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Fair Market Value for Call Coverage: Benchmark Tables Are Not Enough

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In the past decade, emergency departments (EDs) became the front door to health care for a sizable number of Americans. The trend is well known. A recent report by the RAND Corporation points to research findings indicating that utilization of hospital EDs grew almost double the rate of U.S. population growth between 2001 and 2008. And the trend has not abated.

Historically, specialists have provided coverage for emergency visits gratis, as a condition of medical staff membership. More recently, though, physicians have resisted the "weight" of the beeper, and hospitals have found it increasingly difficult to ensure coverage without compensation.

In fact, industry surveys indicate that most hospitals now compensate both employed and independent physicians to provide call coverage. This remuneration takes many forms including stipends, subsidies for unassigned/uninsured patients, response/activation fees, or malpractice premium support.

With all these deals being made, how can hospitals be certain that compensation for call coverage meets fair market value (FMV) requirements? Many hospitals and their advisers assume that any amount between the 25th and 75th percentile of publicly available benchmarks for a given specialty is consistent with FMV.

There are two major problems with this approach. First, it provides an unhelpfully wide range of potential values. For example, daily call coverage compensation rates for neurosurgeons (reported in the Medical Group Management Association's Medical Directorship and On-Call Compensation Survey 2012 Report Based on 2011 Data) vary by more than 200 percent from the 25th percentile ($1,138) to the 75th percentile ($2,350).

Second, as anyone who has bought a home knows, there are multiple factors that impact value. For a home, these factors include location, size, condition, amenities, and age. In the case of call coverage, the government has indicated—generally through advisory opinions issued by the Department of Health & Human Services Office of Inspector General—that "call burden" should be considered when determining the value of call coverage. Multiple factors should be considered when evaluating call burden, including:

- The number of physicians rotating on-call responsibilities
- The physician response time required
- The frequency with which each physician is required to respond, via telephone or in person
- The opportunity to receive compensation for professional services provided in connection with a call event
- The risk profile of the call events and physician obligations for follow-up and documentation

Publicly available benchmarks can be a very useful tool if applied correctly.

Once all of the facts particular to a given call panel have been gathered, they need to be compared to the typical call burden for the same specialty at similar facilities, to determine whether the call panel's burden is typical or the degree to which it is relatively higher or lower.

Publicly available benchmarks can be a very useful tool if applied correctly. However, to ensure compensation conforms to FMV requirements, hospital finance professionals must be aware of the appropriate way to use qualitative and quantitative factors in defining reasonable compensation for call coverage and other physician services.

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