On-Call Compensation Arrangement Defined

When commercially reasonable factors exist to compensate a physician to provide either restricted or unrestricted call coverage for their immediate availability (by phone or pager for unrestricted call) to provide consultation or direct patient care at the request of the hospital:

The compensation is paid for the hospital's access to the physician who is required to remain in close proximity to the hospital and be physically and mentally capable of providing consultation and/or direct patient care. As such, on-call physicians must also refrain from drinking alcohol or taking any medication that would inhibit the physician's ability to treat patients.
Market Trends

- Nearly two-thirds of health care organizations provide call pay to at least some physicians today\(^1\)
  - Up from 54% in 2010 and 2009
- According to SullivanCotter's 2011 Physician On-Call Pay Survey on-call pay expenditures were:
  - $2.3M for all types of survey participants
  - $3.2M for trauma centers
- Nearly one-half of the 189 survey participants reported that their on-call pay expenditures have increased over the past 12 months

\(^1\) Data abstracted from SullivanCotter’s 2011 Physician Compensation and Productivity Survey
Market Trends

- Call coverage is either restricted or unrestricted:
  - Restricted call coverage means that the physician is required to remain on the premises
  - Unrestricted call coverage means that the physician is not required to remain on the premises but must be on-site within a specified time frame (typically 30 minutes)
- Most call coverage arrangements are for unrestricted call

Market Trends

<table>
<thead>
<tr>
<th>Type of Call</th>
<th>25th Percentile</th>
<th>50th Percentile</th>
<th>75th Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restricted</td>
<td>$48.75</td>
<td>$77.70</td>
<td>$100.00</td>
</tr>
<tr>
<td>Unrestricted</td>
<td>$14.58</td>
<td>$21.23</td>
<td>$40.00</td>
</tr>
</tbody>
</table>

*The rates paid for restricted call are higher than the rates paid for unrestricted call*
Market Trends

• There are two types of call coverage:
  – General emergency department call coverage (most common)
  – Trauma call coverage

<table>
<thead>
<tr>
<th>Neurosurgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Call</td>
</tr>
<tr>
<td>General ED</td>
</tr>
<tr>
<td>Trauma Call</td>
</tr>
<tr>
<td>Level I Trauma Center</td>
</tr>
</tbody>
</table>

*Trauma call rates are typically higher than the rates paid for general emergency department call*

Market Trends

• Telephonic call coverage is an emerging practice:
  – The physician is not required to be physically present at the hospital; but must be available for telephone consultation
  • Nearly one-quarter of the survey participants indicate that at least some physicians receive on-call pay for telephonic consultations
  • The compensation approaches are shown below:

<table>
<thead>
<tr>
<th>Methods of Compensation</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paid 100% of the unrestricted on-call rate for the specialty</td>
<td>55%</td>
</tr>
<tr>
<td>Paid a flat rate per consult</td>
<td>25%</td>
</tr>
<tr>
<td>Paid a flat monthly rate for the provision of telephonic coverage</td>
<td>10%</td>
</tr>
<tr>
<td>Paid a percent of the unrestricted on-call rate for the specialty</td>
<td>10%</td>
</tr>
</tbody>
</table>
Market Trends

- Compensation for call coverage is paid as:
  - Stipend or hourly rate for coverage
    - For example: $1,000 per day for 24 hours of coverage
  - Compensation for actual services provided when called in
    - For example:
      - $150.00 per hour for actual services provided
      - Guarantee of 100% of the Medicare rate for services provided
      - $45.00 per work Relative Value Unit (wRVU)
  - Compensation for both call coverage and services provided when called in

Each of these has different implications when determining if the compensation is within FMV

Market Trends

On-Call Pay Practices for Non-Employed Physicians

- 92% of the survey participants in the on-call survey provide on-call pay to non-employed physicians. Of these:
  - 24% provide compensation for trauma coverage only
  - 44% percent provide compensation for services when called in
  - Of these, nearly one-half (46%) provide this compensation in addition to a stipend or hourly rate for coverage
    - Most common is a subsidy for unassigned or uninsured patients
      » Such as percent of Medicare fee schedule, rate per wRVU
      » Some provide an hourly rate or activation fee
  - 72% of survey participants indicate that non-employed physicians always retain the professional fees generated while on-call
Market Trends

