of these has different implications when determining if the compensation is within FMV

MARKET TRENDS

About one-quarter of organizations provide compensation for *excess call* only

- **Medical Specialties** are required to be on-call **more than 1:4**, on average, *or* provide an average of seven **shifts of call coverage per month** before receiving on-call pay
- **Surgical Specialties** are required to be on-call **more than 1:5,** on average, *or* provide an average of six **shifts of call coverage per month** before receiving on-call pay
- Physician Extenders provide call coverage.

KEY ON-CALL COMPLIANCE ISSUES

Is compensating for call coverage commercially reasonable?

- Factors to consider include:
  - History of on-call services without compensation
  - Frequency of call
  - Number of physicians participating in call rotation
  - Refusal of physicians to provide uncompensated call
  - Competing hospitals providing call compensation
  - Compensating targeted specialties (i.e., trauma) vs. compensating all specialties

KEY ON-CALL COMPLIANCE ISSUES

Documentation supporting on-call services:

- Medical staff call schedule
- Documentation that physician responded when called by the hospital
- Physician certification of call services

Physician providing call services at multiple unrelated hospitals:

- Backup plan implemented when physician providing direct care services at one hospital, but called by second hospital
- Impact on FMV compensation – cannot receive 2x fair market value for covering multiple facitilities
- Possible certification by physician in contract that compensation for call services is not being paid by multiple hospitals

What if multiple hospitals are related?

KEY ON-CALL COMPLIANCE ISSUES

The issue of providing coverage for multiple related sites is becoming more common

- Will likely continue to increase due to merger and acquisition trends

One approach that organizations have taken to address call coverage at multiple related sites is to provide on-call pay using tiered rates. For example:

- 100% call pay rate at Hospital 1
- 50% call pay rate at Hospital 2
- 25% call pay rate at Hospital 3
  - Such arrangements require that the hospitals are within the same vicinity
  - May require back up call, depending on the specialty and the likelihood of being called in

KEY ON-CALL COMPLIANCE ISSUES

When to compensate employed physicians?

- Everyday?
- Only when employee provides a disproportionate amount of call (excess call)?
  - More than six days per month for surgical specialties
  - More than seven days per month for medical specialties
  - Variance related to likelihood of being called in
- May have FMV issues is the physicians are on a productivity-based pay plan. For example, if the physician has a
  - Higher on-call pay rate (e.g, at or above the 75th percentile) and
  - Receives wRVUs allocated to a production-based pay plan for services provided when called in
  - Could result in overpayment for the total services provided

KEY ON-CALL COMPLIANCE ISSUES

How to determine FMV compensation:

- Benchmark resources (i.e., Sullivan Cotter, Medical Group Management Association)
- Market influences
- Factors to consider when applying compensation benchmark range (25^{th}, 50^{th}, 75^{th}, 90^{th} percentiles)
  - Need
  - Availability
  - Physician's Expertise
  - Supply vs. Demand
- Available alternatives
  - Locum tenens?
  - Diversion?

KEY ON-CALL COMPLIANCE ISSUES

Selection of physician/group to compensate for call coverage:

- High referral sources
- Every physician in specialty
- Rotate by individual physicians versus physician groups

Who retains reimbursement for personally performed services when physician is paid to be on-call?

- On-call physician?
- Hospital?
- Can hospital guarantee a minimum amount of reimbursement when called in?

KEY ON-CALL COMPLIANCE ISSUES

On-call compensation is a "financial arrangement" under Stark Law; therefore, an applicable exception must be met. Available exceptions:

- Personal service arrangement
- FMV
- Employment

Unless physician is an employee, the arrangement must be in writing and signed by the parties for a term of at least one year

KEY ON-CALL COMPLIANCE ISSUES

Anti-Kickback Statute could be implicated through compensated call arrangement

- No intent to induce referrals
- No intent to reward physician/group through compensated call arrangement

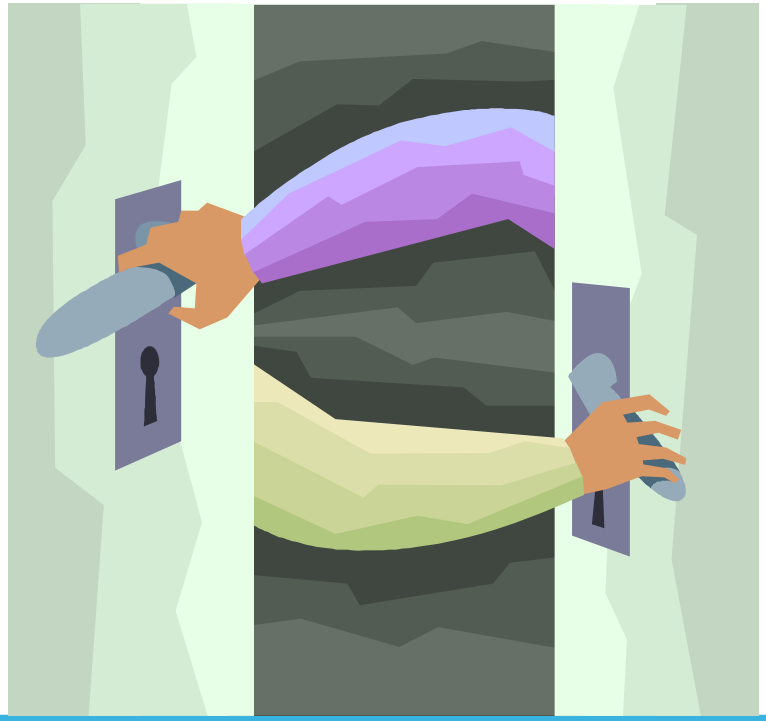
Physician must respond consistent with the contract and the medical staff bylaws/rules and regulations

