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What Types of On-Call Arrangements Pass Muster?

Hospitals increasingly find it necessary to enter into payment arrangements with physicians on staff to obtain call coverage. There are as many payment methodologies as there are arrangements. They range from paying an hourly rate simply to be available and to respond if called, to paying only for services rendered on-site. The payment structure and amount of payment may have limitations and consequences for the hospital under Stark, anti-kickback and tax rules.

Advisory Opinion No. 09-05

In a recently-issued Advisory Opinion, the OIG examined an arrangement by a 400-bed general hospital to pay members of its medical staff a fixed dollar amount for each of several defined services they might be called upon to provide for *uninsured* patients while on call. While stating that it remains concerned that on-call payments may be disguised payments for referrals, the OIG concluded it would not impose administrative sanctions, based on features and safeguards of the arrangement.

The opinion is instructive for its discussion of arrangements at one end of the spectrum – what we call the "safer" end, because it is based on payment for only discreet services rather than availability. However the opinion should not be misread to undermine other arrangements.

Favorable Factors

Among the favorable factors built into the arrangement were the following:

1. Payment was based on actual services rendered on-site rather than on availability. As part of its discussion of the fair market value component, the OIG stated:

   "Several features of the Proposed Arrangement appear to support the certification (that amounts to be paid are fair market value). No 'lost opportunity' or other *amorphous payments* will be made under the Proposed Arrangement, and, unlike some on-call arrangements that pay regardless of actual emergency department calls, the Proposed Arrangement only reimburses physicians for time they actually spend providing services in the Emergency Department."

Contrast this with typical on-call arrangements that do pay a *per diem*, either an hourly or other fee, merely to be available and respond if needed during defined periods. The OIG seems to be favoring a service-based fee approach,

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particularly with a fee schedule, because it lends itself to the certification of fair market value.

However, in Advisory Opinion 07-10 issued less than two years ago, the OIG favorably ruled on a *per diem* on-call coverage fee for weekday and weekend availability, noting that participants "must adjust their work schedules and lifestyles to accommodate the Arrangement . . .." We do not interpret the new Advisory Opinion as undercutting the prior Advisory Opinion and its acceptance of a *per diem* form of payment. It is worth noting, however, that the OIG seems to favor the service-based approach and that such an approach may be easier to defend from a fair market value standpoint.

2. The payment was for uninsured patients only. This eliminated a risk that a physician might be paid twice – once by the hospital for performing an on-call service, and once by an insurer.

The lesson here, when drafting service-based fee arrangements, is to assure that the physician does not receive double payment for a defined service (although payment on top of, for example, a deeply discounted Medicaid amount to raise total compensation for the service to an acceptable FMV level might still be acceptable). Translated to hourly or *per diem* arrangements as discussed in AO 07-10, hospitals should try to back out of compensated hours, those hours when the on-call physician is on-site and rendering a potentially billable professional service or possibly take reassignment and retain professional fees billed as a result of an on-call encounter.

3. The arrangement imposed risk on the physician. In the arrangement under review, participating physicians were required to sign on-call agreements obligating them to provide post-admission services to these uninsured patients seen in the ED under the on-call arrangement, and these post-admission services were subject to relatively low fee schedule amounts. While the OIG viewed this as a favorable factor, it by no means made this a prerequisite to favorable ruling.

4. The hospital had clearly demonstrated the *need* to shift to a compensation model, as fewer and fewer physicians were willing to accept on-call burdens. It is easy to forget that this is the first prerequisite. The hospital must always be able to demonstrate that the *service* itself is necessary *and* that it is necessary *to pay for it* – even before the form of payment becomes relevant. It is not enough that other hospitals pay; the need must be documented on a hospital-by-hospital basis. When negotiating these arrangements, hospitals must remember to enumerate the *reasons* why they are necessary and then *structure* the arrangement to address each identified need.

5. The arrangement was available to all physicians, but only those who accepted the terms and entered into an agreement ultimately participated. The arrangement was thus "open" and not limited to selected sources of referral. The amount was fixed by specialty so as not to favor one group over another.

Conclusions

The Advisory Opinion is helpful if not read in too limiting a fashion. It is a reminder that on-call agreements are not automatically permissible without attention to the details. Just because they are nearly universal does not mean that on-call arrangements can be offered on any terms. An abbreviated summary of the OIG requirements, drawn from the two Advisory Opinions, includes:

1. Identify and support the need and structure the agreement to fit the need.

2. Adopt a payment structure that pays only fair market value – whether for availability or services or both. The OIG apparently prefers payment tied to on-site services over payment tied to availability, but both should be permitted, assuming other factors are present.

3. Document fair market value – how will you defend the payment methodology and amount if challenged or audited? As part of this analysis, try to avoid a methodology under which the physician may collect twice – for

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example, once from the hospital for being available to respond and again for rendering a billable service when responding. This does not mean there cannot be two sources of payment, just that the potential for compensation in excess of FMV must be addressed. For example, a hospital might contract to make up the difference between what a physician can bill for actual services while on call and a permissible and verifiable fee schedule amount, such as the Medicare fee schedule.

