

# Legal Q/A

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*Is it legal for a hospital to pay physicians for on-call services and, if so, how can the payment be structured?*



It is becoming increasingly common for hospitals to compensate physicians for on-call coverage for hospital emergency rooms. Hospitals must comply EMTALA, which means they must have a list of physicians willing and able to respond quickly to the needs of patients who present for treatment at the ED. In addition, many hospitals have a shortage of qualified specialists on their medical staff. At the same time, physicians cannot afford to render care to people without insurance. Moreover, studies have shown that the risk of getting sued for malpractice is higher for patients initially treated in the ED by on-call physicians (probably due to the lack of any pre-existing relationship with the patient). CMS recognizes the dilemma facing hospitals and has therefore given its blessing to certain compensation arrangements.

The federal anti-kickback statute prohibits giving or receiving any kind of remuneration in exchange for referrals of health care business. The government is concerned that on-call coverage compensation might be disguised unlawful remuneration. Covert kickbacks might take the form of payments that exceed fair market value for services rendered or payments for on-call coverage not actually provided.

The Office of Inspector General (OIG) has identified at least four kinds of arrangements for on-call coverage compensation that it would consider suspect under the anti-kickback statute:

- “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; or

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.

In 2007, the OIG issued an advisory opinion approving a *per diem* arrangement for on-call coverage which was intended to reflect the burden on a physician and likelihood that the physician would actually be required to respond while on-call, as well as the likelihood that he or she would have to provide uncompensated treatment. The *per diem* amount in that case varied depending on the specialty, and was supported by a fair market value opinion from an independent consultant. The physicians participating in the call were obligated to provide in-patient follow-up care to any patient seen in the ED while on call if the patient was admitted to the hospital. Interestingly enough, the OIG noted that after the implementation of the compensation arrangement for call coverage, physician responses to on-call requests improved dramatically and patient surveys indicated that overall satisfaction with the ED increased as well.

The OIG issued another favorable advisory opinion in 2009 for an arrangement established under the hospital's medical staff bylaws compensating on-call physicians who treat individuals with no insurance. The bylaws provided that the physician would receive a flat fee of \$100 for each emergency consultation in the ED, \$300 per admission for any patient subsequently admitted to the hospital, and a flat fee of \$350 for each surgical procedure performed on the uninsured patient.

In the author's experience, the *per diem* is the most common form of on-call coverage compensation, and usually ranges from \$500 to \$1500 depending on the subspecialty of the on-call physician. The arrangement should not prohibit the physician from billing an insured patient; however, it is important under the anti-kickback statute to have a comfort level that the *per diem* amount takes into account that some of the care is likely to be compensated by third-party payers. In other words, a *per diem* compensation arrangement that assumes none of the care will be compensated by third-parties might be suspect as unreasonably high.

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