



THE ABA HEALTH LAW SECTION

THE HEALTH LAWYER

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COMPENSATED ON-CALL COVERAGE: WHAT'S NEW AND WHAT'S FMV?

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For a variety of reasons, the prevalence of compensated on-call coverage arrangements has been increasing for several years.¹ As the number of such arrangements has increased, the complexity of considerations related to structuring them and determining their fair market value (“FMV”) has also increased.

Just a few years ago, the idea of compensating physicians to be on-call was somewhat novel, and structuring compensation arrangements for on-call coverage was akin to venturing into an unknown “wild west.” Now, arrangements for compensating physicians for on-call coverage are the subject of multiple advisory opinions from the Office of the Inspector General of the United States Department of Health and Human Services (the “OIG”), as well as of considerable federal rulemaking and commentary. The result is that there is an array of regulatory guidance to consider when structuring and determining the compensation to be paid for on-call coverage, with much of it focused on the importance of assuring that the compensation is FMV² for the services provided.

In addition, as greater numbers of physicians have begun to receive compensation for providing on-call coverage, the pool of both anecdotal and statistical data concerning the “going rate” for on-call coverage has increased, providing new bases for claims and opinions regarding what constitutes FMV for on-call services. Hospitals and physicians increasingly share news of on-call pay at the proverbial “water cooler,” while the publishers of well-known physician compensation surveys such as Sullivan

Cotter & Associates, Inc. have begun publishing annual compilations of on-call compensation rates. However, heightened media coverage and physician attention to the burdens associated with providing on-call coverage, as well as the consequences of failing to do so, have increased not only the *volume* but also *variety* of arrangements under which some form of compensation is provided to physicians who furnish on-call coverage, which makes valid comparisons among arrangements (and, thus valid conclusions about FMV that are based on such comparisons) more difficult.

The purpose of this article is to discuss the new and emerging influences and trends in the prevalence and structures of on-call arrangements, and how these influences and trends affect FMV compensation in such arrangements.

OIG Advisory Opinions

To date, the OIG has issued several Advisory Opinions concerning compensation arrangements for on-call coverage. These Advisory Opinions provide the most topically specific of the available government commentary regarding regulatory concerns related to compensation for on-call coverage. Although OIG Advisory Opinions are specific to the facts and circumstances that are submitted by their requestors, and, therefore, may not be “relied upon” by parties other than the requestors, the OIG Advisory Opinions concerning compensation arrangements for on-call coverage provide useful guideposts for assessing the government’s general concerns and areas of regulatory focus with respect to compensation arrangements for on-call coverage.

Advisory Opinion 07-10

In OIG Advisory Opinion 07-10,³ the OIG examined an on-call

coverage arrangement under which a hospital provided *per diem* compensation for physicians providing on-call coverage. The OIG warned that the practice of paying physicians to provide on-call coverage may implicate the Federal Anti-Kickback Statute (“AKS”)⁴ because the existence of such payment practices creates a risk that physicians may demand such compensation as a condition of doing business at a hospital, and that on-call coverage compensation could be misused by a hospital to entice physicians to join or remain on the hospital’s medical staff or otherwise to generate additional business for the hospital. The OIG also warned that an arrangement under which physicians are paid *per diem* compensation for providing on-call coverage will not fit within the AKS’s safe harbor⁵ for personal services and management contracts if the total payments to the physicians vary each month based on the number of shifts worked, since the monthly variation in compensation means that aggregate compensation is not “set in advance” as required to comply with the requirements of the safe harbor.⁶

Nonetheless, the OIG indicated that *per diem* compensation arrangements may withstand scrutiny under the AKS if the *per diem* compensation is: (i) FMV; (ii) for actual and necessary services; and (iii) without regard for referrals or other business generated by the parties.⁷ OIG then set forth specific guidance regarding acceptable and unacceptable methods for establishing the FMV of on-call compensation. Among the unacceptable methods mentioned by OIG (collectively, “Compensation Methods Subject to Scrutiny”) are those based on:

- “lost opportunity” when they do not reflect *bona fide* lost income;

- payment structures that compensate physicians when no identifiable services are provided;
- aggregate payments that are disproportionately high compared to the physician's regular medical practice income; and
- payment structures that compensate the on-call physician for professional services for which s/he receives separate reimbursement from insurers or patients, resulting in the physician being paid twice for the same service.