4. It is preferable that physicians have responsibility beyond the ED call phase. Assuming the patient is not discharged or transferred, the OIG approves of an arrangement wherein the on-call physician is obligated to assume responsibility for the next phase of care (assuming appropriate privileges).

5. Be cautious of payment structures based on "lost opportunity" or similarly designed payments that do not reflect *bona fide* lost income. The OIG seems to be skeptical and refers to these arrangements later as "amorphous payments" meaning, in its view, difficult to tie to a fair market value standard. This caution should apply mainly if a physician is compensated for responding during regular clinic hours where the fee is based on what the physician states he or she could have earned by seeing patients in the clinic instead. The OIG seems to be skeptical that amounts used in these constructs will be realistic, which is not to say lost opportunity-based fees cannot be validated.

6. Include features that act as safeguards to prevent payments from being used to reward high-referral sources or induce referrals. Opening the panel to all willing physicians and using a uniform hourly or fee schedule amount, at least by specialty, are examples. Be ready to show that neither selection of the physician nor payment methodology is based on volume or value of referrals.

In conclusion, do not treat on-call arrangements as routine and not needing individual attention just because they are commonplace. The justification for on-call arrangements will continue to be specific to the individual arrangement.

Alex M. "Kelly" Clarke

Proposed Policy Changes: Physician Supervision for Outpatient Therapeutic Services Provided in On Campus Provider-Based Locations

Direct supervision requires the physician to be physically present in the outpatient department when the therapeutic service is being performed.

The final 2009 Outpatient Prospective Payment System rulemaking threw hospitals a curve by "clarifying" its interpretation of the phrase, "on hospital premises" to exclude on-campus provider-based outpatient departments. CMS took the position that direct physician supervision is required in such excluded departments—an apparent reversal of the policy that the physician supervision is generally assumed to be met when services are performed on hospital premises. Direct supervision requires the physician to be physically present in the outpatient department when

the therapeutic service is being performed.

Subsequent to this controversial clarification, CMS received numerous questions and concerns from hospitals and other stakeholders. Apparently, the message was received and although CMS protested in commentary that it "made no change to longstanding hospital outpatient physician supervision policies as incorporated in prior statements of policy," a proposed final rule was published in the Federal Register on July 20, 2009 that included several changes to physician supervision requirements for 2010:

- Non-physician practitioners, specifically physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse-midwives may directly supervise all hospital outpatient therapeutic services that they may perform themselves in accordance with their State law, provided that they continue to meet all additional requirements (i.e. collaboration or supervision). A doctor of medicine or osteopathy must be present, however, for sufficient periods of time to provide medical direction, medical care services, consultation and supervision and must be available through radio or telephone for assistance with medical emergencies or patient referral.

- "Direct supervision" would be re-defined to mean that the supervisory physician or non-physician practitioner must be present on the same campus, in the hospital or the on-campus provider-based department of the hospital, and immediately available to furnish assistance and direction throughout the performance of the procedure. The proposed regulations define "in the hospital" as areas in the main buildings of a hospital that are under the ownership, financial, and administrative control of the hospital; that are operated as part of the hospital; and for which the hospital bills the services furnished under the hospital's CMS certification number. Furthermore, it specifies that the supervisory physician or non-physician practitioner of the hospital's outpatient therapeutic services may not be located in any other entity, such as a physician's office, co-located hospital, or hospital-operated provider or supplier such as skilled nursing facility.

The 2009 clarification established that direct supervision requires immediate physical presence. While CMS has not specifically defined the word "immediate" for direct supervision in terms of time or distance, the proposed regulations indicate that the general definition, "without interval of time," is applicable. Therefore, the supervising physician or non-physician practitioner could not be immediately available while, for example, performing another procedure or service that he or she could not interrupt. In addition, because of the prevalence of expansive hospital campuses it is not "immediate" for the supervisory physician or non-physician practitioner to be so physically far away on the campus from the location where hospital outpatient services are being furnished that her or she could not intervene right away if summoned.

- CMS originally stated that the physician does not "necessarily need to be of the same specialty as the procedure or service that is being performed." CMS also stated in manual guidance that hospital medical staff that supervises the service "need not be in the same department as the ordering physician." The proposed regulations, however, state that, to furnish appropriate assistance and direction for any given service or procedure, the supervisory physician or non-physician practitioner must have the ability to perform the service or procedure.

The public comment period for these proposed regulations is currently open. All comments must be received by Centers for Medicare and Medicaid Services by 5 p.m. EST on August 31, 2009.

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Nebraska Hospitals – There's Good Reason to Revise Your Informed Consent

In 2009, Nebraska law regarding obtaining informed consent for testing for human immunodeficiency virus (HIV) was changed. Both the previous and the current statute mandates that no person may be tested for the presence of HIV infection unless he or she has given written informed consent for the performance of the test. However, consent may now be included in a hospital's general consent form to apply in certain circumstances.

