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HEALTHCARE MANAGEMENT ADVISORS

Compensation to Employed Physicians for Providing On-Call Coverage

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Hospitals are increasingly challenged to meet their Emergency Department (ED) and trauma center coverage requirements. This challenge has been enhanced by the shortage of specialty physicians in certain markets, and the increasing number of physicians unwilling to provide the coverage, due to quality-of-life issues, reimbursement pressures, and increased malpractice liability related to emergency care.

Therefore, more and more frequently, employed physicians are receiving compensation for providing on-call coverage services. While there are a variety of factors that contribute to determining the fair market value (FMV) rates for on-call services, there are two key factors requiring careful consideration before *any* payments are made for on-call services to employed providers:

1. Baseline (minimum) call requirements; and
2. Concurrent call, that is, providing call coverage for more than one hospital simultaneously.

We discuss both of these concepts below. Properly structuring on-call arrangements with employed physicians is critical from a financial, strategic, and regulatory perspective.

BASELINE VERSUS EXCESS CALL

Emergency Department call coverage is an expected responsibility for most employed physicians. It is important that organizations spell out, in the medical staff bylaws, departmental policies, or in the employment agreement itself, the minimum number of uncompensated call days that are required. This is especially important in specialties with significant and burdensome ED call needs. SullivanCotter reports that 50% of respondents require their employed physicians to provide a minimum number of monthly call coverage hours or shifts prior to being eligible for on-call compensation.

Various surveys including MGMA and Sullivan Cotter publish information on unpaid call coverage requirements. These benchmarks can help the institution establish internal policies. These baseline requirements typically range from 5 days per month for obstetrics and gynecology to 7 days per month for medical specialties.

Consider the median daily rate for orthopedic call coverage of $1,000. It would not make business sense, nor would compensation be consistent with fair market value, if an employed physician earning the median compensation of approximately $600,000 and providing call coverage one in five nights, (six days per month and 73 days per year) is paid an additional $1,000 per day for call coverage, totaling $73,000 per year. We believe that implicitly, the market data includes the baseline level of call.

However, any call coverage provided beyond those baseline days per year could be considered “excess” call coverage and therefore compensable.

Compensable on-call coverage = Total on-call coverage days – Baseline days

It is reasonable to compensate for call if it is in excess of what is expected – as long as some baseline parameters are established. Just as compensation market data varies by physician specialty, so do the baseline number of on-call days expected. The key is to determine the baseline level of call for each specialty and to codify that via policies and/or employment agreements.

Once it is established that the call is compensable, the same factors that apply to determining the FMV of call coverage, apply to the determination of the FMV of excess call coverage, namely:

- The number of physicians rotating on-call responsibilities;
- The response time required;
- The frequency with which the physicians are required to respond;
- The opportunity to receive compensation for professional services provided in connection with a call event; and
- The risk profile of the call events and the physicians’ obligations for follow-up care and documentation.

CONCURRENT CALL

With growing health system consolidation, it has become fairly standard for physicians to provide call coverage at multiple locations simultaneously (i.e., concurrent call coverage). While incremental hospital locations may increase the burden of on-call coverage, the addition of a second hospital to a call panel does not necessarily *double* the burden.

Therefore, it is not appropriate to simply double the rate when a second hospital is added to the call coverage rotation.

This is because there are two distinct aspects to consider when evaluating the burden associated with call coverage. The first can be referred to as the "baseline burden" and represents the on-call physician's ***availability*** to respond by phone or in person to emergent medical situations within a specified period. This relates to the restrictions on a physician's activity due to being on call. This "baseline burden" is the same regardless of how many hospitals are covered.

The second aspect of the burden of concurrent coverage can be referred to as "incremental burden." This incremental burden reflects the additional responsibility and burden placed on the on-call physicians for covering multiple hospital locations (such as the number of phone calls, the number of times the physician is required to present to a hospital, the need to travel between the facilities during each shift, familiarity and judgement with respect to managing additional staff and facilities). Therefore, to assure that a physician is not paid twice for the same service, hospitals should consider that the FMV compensation for concurrent call coverage for multiple facilities is less than the sum of the FMV rates for single-facility coverage at each facility.

CONCLUSIONS

Compensating employed physicians for on-call coverage is increasingly prevalent. Due to the costs associated with these practices, in addition to the complex regulatory implications, we encourage provider organizations to:

- Develop institutional policies to establish minimum or baseline call requirements for employed physicians; and
- Consider the efficiencies of covering multiple facilities at once.