On-Call Pay Practices for Employed Physicians

- 77% of the survey participants in the on-call survey provide on-call pay to employed physicians. Of these:
  - 22% provide compensation for trauma coverage only
  - 21% indicate that call pay is factored into the total compensation provided to employed physicians

Market Trends

- About one-quarter of organizations provide compensation for excess call only
  - Medical Specialties are required to be on-call more than 1:4 or provide an average of seven shifts of call coverage per month before receiving on-call pay
  - Surgical Specialties are required to be on-call more than 1:5 or provide an average of six shifts of call coverage per month before receiving on-call pay
Market Trends

- More than two-thirds (68%) of survey participants employ physician extenders
  - Of these, 38% indicate the physician extenders provide call coverage:
    - Rates range from:
      - 25th percentile: $6.25
      - 50th percentile: $7.00
      - 75th percentile: $8.35

Key On-Call Compliance Issues

- Is compensating for call coverage commercially reasonable?
  - Factors to consider include:
    - History of on-call services without compensation
    - Frequency of call
    - Number of physicians participating in call rotation
    - Refusal of physicians to provide uncompensated call
    - Competing hospitals providing call compensation
    - Compensating targeted specialties (e.g., trauma) vs. compensating all specialties
Key On-Call Compliance Issues

- Documentation supporting on-call services:
  - Medical staff call schedule
  - Documentation that physician responded when called by the hospital
  - Physician certification of call services

- Physician providing call services at multiple *unrelated* hospitals:
  - Backup plan implemented when physician providing direct care services at one hospital, but called by second hospital
  - Impact on FMV compensation
  - Possible certification by physician in contract that compensation for call services is not being paid by multiple hospitals

| What if multiple hospitals are related? |

---

Key On-Call Compliance Issues

- When to compensate employed physicians?
  - Everyday?
  - Only when employee provides a disproportionate amount of call (excess call)?
    - More than six days per month for surgical specialties
    - More than seven days per month for medical specialties
    - Variance related to likelihood of being called in
  - Call pay cannot be provided concurrent with other services such as clinical or medical director services
  - Therefore, most call pay arrangements for employed physicians are for weekend or night coverage only
Key On-Call Compliance Issues

• How to determine FMV compensation:
  – Benchmark resources
  – Market influences
  – Factors to consider when applying compensation benchmark range (25th, 50th, 75th, 90th percentiles)
  – Available alternatives

Key On-Call Compliance Issues

• Selection of physician/group to compensate for call coverage:
  – High referral sources
  – Every physician in specialty
  – Rotate by individual physicians versus physician groups

• Who retains reimbursement for personally performed services when physician is paid to be on-call?
  – On-call physician?
  – Hospital?
  – Can hospital guarantee a minimum amount of reimbursement when called in?
Key On-Call Compliance Issues

- On-call compensation is a “financial arrangement” under Stark Law; therefore, an applicable exception must be met. Available exceptions:
  - Personal service arrangement
  - FMV
  - Employment

Unless physician is an employee, the arrangement must be in writing and signed by the parties for a term of at least one year

Key On-Call Compliance Issues

- Anti-Kickback Statute could be implicated through compensated call arrangement
  - No intent to induce referrals
  - No intent to reward physician/group through compensated call arrangement
- Physician must respond consistent with the contract and the medical staff bylaws/rules and regulations
  - EMTALA is implicated
  - Physician at the hospital makes determination whether on-call physician is required to come to the hospital for specialty service
- Ensure all physicians providing call coverage are appropriately licensed and credentialed
What is FMV?

- According to the Stark Law, FMV is “the value in arm’s length transactions, consistent with the general market value”

What is FMV?

- “General Market Value” means the price that an asset would bring as a result of *bona fide* bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party, or the *compensation* that would be included in a service agreement as a 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, on the date of acquisition of the asset or at the same time of the service agreement. 42 C.F.R. § 411.351
What is FMV?