The method that the requesting hospital in Advisory Opinion 07-10 used to establish FMV, and that OIG apparently accepted as valid, was based on:

- the actual *burden* on the physician who is providing call coverage, including whether the on-call coverage is on weekdays or weekends, and the likelihood of a physician having to respond to a call event when on call;
- the likelihood that the physician will have to provide care for an uninsured patient; and
- the severity of illness that physicians of a specialty typically encounter when on call and the degree of inpatient care that they must typically provide to patients admitted from the emergency department.

Advisory Opinion 09-05

In OIG Advisory Opinion 09-05,⁸ the OIG examined a different structure of arrangement under which a hospital would *not* provide *per diem* compensation to physicians for providing on-call availability, but instead, would provide reimbursement to on-call physicians for professional services rendered to patients for whom there is no alternative payor source (*i.e.*, uninsured patients). Advisory Opinion 09-05 does not represent any significant change in the government's position with respect to compensation

for on-call coverage; rather, it reflects OIG's recognition of an expansion in the types on-call coverage arrangements being implemented in the marketplace.⁹

In issuing this advisory opinion, the OIG reiterated its reasoning why compensation arrangements related to the provision of on-call coverage implicate the AKS, and again stressed that the key inquiry that is undertaken by the OIG to determine whether an on-call coverage arrangement passes muster is whether the compensation provided is consistent with FMV in an arm's-length transaction for actual and necessary items or services. The OIG also restated the four "Compensation Methods Subject to Scrutiny" from Advisory Opinion 07-10 and underscored that these are problematic compensation structures because of their potential to disguise kickback payments. However, the OIG ultimately indicated that although the arrangement at issue in Advisory Opinion 09-05 *could* generate prohibited remuneration and warrant prosecution if the requisite intent to induce or reward referrals were present, the proposed arrangement would not warrant administrative sanctions under the AKS because certain characteristics of the arrangement assured that it presented a low risk of abuse. The foremost of these characteristics was the fact that the hospital was able to certify that the planned payments to the physicians were consistent with FMV based on the following factors:

1. The arrangement would allow payments only for tangible and quantifiable services that physicians render pursuant to their on-call duties (*i.e.*, payment would only be made for actual time spent providing services in the emergency department);
2. The payments were not based on "lost opportunity";
3. Physicians would only receive payments when they could document

that no other payment source was available for the professional services rendered, so as to eliminate the possibility of the physician being paid twice for the same service; and

4. The rates to be paid to the physicians were tailored to reflect the value of services actually provided and were determined using a valuation methodology that took into account actual facts and circumstances, such as: patient acuity levels for emergency department patients in the relevant specialty at the relevant hospital; marketplace fees for services across public, private and self-payers; the hospital's payor mix; and the probable physician time commitment associated with the service.

Common Themes in the OIG Advisory Opinions

- OIG Advisory Opinions 07-10 and 09-05 (collectively, the "Advisory Opinions") each address a different type of on-call coverage arrangement, but contain similar themes and guidance from the OIG with respect to the OIG's mode of scrutiny for on-call compensation arrangements. In both advisory opinions, the OIG indicated that:
- The OIG recognizes that there are legitimate reasons why hospitals may find it necessary to provide compensation to physicians in connection with on-call coverage.
- Regardless of whether legitimate reasons exist for compensating physicians for on-call coverage, compensated on-call coverage arrangements implicate the AKS to the extent that they carry the potential to disguise prohibited payments for referrals. Moreover, on-call coverage arrangements will not fit within the AKS safe harbor for personal services and management contracts when total compensation fluctuates based on shifts worked or volume of call events, because aggregate compensation in such cases is not "set in advance."

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- Each arrangement involving compensation for on-call services will be evaluated by the OIG based on the totality of its specific facts and circumstances.
- The OIG's key inquiry when scrutinizing compensation for on-call coverage is whether the compensation is: (i) consistent with FMV in an arm's-length transaction; (ii) for actual and necessary items or services; and (iii) not determined in a manner that takes into account the volume or value or referrals or other business generated between the parties.
- The OIG views any arrangement based on one or more of the four "Compensation Methods Subject to Scrutiny" as problematic and potentially inconsistent with FMV.

