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Compliance Today - May 2020
Ten questions to ask when structuring a compliant call coverage agreement

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The on-call coverage environment has seen significant changes over recent years. While call coverage was once considered to be a requirement alongside clinical services, due to the growing uninsured patient population and emphasis on physician work-life balance, it has become more common for physicians to require additional compensation for providing this coverage. As a result of these changes, hospital leadership faces the difficult task of ensuring sufficient physician coverage to handle emergent case volume, in-patient consults, and continued care for admitted patients. This challenge is further exacerbated by the low quantity of physicians willing to provide the coverage, the rising compensation amounts paid to these physicians, and the need to meet the rules and regulations of the desired trauma designations. Since the passage of the Emergency Medical Treatment and Labor Act of 1986 (EMTALA),[1] on-call compensation for physicians has become a more significant issue. EMTALA requires hospitals participating in Medicare to have adequate physician coverage to provide medical services to patients presenting to the emergency department. As a result, hospitals are confronted with determining not only the appropriate level of coverage, but also whether such coverage should be provided on a restricted (on-site) or unrestricted (off-site) basis. This discussion focuses on unrestricted (availability or beeper) coverage, during which on-call physicians must be available to report to the hospital within a set, emergent time frame.

On-call compensation regulatory environment

There are several legal regulations that must be considered when determining compensation for call coverage arrangements. Two of the most relevant laws guiding healthcare compensation arrangements are the federal Anti-Kickback Statute (AKS)[2] and the Physician Self-Referral Law (Stark Law).[3] AKS is a criminal statute that prohibits the exchange or solicitation of anything of value for the referral of services reimbursable by Medicare or Medicaid. The Stark Law is a set of United States federal civil laws that prohibit physicians (or their immediate family members) from making referrals for Medicare or Medicaid patients to any entities with which they have a financial relationship. To be compliant with these regulations and in order to limit the influence of remuneration on medical decision-making, the government requires physician compensation to be set at fair market value (FMV). In regard to healthcare transactions, FMV can be defined as "the value in arm's-length transactions, consistent with the general market value. 'General market value' means the price that an asset would bring as the 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 the 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 time of the service agreement."[4]

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