Valuation of Physician On-Call Pay and Coverage Arrangements



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he Emergency Medical Treatment and Labor Act of 1986 (EMTALA) requires most Medicare participating health care organizations to have physicians available to provide services to patients presenting the in emergency room.1 Two types of call coverage are typically provided by physicians:

- >>> Unrestricted call coverage, which allows for the physician to remain off of the premises but available to report for duty within a specified timeframe (typically within 30 minutes), and
- >>> Restricted call coverage, which requires the physician to remain on hospital premises.

Within the unrestricted and restricted call categories, physicians typically serve on a general emergency department (ED) or trauma call panel. There are also emerging practices in which the physicians provide telephonic call coverage only.

On-call pay is the hospital's payment for access to physicians providing call coverage. Over the past several years, the provision of on-call pay has continued to increase.² On-call pay expenditures have also increased (see Figure 1 on following

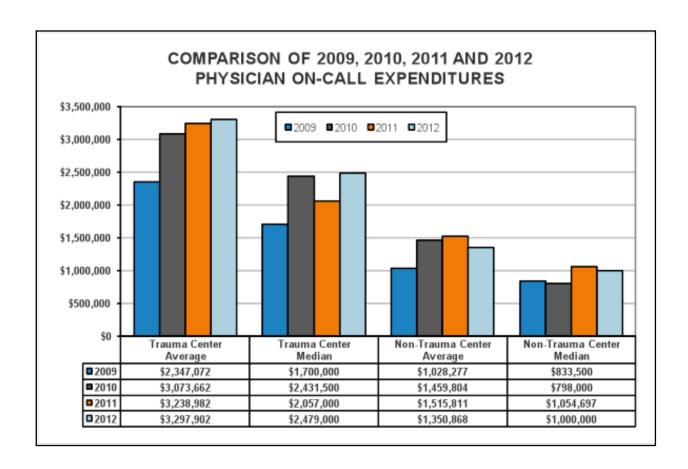
page).3 Therefore, it is important from a strategic, financial and regulatory perspective to properly structure physician on-call pay arrangements.

Valuation of Physician On-Call Pay Arrangements

When structuring on-call pay arrangements, there are a number of regulatory issues that must be considered, including the Stark Law and the Antikickback Statute. Each of these requires that physician compensation arrangements fall within fair market value (FMV).4 If the arrangement occurs between physicians and a not-for-profit organization, the organization must also ensure that the compensation provided for call coverage falls within FMV in accordance with IRS tax exempt laws. In addition to FMV, organizations should review the commercial reasonableness of the on-call pay arrangement. Commercial reasonableness addresses the fundamental question of whether the health care organization has a legitimate business need for the service for which compensation is provided.5

The Office of the Inspector General of the United States Department of Health and Human Services (OIG) has issued three helpful Advisory Opinions (AOs) concerning physician on-call pay arrangements. Each is summarized below.

- 1 Section 1867 of the Act sets forth requirements for medical screening examinations for individuals who come to the hospital and request examination or treatment for a medical condition. The section further provides that if a hospital finds that such an individual has an emergency medical condition, it is obligated to provide that individual with either necessary stabilizing treatment or an appropriate transfer to another medical facility where stabilization can occur, regardless of the patient's ability to pay for services.
- According to SullivanCotter's Physician Compensation and Productivity Surveys, the provision of call pay for physicians increased from 48% to 63% from 2007-2012.
- Abstracted from SullivanCotter's 2012 Physician On-Call Pay Survey.
- Stark Law defines FMV as the: "value in arm's length transactions, consistent with the general market value. General market value means 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, at the time of the service agreement. Fair market price is generally based on bona fide comparable services agreements, where the compensation has not taken into account the volume or value of anticipated or actual referrals."
- 5 According to Stark Law: An arrangement will be considered "commercially reasonable" in the absence of referrals if the arrangement would make commercial sense if entered into by a reasonable entity of like type and size and a reasonable physician ... of similar scope and specialty even if there were no potential DHS referrals 69 Fed. Reg. 16093, 16107 (Mar. 26, 2004).