- EMTALA is implicated
- Physician at the hospital makes determination whether on-call physician is required to come to the hospital for specialty service

Ensure all physicians providing call coverage are appropriately licensed and credentialed

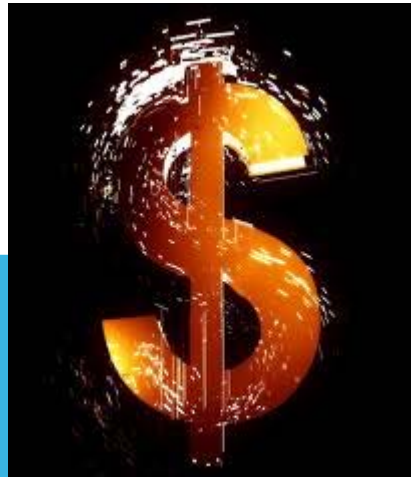
WHAT IS FMV?

According to the Stark Law, FMV is “the value in arm’s length transactions, consistent with the general market value”



WHAT IS FMV?

"**General Market Value**" means the price that an ***asset*** would bring as a result of *bona fide* bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party, or the ***compensation*** that would be included in a service agreement as a result of *bona fide* bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party, on the date of acquisition of the asset or at the same time of the service agreement. **42 C.F.R. § 411.351**



WHAT IS FMV?

An FMV safe harbor for *hourly rates* was developed under Stark in the Phase II regulations.

- Safe harbor deleted in Phase III regulation; however, OIG stated that safe harbor methodology is still prudent documentation process.

FMV SAFE HARBOR DELETED

An *hourly rate* is deemed to be FMV if it meets on of the following two tests:

- Hourly rate is less than or equal to the average hourly rate for emergency room physician services in the market provided there are at least three hospitals providing emergency room services in the market
- Phase II Stark Law Analysis: Hourly rate is determined by averaging the 50th percentile national compensation level with the same physician specialty in at least four of the following surveys, and dividing by 2000 annual hours:
  - **Sullivan, Cotter and Associates, Inc.:** *Physician Compensation and Productivity Survey Report*
  - **Hay Group:** *Physician's Compensation Survey*
  - **Hospital and Health Care Compensation Services:** *Physician Salary Survey Report*
  - **Medical Group Management Association (MGMA):** *Physician Compensation and Production Survey*
  - **ECS Watson Wyatt:** *Hospital and Health Care Compensation Report*
  - **William M. Mercer:** *Integrated Health Networks Compensation Survey*

GOVERNMENT OVERSIGHT

Cases: None.

- Why?
  - New phenomena
  - FMV hard to litigate

There are two helpful OIG Advisory Opinions regarding physician on-call pay arrangements

- Can be used to help guide determination of FMV

OIG ADVISORY OPINIONS

OIG ADVISORY OPINION 07-10 (SEPTEMBER 20, 2007)

- Medical center intended to pay certain physician specialties a per diem rate for each day spent on-call for the ED; arrangement required physicians to participate in a call rotation schedule, respond to calls in a timely fashion, and provide inpatient care to any patient seen in the ED while on-call
- OIG issued ***examples of problematic compensation*** for on-call pay arrangements which included:
  - "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 relative to the physician's regular 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"

OIG ADVISORY OPINIONS

OIG ADVISORY OPINION 09-05 (MAY 14, 2009)

- Hospital proposed to pay physicians a uniform fee schedule related to ER consultations ($100); ER admissions ($300) and ER surgical procedures ($350); arrangement required physicians to waive all rights to bill any other insurance company or receive additional payments for the services provided
- OIG highlighted the following factors in its ***favorable review*** of this arrangement:
  - Physicians are paid for "tangible" services provided to indigent patients, as opposed to lost opportunity
  - Patients served must be uninsured, thus there is no risk of a double payment where the physician receives compensation under the arrangement and also from an insurer
  - Physicians are responsible for providing follow-up care with no additional compensation
  - Rates of payment reflect the value of the services provided

OIG ADVISORY OPINIONS

WHAT DOES THIS MEAN?

- Reason(s) for providing on-call pay should be well documented
- Compensation approach and rate of pay should be set in advance
- Compensation should be based on fair market value (FMV) standards:
  - Market survey data specific to call pay
  - Percent of Medicare fee schedule
  - Hourly rate for the specialty for actual services provided
- Call pay should be paid for actual services provided only
- Call pay should be available to all physicians in the specialty
- Watch for “double” payment for services

Questions?