Other Regulatory Considerations

The Advisory Opinions provide general guidance to help avoid AKS scrutiny by assuring that arrangements by hospitals to compensate physicians in connection with on-call coverage are carefully structured to fit the facts and circumstances, and are consistent with FMV. In addition to the Advisory Opinions, there is other regulatory guidance that is influencing the structure of on-call arrangements, including:

- Provisions of the Emergency Medical Labor and Treatment Act ("EMTALA")¹⁰ that permit hospitals to allow on-call physicians to schedule elective surgery during the time that they are on call and/or to have simultaneous on-call duties;¹¹ and
- Changes to EMTALA that are set forth in the 2009 Inpatient Prospective Payment System ("IPPS") Final Rule,¹² and that permit hospitals to participate in a formal community call plan ("CCP") under which they may share on-call physicians, provided that certain conditions are met.¹³

The Trends in On-Call Coverage Arrangements

Together, the Advisory Opinions and changes to EMTALA regulations, coupled with other factors such as heavy news reporting of shortages of on-call physicians and changes in the practice patterns of specialist physicians, have contributed not only to increases in the prevalence of compensated on-call arrangements, but also the complexity and variety of such arrangements.

Subspecialty Coverage Arrangements

Several years ago, compensation for on-call coverage was generally limited to call panels in a few select specialties, such as neurosurgery and trauma surgery. These specialties shared common characteristics: they were the subject of severe physician shortages, and they were associated with very high burdens for those who take call. In the present environment, hospitals routinely provide compensation for on-call services in a variety of different specialties that are associated with a variety of different burdens. The expanding universe of compensated on-call coverage arrangements now encompasses physicians of a large number of specialties and subspecialties.

In light of the Advisory Opinions and other sources of guidance concerning the government's view on compensation for on-call coverage, establishing FMV for on-call coverage in less common specialties and subspecialties requires consideration of a number of factors, including:

- the degree to which there is a legitimate need for on-call coverage at the specialty or subspecialty level (*i.e.*, is it necessary and commercially reasonable to pay a hematologist/oncologist to be on call for the emergency department?);
- the fact that physicians of unique specialties and subspecialties may

number only one or two on a medical staff and may be expected to individually provide continuous (*i.e.*, 24 hours per day and 365 days per year) or near continuous on-call coverage;

- the fact that although a subspecialty physician may be the only provider of subspecialty services on a medical staff, s/he may be part of a larger specialty department and required to participate in the general specialty call panel. If this is the case, the subspecialty physician may on certain days be required to provide simultaneous (*i.e.*, concurrent) on-call coverage for patients needing general specialty services as well as for those needing subspecialty services; and
- based on all of the factors above, marketplace data concerning what other physicians are paid for clinical services and/or on-call coverage in the physician's specialty at other hospitals may be of limited value for determining FMV for specialty or subspecialty on-call coverage at the subject hospital, and reliance on such data may result in one or more Compensation Methods Subject to Scrutiny.

On-Call Coverage by Employed Physicians

Uncertainty about the future of private practice medicine is prompting physicians of many specialties to select hospital employment over independent practice. A number of articles are being written on this topic, there has been a significant increase in the number of transactions involving private practice physicians who are seeking hospital employment. As the number of hospital-employed physicians increases, it has become common for call panels to contain one or more physicians who are hospital employees. The existence of hospital employees on a compensated call panel necessitates

careful evaluation of the FMV of on-call compensation, including specific consideration for:

