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CALLING ALL PHYSICIANS: *The On-Call Challenge Continues*

There was a time in the not-too-distant past when physicians volunteered to take call for unassigned patients, or at least were willing to take call, without much grumbling. Now, many of those same physicians just aren't available, or don't want to be available, 24/7. Hospitals can use a variety of strategies to fulfill their on-call coverage requirement, including taking advantage of a recent regulatory amendment that allows hospitals to participate in a "community call plan." But the on-call issue remains a challenge for many hospitals.

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires that Medicare hospitals with emergency departments maintain a list of physicians who are on-call for duty to provide the treatment necessary to stabilize a patient with an emergency medical condition. However, there are no specific requirements that address how often hospital staff must serve on-call; those obligations are imposed on physicians by hospital medical staff bylaws or other agreements.

Filling an on-call list involves numerous hurdles. For instance, physicians increasingly focus on sub-specialties. An orthopedic surgeon may have core privileges to treat all orthopedic cases, but in reality, the physician's practice is limited to joint replacement or spinal surgery. Is it appropriate to make that physician serve on-call as an orthopedist? Also, it is increasingly common for physicians to resign from certain privileges either because the physician doesn't want to be on-call for certain emergency cases or the physician does not feel qualified to handle certain cases. Hospitals need to be prepared to address the OB/GYN who wants to resign OB privileges, but maintain GYN privileges. Or, if there are two hospitals in a community, the physician may seek to maintain OB/GYN privileges at one hospital, but GYN privileges only at the other hospital in order to reduce his or her on-call obligations. If a hospital permits a physician to selectively resign privileges, it may become difficult for the hospital to assure adequate on-call coverage. Conversely, if a hospital requires a physician to maintain privileges outside the scope of the physician's usual practice area, a negligent credentialing cause of action could ensue. In short, each situation must be carefully evaluated on its own terms.

Hospitals can discipline physicians who refuse to assume or carry out their on-call responsibilities by suspending, curtailing or revoking the offending physician's medical staff membership or privileges, or they can entice physicians to take call by compensating them for it. But the latter requires careful consideration. In the September 27, 2007, OIG Advisory Opinion No. 07-10, the Department of Health and Human Services Office of Inspector General stated,

There is a substantial risk that improperly structured payments for on-call coverage could be used to disguise 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. Problematic compensation structures that might disguise kickback payments could include, by way of example:

- (i) "lost opportunity" or similarly designed payments that do not reflect bona fide lost income;
- (ii) payment structures that compensate physicians when no identifiable services are provided;
- (iii) aggregate on-call payments that are disproportionately high compared to the physician's regular medical practice income; or
- (iv) 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.

Hospitals may choose to compensate one specialty, such as OB, and not compensate another specialty, such as dermatology. Compensation decisions are often made based upon the number of physicians on the hospital's medical staff in that specialty and the frequency with which those physicians are required to provide emergency care. Compensation for any on-call obligation must be carefully evaluated.

The Centers for Medicare & Medicaid Services (CMS) continues to try to address the on-call problem, but so far there are no easy answers. On August 19, 2008, CMS published the final Inpatient Prospective Payment System (IPPS) rule, effective October 1, 2008. The new rule addresses hospital emergency services under EMTALA and, among other things, permits hospitals to satisfy the on-call list requirement by participating in formal "community call plans." These plans, which are voluntary, are designed to permit participating hospitals to coordinate on-call coverage for chosen specialties. Such arrangements may be worth exploring, particularly in rural areas.

The frequency of on-call coverage, as well as any penalties for failing to take call and any inducements to be on-call, must be determined by the hospital and the physicians on its call roster. Physician/hospital on-call arrangements are rapidly evolving and increasingly complicated. The short- and long-term consequences of any proposed arrangement must be carefully considered by all parties. Stay tuned for further developments.

If you have a question on this material or would like to discuss legal services, please contact us at healthcare@duanemorris.com.



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