

# Using “Relative Burden” to Determine Reasonable ED Call Coverage Compensation

Stuart J. Schaff, Senior Manager



Many hospitals are finding themselves in discussions with physician specialists regarding compensation for emergency department (ED) call coverage. An increasing number of physicians are paid for this coverage, and information on these payments is becoming more widely available to physicians in the form of published surveys and conversations with fellow physicians.

While healthcare finance leaders certainly understand that being on call is a burden for physicians, they also recognize that this burden can vary depending on various factors. So how can healthcare finance leaders determine what level of payment is consistent with fair market value and is commercially reasonable? To begin to answer this question, it is important to understand the concept of “relative burden,” the degree to which physicians are impacted by a hospital’s needs, relative to other physicians who provide the same coverage to other hospitals. This concept is also helpful in helping physicians compare the services they provide to one hospital to payments at another hospital, or to market data.

## QUESTIONS THAT UNCOVER RELATIVE BURDEN

Six generally accepted drivers of relative burden can help finance leaders in discussions with physicians:

**Is the coverage restricted or unrestricted?** Specialists who need to be physically present at the hospital 24/7 when on call (i.e., restricted coverage) have a heavier relative burden than those who are able to be at home or seeing other patients in between calls (i.e., unrestricted coverage). The type of coverage is ultimately dictated by how quickly the on-call physician is required to respond and in what manner (i.e., by phone or in person).

**How many days is the specialist on call?** Finance leaders should understand whether a physician is on call more or less frequently than the norm for his or her specialty. For instance, market data indicate that the median size of an ED call panel for orthopedic surgery is five physicians. Assuming that physicians represented by the market data generally share call shifts equally<sup>1</sup>, an orthopedic surgeon who is on call every third day has a relatively higher burden than his or her peers.

**How often will the physician's phone (or pager) likely ring?** Many different factors influence how often a physician is likely to be contacted while on call, including:

- The hospital's market (i.e., rural, suburban, urban)
- The patient population (e.g., a relatively large number of older or sicker people)
- The type of hospital (i.e., tertiary versus community)
- The timing of the physician's shift (e.g., days versus nights or weekends)

While it is impossible to predict with certainty how often a physician's phone will ring, hospital leaders can get a sense of what an average on-call shift looks by asking ED staff to keep a call coverage log. Whenever an on-call specialist is contacted, staff should document the date, time, reason for call, specialty needed, and any other relevant information. Hospitals that engage in this best practice approach will be better prepared to quantify the burden.

**What is the likelihood that the physician will need to come to the hospital?** A call coverage log might also be used to track how often on-call physicians of various specialties answer clinical inquiries via phone versus how often they need to get out of bed or leave a social function to drive to the hospital, and how much time they spend treating patients once they arrive there.

**How complex are the cases that the physician is likely to take as a result of being on call?** This question relates to malpractice risk, which tends to be higher at trauma centers, tertiary medical centers, and other hospitals that cater to more complicated cases.

**Will the physician be paid in any manner for services provided while on call?** It is fairly common for hospital-employed physicians to have a flat salary and/or WRVU-based pay that ensures they receive credit for services provided to patients in the ED, regardless of those patients' insurance status.

---

<sup>1</sup> It should not be assumed that all the physicians on a hospital's ED call panel for a given specialty are sharing the duty in an even manner. For instance, in a panel of four orthopedists, one may not take calls and another may not take night or weekend calls, leaving the remaining two orthopedists with the brunt of the burden.

Independent physicians, on the other hand, tend to be more concerned about the loss of potential income. If they see few patients while on-call, or take care of many uninsured or low-paying patients, then they will be limited in the amount they will receive as reimbursement for their services.

### **A MATTER OF FAIRNESS**

During discussions with physicians about on-call compensation, hospital leaders can point to the concept of relative burden as a key aspect driving the fair market value of the coverage. Talking through these six questions can be a good way to demonstrate that the hospital aims to ensure that compensation is fair relative to what others in the market are paying. ●