- An FMV safe harbor for *hourly rates* was developed under Stark in the Phase II regulations
  - Safe harbor deleted in Phase III regulation; however, OIG stated that safe harbor methodology is still prudent documentation process

FMV Safe Harbor Deleted

- An *hourly rate* is deemed to be FMV if it meets one of the following two tests:
  - Hourly rate is less than or equal to the average hourly rate for emergency room physician services in the market provided there are at least three hospitals providing emergency room services in the market
  - Hourly rate is determined by averaging the 50th percentile national compensation level with the same physician specialty in at least four of the following surveys, and dividing by 2000 annual hours:
    - **Sullivan, Cotter and Associates, Inc.**: *Physician Compensation and Productivity Survey Report*
    - **Hay Group**: *Physician’s Compensation Survey*
    - **Hospital and Health Care Compensation Services**: *Physician Salary Survey Report*
    - **Medical Group Management Association (MGMA)**: *Physician Compensation and Production Survey*
    - **ECS Watson Wyatt**: *Hospital and Health Care Compensation Report*
    - **William M. Mercer**: *Integrated Health Networks Compensation Survey*
Government Oversight

• Cases: None
  – Why?
    • New phenomena
    • FMV hard to litigate

Government Oversight

• There are two helpful OIG Advisory Opinions regarding physician on-call pay arrangements
  – Can be used to help guide determination of FMV
OIG Advisory Opinions

OIG ADVISORY OPINION 07-10 (SEPTEMBER 20, 2007)

• Medical center intended to pay certain physician specialties a per diem rate for each day spent on-call for the ED; arrangement required physicians to participate in a call rotation schedule, respond to calls in a timely fashion, and provide inpatient care to any patient seen in the ED while on-call

• OIG issued examples of problematic compensation for on-call pay arrangements which included:
  – “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 Opinions

OIG ADVISORY OPINION 09-05 (MAY 14, 2009)

• Hospital proposed to pay physicians a uniform fee schedule related to ER consultations ($100); ER admissions ($300) and ER surgical procedures ($350); arrangement required physicians to waive all rights to bill any other insurance company or receive additional payments for the services provided

• OIG highlighted the following factors in its favorable review of this arrangement:
  – Physicians are paid for “tangible” services provided to indigent patients, as opposed to lost opportunity
  – 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 responsible for providing follow-up care with no additional compensation
  – Rates of payment reflect the value of the services provided
OIG Advisory Opinions

WHAT DOES THIS MEAN?

• Reason(s) for providing on-call pay should be well documented
• Compensation approach and rate of pay should be set in advance
• Compensation should be based on FMV standards:
  – Market survey data specific to call pay
  – Percent of Medicare fee schedule
  – Hourly rate for the specialty for actual services provided
• Call pay should be paid for actual services provided only
• Call pay should be available to all physicians in the specialty
• Watch for “double” payment for services

On-Call Pay Approaches

• Organizations are beginning to develop strategic approaches to addressing on-call pay. Such approaches may include:
  – Tiered levels of on-call pay which vary based on
    • The frequency of call coverage
    • The likelihood of being called in
    • The market rates for the specialty
    • Trauma call versus non-trauma call
    • Multiple facilities vs single facility
    • Others?
  – Compensation for excess call only (mentioned earlier)
  – Compensation for services only
• An example of a tiered approach is shown in the next page
On-Call Pay Approaches

Example On-Call Pay Tiered Approach

<table>
<thead>
<tr>
<th>Frequency of Call</th>
<th>Likelyhood of Being Called In</th>
<th>Score</th>
<th>Median Market Rate for Specialty</th>
<th>Score</th>
<th>Trauma Call</th>
<th>Score</th>
<th>Multiple Facilities</th>
<th>Score</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2 - 1:4</td>
<td>Every time every other time on call</td>
<td>5</td>
<td>$55.00 or more</td>
<td>10</td>
<td>Yes</td>
<td>5</td>
<td>Yes</td>
<td>5</td>
<td>30</td>
</tr>
<tr>
<td>1:4 - 16</td>
<td>Every 3rd or 4th time on call</td>
<td>3</td>
<td>$35.00 - $50.00</td>
<td>7</td>
<td>No</td>
<td>0</td>
<td>No</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1:5 - 18</td>
<td>Every 5th or 6th time on call</td>
<td>3</td>
<td>$20.00 - $25.00</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; 1:5</td>
<td>Every 7th time or more on call</td>
<td>0</td>
<td>Less than $20.00</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Frequency</th>
<th>Likelyhood</th>
<th>Market Rate</th>
<th>Trauma Call</th>
<th>Multiple Facilities</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopedic Surgery</td>
<td>10</td>
<td>5</td>
<td>10</td>
<td>5</td>
<td>5</td>
<td>35</td>
</tr>
<tr>
<td>Oral &amp; Maxillofacial</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>11</td>
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<td>Urology</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>8</td>
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<tr>
<td>General Surgery</td>
<td>7</td>
<td>3</td>
<td>7</td>
<td>5</td>
<td>0</td>
<td>22</td>
</tr>
</tbody>
</table>