- whether (as well as the extent to which) the employment agreement requires the employee physician to provide on-call coverage as part of employment duties. Often, physician employment agreements require performance of a *minimum* number of on-call days. When this is the case, hospitals must consider whether call panel compensation (*i.e.*, any compensation under a compensated on-call coverage agreement that is separate from the employment agreement) should apply only to days of coverage that are *in excess* of the days of coverage that the physician is required to provide by the terms of employment. This is to assure that the employee physician is not paid twice (*i.e.*, under both the employment agreement and the on-call coverage agreement) for providing the same services, and to ensure that total compensation to the physician does not exceed FMV.
- whether either: (i) the compensation being paid for specialty call coverage in the marketplace (*i.e.*, what other hospitals are apparently paying), and/or (ii) what a hospital pays to non-employee physicians on the same call panel, is a reasonable barometer for FMV of the on-call coverage that is to be provided by the employed physician. Many existing on-call coverage arrangements, and much of the published survey data concerning such arrangements, reflect agreements with “independent contractor physicians” who are responsible for paying their own costs and expenses, including their own malpractice insurance premiums, payroll taxes, retirement contributions and health insurance premiums. The rates that these independent contractor physicians receive for their services reasonably include allowances for the payment

of such costs. When physicians are hospital employees, such costs and benefits are typically borne by the hospital as part of the employment package. As such, paying the same *per diem* rates to employee and non-employee physicians on the same call panel may suggest duplicative (and greater than FMV) compensation to the employed physicians.

Arrangements Involving Concurrent Call Coverage for Multiple Hospitals

Local shortages of physicians in certain specialties and/or subspecialties have led some hospitals that share common ownership or corporate affiliation to enter into “concurrent” on-call coverage arrangements – *i.e.*, arrangements for one physician to provide on-call specialty coverage simultaneously for several affiliated hospitals during each coverage day. With the proliferation of “chain” hospitals, concurrent coverage arrangements have become fairly common. With recent changes to the EMTALA regulations, which allow hospitals to meet their on-call obligations through CCPs, there may be additional increases in the prevalence of concurrent on-call coverage arrangements as otherwise unaffiliated hospitals begin to explore the option of sharing on-call physicians.

Although there are a variety of methods being used to compensate physicians for services provided in connection with on-call coverage, the most common method is the payment of a *per diem* rate. Determining FMV for *per diem* compensation in connection with concurrent on-call coverage requires consideration of a number of factors that generally include the following:

- Physicians who provide concurrent on-call coverage for multiple hospitals may bear some additional burden (in comparison to their counterparts who provide on-call coverage at one facility at a time) because of the relatively high

frequency and probability of calls during each coverage period when a physician covers multiple hospitals. This increased call burden may reasonably warrant higher *per diem* compensation rates for physicians who provide concurrent on-call coverage for multiple hospitals than for their counterparts who provide on-call coverage at just one facility at a time.

- The degree of “forbearance” for a physician providing a single day of concurrent on-call coverage is less than the degree of forbearance for a physician who provides a total of two days of on-call coverage by covering one hospital each day. One day of concurrent on-call coverage means one day that a physician is restricted from traveling and engaging in social activities that may compromise his or her ability to rapidly respond to a call, regardless of the frequency or probability of call events during that day. On the other hand, single-facility on-call coverage on two separate days means that there are two days that a physician is restricted from traveling and engaging in social activities that may compromise his or her ability to respond to a call, regardless of the frequency or probability of call events during each of those days. Therefore, in order to assure that an on-call physician is not paid twice for the same service, hospitals should consider that the FMV of *per diem* compensation for concurrent call coverage for multiple facilities is *less* than the sum of the FMV *per diem* rates for single-facility coverage at each facility.
- As suggested in the Advisory Opinions, patient payor mix affects the FMV of compensation for on-call services in proportion to the frequency of events to which the on-call physician will have to respond. When the relevant patient population is characterized by a high proportion of poorly

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reimbursing payors (e.g., Medicaid, charity, self-pay¹⁴, etc.) such as Medicaid and uninsured patients, the degree to which on-call physicians will be exposed to these poorly reimbursing payors will depend on the frequency with which they are called to provide patient care services. Therefore, determining the FMV of compensation for a physician who provides concurrent on-call coverage for multiple hospitals reasonably entails consideration of the percentage of poorly reimbursing payors in relation to the frequency of call events at each of the relevant hospitals.

- Overall, the FMV of *per diem* compensation for concurrent on-call coverage is affected by a variety of factors, and should be determined based on careful consideration of the specific facts and circumstances pertaining to the planned arrangement. Anecdotal and survey data regarding what other hospitals pay is not necessarily definitive of FMV for a concurrent call coverage arrangement, and should be carefully scrutinized to determine whether it is an appropriate basis for determining compensation in any specific arrangement.