OIG Advisory Opinion 07-10

The September, 2007 OIG Advisory Opinion was issued in response to a Medical Center arrangement that intended to pay physicians in certain specialties a per diem rate for each day spent on-call for the emergency department. The arrangement required physicians to:

- >>> Participate in a call rotation schedule.
- >>> Respond to calls in a timely fashion.
- >>> Provide inpatient care to any patient seen in the emergency department while on-call.

Although the OIG issued a favorable review, it noted examples of potential problematic on-call compensation:

- >>> 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 relative to the physician's regular practice income.
- 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.

OIG Advisory Opinion 09-05

This May 2009 opinion reviewed an on-call pay arrangement in which a hospital proposed to pay physicians a uniform fee schedule for services provided to uninsured patients:

- >>> ER consultations (\$100).
- >>> ER admissions (\$300).
- >>> ER surgical procedures (\$350).

The arrangement required physicians to waive all rights to bill any other insurance company or receive additional payments for the services provided. Favorable review factors in this opinion included the following:

- Patients served must be uninsured, thus there is no risk of a double payment where the physician receives compensation under the arrangement and also from an insurer.
- Physicians are paid for "tangible" services provided to indigent patients, as opposed to lost opportunity.
- Physicians are responsible for providing follow up care with no additional compensation.

>>> Rates of payment reflect the value of the services provided.

OIG Advisory Opinion 12-15

In October, 2012, the OIG reviewed an arrangement in which a non-profit hospital paid a per diem fee to specialists providing unrestricted on-call coverage for the hospital's emergency department. The arrangement under review included oneyear contracts requiring that physicians be available to respond within required response times and provide appropriate inpatient and follow-up care to admitted patients. Upon review, the OIG concluded that it would not impose administrative sanctions on the hospital in conjunction with the arrangement as described in the opinion.

The favorable review of this arrangement included the following considerations:

- >> The hospital administers a per diem fee, calculated annually in advance, to specialist physicians to provide unrestricted on-call coverage for the emergency department.
- >>> All specialists on the hospital's medical staff are offered the opportunity to participate in the call arrangement. Thus, the on-call pay cannot be offered only to select physicians or physician groups within the specialty.
- >>> Physicians must agree to provide inpatient care required by any patient admitted by the physician, as well as outpatient follow-up care following discharge, without additional compensation.
- >> A uniform methodology is used by the hospital to allocate call coverage equitably among participants within each specialty.

A key factor noted in the opinion is that, based on an independent valuation, the hospital certified the per diem rates to be commercially reasonable and fair market value for the services provided.

Common to all opinions is the OIG's stipulation that compensation arrangements must be based on FMV and that reasons for on-call pay should be well documented.

What Does this Mean?

When developing and/or reviewing a physician on-call pay contract, there are a number of factors that must be taken into consideration:

>> Physician specialty area. On-call pay rates vary significantly by specialty area. Surgical specialties are generally paid more than medical specialties;

however, there are some surgical specialty areas that do not have high call pay levels. For example, the median hourly on-call pay rate⁶ for Ophthalmology was \$12.50 compared to General Surgery, which was \$32.29. The variance is typically due to the fact that the physicians within the specialty area are not frequently called in when on-call.

- >>> Frequency of the call coverage and the number of available physicians on the call panel. The amount of call coverage physicians provide is an important factor when evaluating if on-call pay is appropriate and reasonable, and can impact the actual rate paid for coverage. The fewer the number of physicians available to serve on a call panel, the more shifts of call coverage each physician on the call panel must provide. Given the increased burden, by individual physician, of providing coverage in these circumstances, there is higher likelihood that the physicians will receive on-call pay. It may also increase the amount of call pay provided. Call coverage rotations of 1 shift in 5 days (1:5) for surgeons and 1 shift in 4 days (1:4) for medical specialists are average and typical. Physicians providing 1:2 coverage are more likely to receive call pay than physicians providing 1:10 coverage.
- >> The likelihood of the physician to be called in when providing call coverage. Physicians in some specialties are seldomly called in when on call (as in the Ophthalmology example above), however, due to EMTALA, are required to be on an ED call panel. Physicians in other specialties, such as Orthopedic Surgery, Neurosurgery or Trauma Surgery are much more likely to be called in when on-call. These specialties tend to receive the highest on-call pay rates.
- >> Acuity of care typically provided when called in. Physicians serving on a trauma call panel are more likely to be compensated for call coverage and the rates are generally higher than physicians providing general ED coverage. For example, the median hourly rate for Neurosurgery call in a Level 1 Trauma Center was \$83.33, compared to a median rate of \$62.50 for all types of organizations.7