The previous statute provided strict requirements for the written consent. It stated that written consent included an explanation of the test, including the test's purposes, potential uses, limitations, and the meaning of both positive and negative results. Further, it required an explanation of the nature of HIV and acquired immunodeficiency syndrome (AIDS), including the relationship between the test results and the diseases which are part of the syndrome. The old provision required an explanation of the procedures to be followed, including the fact that the test is entirely voluntary. Finally, information concerning behavioral patterns known to expose a person to the possibility of contracting HIV and the methods for minimizing the risk of exposure was required.

The new 2009 law replaces the old written consent requirements with a more general consent provision. According to the new statute, if a person signs a general consent form for the performance of medical tests or procedures which informs the person that a test for the presence of HIV may be performed and that the person may refuse to have such test performed, the signing of an additional consent for the specific purpose of consenting to a test related to HIV is not required during the time in which the general consent form is in effect. The consent must still provide an explanation of HIV and the meaning of both positive and negative test results, but it's a greatly diminished requirement.

Also a positive change for providers, the new statute now specifies persons who may give substitute consent. If a person is unable to provide consent, the person's legal representative may provide consent. If the person's legal representative cannot be located or is unavailable, a health care provider may authorize the test when the test results are necessary for diagnostic purposes to provide appropriate medical care. Under the language of the old statute, health care providers did not have the ability to authorize an HIV test except in limited circumstances of exposure by health care workers. This expanded authority will give needed clarity in cases of emergency treatment.

Nebraska hospitals should update their general consent forms to include a provision informing patients that an HIV test may be performed and that the patient may refuse to have the test performed. This will allow hospitals to avoid further written consent for HIV testing so long as the general consent form is still in effect.

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According to the new statute, if a person signs a general consent form for the performance of medical tests or procedures which informs the person that a test for the presence of HIV may be performed and that the person may refuse to have such test performed, the signing of an additional consent for the specific purpose of consenting to a test related to HIV is not required during the time in which the general consent form is in effect.

New Nebraska Physician Assistant Laws

On May 22, 2009, the Nebraska Unicameral passed Legislative Bill 195 amending the rules that govern the practice of physician assistants (PAs) within the State. The amendments decreased physician supervision requirements, prescribed the scope of practice areas for PAs, and redefined the contents of physician and PA practice agreements. The main thrust of the bill was to decrease the physical presence requirements of a supervising physician. For example, an experienced PA may now render services in remote locations without a supervising physician being present.

Former laws significantly restricted the sites where PAs could practice. Previously, some level of physical presence of the supervising physician (typically 20%) was required at the PA's primary practice site, depending upon the experience of the PA. Further, a PA could perform medical services in a secondary practice site operated by the supervising physician only if the supervising physician was present at all times to assure quality medical care. These strict supervision requirements worked hardships on many PAs and supervising physicians who practiced at multiple clinic locations in several rural communities. Strict supervision rules created inefficiencies in the use of health care resources, increased the burden on health care providers and suppliers, and decreased patients' access to care.

Under the new legislation, PAs with more than two years of experience may practice at any location without the physical presence of a supervising physician. Supervising physicians must still be available to communicate and consult with PAs, but the Unicameral has eliminated the burdens previously associated with the required physical presence of the supervising physician. For PAs with less than two years of experience, the Unicameral has given the licensure board the ability to vary the supervision requirements based upon the geographic location of the supervising physician's primary and secondary practice sites. Additionally, whereas a physician could formerly supervise only two PAs, a physician may now supervise up to four PAs at any one time. Furthermore, the board may waive this limit if the supervising physician meets the minimum requirements for a waiver.

The Legislature also prescribed the scope of a PA's practice. A PA may only perform medical services that are delegated by the supervising physician, that are appropriate to the PA's level of competence, that form a component of the supervising physician's area of expertise, and that are not otherwise illegal. If these requirements are satisfied, a PA now has the express authority to pronounce death and complete and sign death certificates and any other forms that are within the PA's scope of practice. This clarified an ambiguity that existed under the prior rules.

Finally, the Unicameral redefined the necessary contents of supervision agreements between supervising physicians and PAs. The supervision agreement must:

1. state that the supervising physician will exercise supervision over the PA in accordance with law;

2. define the scope of practice of the PA;

3. provide that the supervising physician will retain professional and legal responsibility for medical services rendered by the PA under the agreement; and

4. be signed by the supervising physician and the PA.

The supervising physician must keep the original agreement on file at the primary practice site, and must keep a copy of the agreement on file at each practice site where the PA provides medical services.

With this legislation, the Unicameral has significantly lessened the burdens traditionally associated with supervising PAs. The Unicameral also gave the Board of Medicine and Surgery great authority

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in implementing and interpreting these statutory amendments, though updated rules have yet to be issued. Stay tuned for the forthcoming implementing regulations!

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Enforcement of Red Flags Rule Further Delayed

The Federal Trade Commission announced July 29, 2009 that the deadline for enforcement for the Red Flags identity theft detection and prevention Rule would be delayed until November 1, 2009. The previous deadline was August 1, 2009. Concurrent with this announcement, the FTC issued additional guidance for compliance with the Rule in the form of "frequently asked questions." The entire FTC announcement and the FAQs may be accessed through the following URL:

http://www.ftc.gov/opa/2009/07/redflag.shtm

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