On-Call Coverage Arrangements Involving "Per Diem Plus" Compensation

As the breadth of specialties for which hospitals provide compensation for on-call services has expanded, the variety and complexity of the on-call compensation structures that are being observed in the marketplace have increased. Although *per diem* compensation for on-call availability remains the most common form of compensation in compensated on-call coverage arrangements, alternative forms of compensation are increasingly being offered either in lieu of or in addition to *per diem* compensation.

Some hospitals are paying "activation fees" in lieu of *per diem* compensation when the frequency of call events in a specialty is very low. Activation fees are one-time, fixed-fee payments that are triggered whenever a physician is required to respond to a call event by presenting to the hospital.

The FMV for activation fees varies based on many of the same factors that influence the FMV for *per diem* payments, such as the likelihood of a physician having to respond to a call event when on call, the likelihood that the on-call physician will have to provide care for an uninsured or otherwise poorly paying patient, and the severity of illness that physicians of a specialty typically encounter when on call. However, for any specialty and hospital, the FMV of an activation fee may be substantially higher than the FMV of the alternative *per diem* rate for on-call availability, since activation fees "concentrate" the physician's compensation for on-call burdens into relatively infrequent, discrete payments, while *per diem* rates spread the compensation over multiple days of on-call availability.

Regardless, the aggregate compensation paid by a hospital under an activation fee model is likely to be *less than* the aggregate compensation paid under a *per diem* compensation model, so long as the frequency of call events that require activation of the on-call physician is very low. For this reason, the selection of activation fee compensation over *per diem* compensation may yield significant cost savings for hospitals in cases where it is necessary to provide compensation to physicians to secure on-call coverage that is required to comply with a regulatory standard, but the frequency with which call events actually occur in the specialty at the hospital is very low.

Other compensation methods that are frequently being used in lieu of or in addition to *per diem* payments include:

1. provision of in-kind compensation, such as coverage of the physician in the hospital's self-insurance plan, payment of the physician's professional liability insurance premiums and/or payment of the physician's dues or premiums to professional organizations and benefit associations; and
2. reimbursement for professional services rendered to uninsured patients while on call.

When one or more of these other forms of compensation are provided in addition to *per diem* compensation, the FMV of each form of compensation that is to be received by the physician should be determined in light of all other forms of compensation that the physician will receive in connection with the requisite on-call coverage.

By way of example:

- If a physician will receive *per diem* compensation for on-call availability, *plus* reimbursement from the hospital for professional services rendered to uninsured patients while on call, a poor hospital payor mix has little bearing on the FMV of the *per diem* rate, even though poor payor mix would have significant bearing if there were no reimbursement for services to uninsured patients, since the risk that the physician will have to render professional services without reimbursement has been removed.
- If a physician will receive *per diem* compensation for on-call availability, *plus* in-kind compensation such as payment of his or her professional liability insurance premiums, then the dollar value of the in-kind compensation must be taken into account when

determining the FMV of the *per diem* compensation. This is necessary to assure that the physician is not paid twice for the same service and that total compensation received by the physician in connection with the on-call coverage does not exceed FMV.

Conclusion

In the current regulatory environment, in which much scrutiny is being given to relationships between healthcare providers in hopes of ferreting out disguised Medicare fraud and abuse, defining FMV and assuring that physician compensation arrangements are consistent with it is important for protecting both hospitals and physicians from costly federal litigation, sanctions, and/or possible exclusion from federal healthcare programs. As the prevalence of hospitals paying for on-call coverage increases, and the breadth of specialties in which hospitals offer compensation to secure on-call coverage expands, the variety and complexity of issues to consider when determining the FMV for compensated call coverage increase. Hospitals and physicians should both be mindful of these issues when negotiating compensation agreements for on-call services.