Similarly, physician specialists that provide services with higher acuity and intensity generally garner higher on-call pay rates than other specialists. For example, the median rate for unrestricted coverage among combined surgical specialties was \$30.73, while the median rate for unrestricted coverage among combined primary care physicians was \$12.50.8

⁶ Based on unrestricted rates reported in SullivanCotter's 2012 Physician On-Call Pay Survey.

⁷ Same source as above.

⁸ Same source as above.

- Provisions for uncompensated care. When call coverage is provided for an organization that delivers care to a large uninsured or underinsured population, the professional fees for services provided by independent physicians are likely to be low or nonexistent. In these environments, the likelihood increases that physicians will require call pay. The call pay amount required is also likely to be higher. Conversely, when call coverage is provided in a setting in which there is a high level of commercial reimbursement and a low risk of non-payment of professional fees, there may be less need or justification for call pay and/or the call pay may be lower. As indicated in the OIG AOs, consideration must be given to both the call pay and the compensation received for services provided when called in.
- >>> Employed Physician Call Pay. For employed physicians receiving call pay, consideration should be given to incentive plans based on work Relative Value Units (wRVUs) or other incentive compensation that may be tied to services performed by physicians when called in to provide services. The call pay for employed physicians should also not overlap with any base salary they may be receiving for clinical work during the call coverage period. For example, an employed physician who is scheduled to work 8-5 on a weekday and is on call for 24-hours that same day should not receive call pay for the 8-5 time period he or she is receiving a salary for scheduled clinical work.
- >>> Compensation for excess call only. Many organizations have started to provide on-call pay for "excess" call only. This means that the physician must provide a specified number of uncompensated call shifts per month before he or she is eligible to receive on-call pay. This is more common for employed physicians.
- >>> Compensation for concurrent call coverage. Another emerging trend is to compensate physicians serving on concurrent call panels. For example, a health system may have a physician providing call coverage for two or three of its entities at one time; or a physician may serve on two or three concurrent call panels for one hospital, such as Hip/Joint Orthopedic Trauma Surgery call and general ED Orthopedic Surgery call. In such instances, the physician typically requires additional call pay due to the increased

volume of calls received and the likelihood of being called in. However, the compensation for concurrent coverage should be carefully reviewed so that the physician does not receive the full amount for each of the call panels. For example, the physician may receive 100% of the call pay for covering Hospital A and 50% for covering Hospital B. This allows the organization to lower its on-call expenditures while acknowledging the increased burden placed on physicians providing concurrent coverage.

As described in the OIG AO's, it is important that on-call pay rates are set in advance and that call pay is available to all physicians in a given specialty. Factors supporting the provision of on-call pay should be well documented.

On-Call Pay Approaches

With the increased prevalence of on-call coverage, organizations are beginning to develop strategic approaches for addressing on-call pay, including the following:

- Tiered Level: Compensation based on call frequency, likelihood of being called in or other call coverage requirements.
- Excess Call: Call pay requiring a minimum threshold of call hours or shifts before call compensation is paid.
- >>> Per-Procedure: Compensation paid to physicians on a per-procedure basis for services provided while on-call.
- Telephonic Coverage: Payment for telephonic consultations with no immediate physician obligation to present to the hospital.
- >>> Concurrent On-Call Coverage: Payment based on simultaneous on-call coverage for more than one hospital within a multi-hospital system.

As the prevalence of on-call pay and the associated expenditures continue to increase among health care organizations, so will the variety and complexity of compensation arrangements. The current regulatory environment dictates that these arrangements be closely scrutinized and consistently monitored to ensure compliance with federal regulations. Though the OIG has recognized the legitimacy of some on-call pay arrangements, it has clearly outlined the requirement that the compensation for such arrangements be FMV and that commercial reasonableness is well-documented.