Tier 1  30 and Up   $45.00-$55.00
Tier 2  20-29        $25.00-$34.00
Tier 3  10-19        $25.00-$34.00
Tier 4  Less than 10  $ -

Questions

Questions?
Attachment – Key Terms and Definitions

Call Coverage – Key Terms

• Types of physician call coverage:
  – Unrestricted call: the physician is not required to remain on the premises, but must be able to respond to the call within a specified time frame (typically 30 minutes)
    • Would not be included in physician clinical work effort
  – Restricted call: the physician is required to remain on the premises
    • May be counted in physician clinical work effort
  – General ED call coverage
  – Trauma call coverage
  – Availability for telephonic consults
    • Would not be included in physician clinical work effort
  – Non-ED call coverage (e.g., NICU)
• While unrestricted call coverage and availability for call are not included in the determination of total clinical work effort, the amount of call coverage provided by an individual physician is important to track
  - Excess call: call coverage up to a specified threshold is considered part of the physician’s role and responsibility and no additional call pay is provided. If that threshold is exceeded, there is a trend to provide on-call pay for excess call
  • Excess call thresholds typically vary based on physician specialty, the likelihood of being called in and to some degree, the intensity of the services provided when called in. Surgical specialties will have a lower threshold as they are more likely to be called in. Trauma coverage will have a lower threshold as the physicians are more likely to be called in and the intensity of services will likely be greater than general ED coverage

**Call Coverage – Key Terms**

- Daily stipend: the amount paid for daily coverage. Daily stipends are typically based on 12, 16 or 24 hour days
- Weekly stipend: the amount paid for weekly coverage. Typically based on 24/7, which equates to 168 hours per week
- Annual stipend: the amount paid for annual coverage. Typically provided by a group. The total annual hours based on 24/7 coverage equates to 8,760 hours per year (365 days x 24 hours)
- There are two OIG Advisory Opinions which provide guidance on how on-call pay

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Physician On-Call Pay Data for 10 Specialty Areas

Physician On-Call Pay Market Survey Data

DATA FOR 10 SPECIALTIES ¹

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Unrestricted - All</th>
<th>Unrestricted - Trauma Call</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>25th</td>
</tr>
<tr>
<td>Aesthetics</td>
<td>27</td>
<td>$31.25</td>
</tr>
<tr>
<td>Cardiology-General</td>
<td>38</td>
<td>$18.07</td>
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<tr>
<td>General Surgery</td>
<td>78</td>
<td>$32.93</td>
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<tr>
<td>Hematology</td>
<td>40</td>
<td>$33.33</td>
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<tr>
<td>Neurosurgery-Int Care</td>
<td>76</td>
<td>$33.32</td>
</tr>
<tr>
<td>Ob/Gyn-Int Care</td>
<td>56</td>
<td>$14.58</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>110</td>
<td>$31.25</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>50</td>
<td>$12.50</td>
</tr>
<tr>
<td>Trauma Surgery-Int Care</td>
<td>32</td>
<td>$31.25</td>
</tr>
<tr>
<td>Urology</td>
<td>52</td>
<td>$12.50</td>
</tr>
</tbody>
</table>

¹ Data abstracted from SullivanCotter's 2011 Physician On-Call Pay Survey. Reflects data provided by 100 organizations from across the U.S.
<table>
<thead>
<tr>
<th></th>
<th>Robert A. Wade, Esq.</th>
<th>Kimberly A. Mobley</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Krieg DeVault.</strong></td>
<td>Partner</td>
<td>Managing Principal, Physician Practice Leader</td>
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<td>4101 Edison Lakes Parkway, Suite 100</td>
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<td></td>
</tr>
<tr>
<td>Mishawaka, IN 46545</td>
<td>Southfield, MI 48075</td>
<td></td>
</tr>
<tr>
<td>Phone: 574.485.2002</td>
<td>Phone: 248.204.9520</td>
<td></td>
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<tr>
<td>Email: <a href="mailto:bwade@kdlegal.com">bwade@kdlegal.com</a></td>
<td>Email: <a href="mailto:kmobley@sullivancotter.com">kmobley@sullivancotter.com</a></td>
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</table>