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Endnotes

- 1 These reasons include the requirements imposed on hospitals by the Emergency Medical Treatment and Labor Act (“EMTALA”), and a decline in the willingness of physicians to provide emergency department on-call coverage due to negative perceptions about the effect of on-call coverage on physician lifestyle, the number of uninsured patients that a physician will encounter when on call, and the risk of malpractice suits stemming from care provided in emergency settings when the physician has no prior knowledge of the medical status of the patient being treated.
- 2 As defined in the International Glossary of Business Valuation Terms, “fair market value” means the price, expressed in terms of cash equivalents, at which property would change hands between a hypothetical willing and able buyer and a hypothetical willing and able seller, acting at arm’s length in an open and unrestricted market, when neither is under compulsion to buy or sell and both have reasonable knowledge of the relevant facts. As defined by the Centers for Medicare & Medicaid Services for compliance with Medicare fraud and abuse laws, fair market value means the value in arm’s-length transactions, consistent with the general market value, when “general market value” means the compensation that would be paid as a result of *bona fide* bargaining between well-informed parties when neither party is otherwise in a position to generate business for the other party. (See 42 C.F.R. § 411.351)
- 3 Dated September 20, 2007.
- 4 42 U.S.C. § 1320-7b. The AKS broadly proscribes any arrangement by which anyone knowingly and willfully offers, pays, solicits or receives any remuneration, including any kick-back, bribe or rebate, directly or indirectly, in cash or in kind, to induce the purchase, lease, ordering or arranging for, or recommending the purchase, lease, or ordering, of any good, service or item for which payment may be made in whole or in part by a federal healthcare program such as Medicare.
- 5 The government has promulgated certain “safe harbors” by setting forth lists of requirements that, if met, will assure that an arrangement will not be subject to government action under the AKS. To benefit from the protection of a

safe harbor, an arrangement must comply with all requirements of the safe harbor.

- 6 The safe harbor for personal services and management contracts is set forth in 42 C.F.R. § 1001.952(d) and includes the requirement that the aggregate compensation to be paid under the contract is set in advance, is consistent with FMV in arm’s-length transactions, and is not determined in a manner that takes into account the volume or value of any referrals or other business otherwise generated between the parties for which payment may be made in whole or in part under federal healthcare programs.
- 7 In addition to specifically identifying the three requirements, the OIG noted the existence of guidance set forth in its Supplemental Compliance Program for Hospitals (70 Fed. Reg. 4858, 4866 (Jan. 31, 2005)) that “The general rule of thumb is that any remuneration flowing between hospitals and physicians should be at fair market value for actual and necessary items furnished or services rendered based upon an arm’s-length transaction and should not take into account, directly or indirectly, the value or volume of any past or future referrals or other business generated between the parties.”
- 8 Dated May 14, 2009.
- 9 Each OIG Advisory Opinion is specific to the set of facts and circumstances that are submitted to the OIG by the requestor. The facts and circumstances that are contemplated in Advisory Opinion 09-05, most notably including the structure of the compensation arrangement, are different from those contemplated in 07-10.
- 10 42 U.S.C. 1395dd. Enacting regulations are codified at 42 CFR 489.24 and 42 CFR 489.20 in subsections (l), (m), (q) and (r). In general terms, EMTALA requires hospitals that participate in Medicare to assure that any patient who comes to the emergency department requesting examination or treatment for a medical condition be provided with an appropriate medical screening examination to determine if an emergency medical condition exists, and if an emergency medical condition is determined to exist with respect to that patient, that the patient be provided with any necessary stabilizing treatment, or else be transferred to another hospital under a protocol that meets certain statutory and regulatory criteria. The EMTALA statute and related regulations specifically require hospitals that participate in Medicare to maintain a list of on-call physicians who are available to provide stabilizing treatment after an initial screening examination has been performed.
- 11 42 CFR 489.24(j)(2).
- 12 73 FR 48434 (August 19, 2008).
- 13 The IPPS FY 2009 Final Rule added a provision to 42 CFR 489.24(j)(2)(iii) to permit hospitals to meet EMTALA obligations by participating in a CCP. The CCP must contain certain elements for a participating hospital to meet EMTALA obligations, such as having a clear delineation of when each of the participating hospitals is responsible for on-call coverage, including time period and specialty/service.
- 14 A variety of statistical data suggests that self-pay patients typically pay less and take longer to pay than commercial insurers and other third party payors who are viewed as favorable payors.