

PHYSICIAN COMPENSATION & RECRUITMENT

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Compensation

On-call pay trends begin to stabilize, survey finds

The tug-of-war between hospitals and physicians over on-call pay may be nearing a truce, and hospitals are seeking ways to strike a balance between their budgetary concerns and physicians' desire to be paid for on-call duty. As a result, on-call pay rates are stabilizing.

Detroit-based Sullivan, Cotter and Associates, Inc., recently released its fourth annual survey of physician on-call pay rates and practices, the *2008 Physician On-call Pay Survey Report*, and although the prevalence of on-call pay for physicians continues to increase, the growth in the rates paid for call coverage has slowed.

The survey of 132 healthcare organizations, conducted in January and released in August, outlines physician on-call pay practices and rates paid for 33 physician specialty areas, along with data reported for trauma and nontrauma centers. Nearly two-thirds of the participants reported that their physician on-call pay expenditures increased within the 12 months preceding the survey.

Hospitals are becoming strategic about how they provide on-call pay. As a result, those rates are stabilizing, says **Kim Mobley**, a principal at SullivanCotter and director of the survey.

When the issue first emerged, hospitals were in a reactive mode and simply threw money at the problem, Mobley explains. "Now, organizations are becoming more sophisticated, working with physician groups to develop a plan to compensate for on-call coverage." In fact, 57% of the organizations surveyed indicate decisions regarding on-call pay levels are developed through a consensus process involving physician leadership.

Hospitals are developing a variety of approaches to ensure that they can obtain adequate on-call coverage.

Sixty-seven percent of the respondents have implemented, or are considering implementing, policies and procedures for addressing the situation. (For a look at the current and pending procedures, see Figure I on p. 2.)

"The pendulum is swinging back, and hospitals are requesting some **on-call coverage before the call pay kicks in.**"

—Kim Mobley

Steven A. Nahm, vice president of The Camden Group in El Segundo, CA, has seen his hospital clients create innovative strategies to address the issue. Some hospitals are turning to hospitalist-like coverage for higher-volume services, such as general and orthopedic surgery, or for services in which timing is crucial, such as cardiac interventions. (Look for a follow-up article on hospitalist-related on-call trends in a future PCR.)

Nahm says he also expects to see more hospitals take advantage of telemedicine technology for consult coverage, especially for rural hospitals that lack a complete complement of specialists. (For more on telemedicine, see Figure 2 on p. 2.)

Compensation

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Costs continue to rise

Of survey participants reporting that their physician on-call pay costs had increased within the past 12 months:

- » 25% reported a 1%–10% increase
- » 24% reported an 11%–50% increase
- » 15% reported a more than 50% increase

Thirty-six percent said expenditures stayed about the same, and none reported a decrease. From 2006 to 2008, the median expenditures reported by trauma centers for physician on-call pay increased by 88%; the median expenditures in nontrauma centers increased by 91%. (For an overview of on-call expenditures for 2006–2008, see Figure 1 below; for the overall national median on-call rates for all specialties, see Figure 3 on p. 3.)

Although overall expenditures have risen due to the number of physician specialties receiving on-call pay, the actual rates paid for call coverage have increased only moderately in recent years, Mobley says. “For the first few years of the survey, median rates were all over the place; over the last two years, things have calmed down,” she adds.

Nahm says he has found considerable variation among the hospitals he works with. “Factors such as supply of willing physicians, ED payer mix, and ED call volume at particular

hospitals have led to substantial increases in certain geographical areas and specialties,” he says, adding that the survey corresponds with his experience. “In general, hospitals and medical staffs [are] coming to an understanding that on-call pay is not a solution, and jointly searching for ways that more effectively spend coverage dollars to reduce ED on-call burden on physicians or to ensure that coverage for their community is available.”

Fewer shutdowns

One promising sign of stabilization is that the number of survey participants who reported shutting down one or more services due to the lack of physicians available to provide on-call coverage has held stable at 16% in this year’s survey and 15% in the 2007 survey.

In contrast, the 2006 survey found that nearly one-quarter of trauma centers and 13% of nontrauma centers had to shut down at least one service due to a lack of physicians available for coverage.

Nevertheless, a few are simply forgoing ED on-call coverage in select specialties and contracting with referral centers to transfer patients, Nahm says, adding that he expects this trend to expand in coming years.

Figure 1

On-call expenditures, 2006–2008

	Trauma center		Nontrauma center	
	Average	Median	Average	Median
2006	\$1,375,000	\$705,000	\$750,000	\$129,000
2007	\$1,815,134	\$1,164,431	\$764,807	\$433,849
2008	\$2,065,000	\$1,326,000	\$1,436,000	\$928,000

Note: Cautious interpretation of these comparisons should be used, as the sample of survey participants varies each year.

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Figure 2

Percentage of respondents implementing or considering various approaches to on-call coverage

Policy or procedure	Implemented*	Considering*
Periodic locum tenens	48%	31%
Temporary transfer agreements with local hospitals	47%	22%
Hiring staff physicians to provide on-call coverage	43%	47%
Cross coverage agreements with local hospitals	26%	39%
Hiring laborists	14%	37%
Hiring surgicalists	10%	41%

*Percentages total more than 100% due to multiple response categories.

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Pay tied to probability

The key variables determining on-call pay rates are tied to local and national market rates, frequency of the call coverage provided, and the likelihood of being called in for service.

What’s interesting is that the survey identifies a significant variance in on-call rates paid by specialty; some highly compensated specialties receive relatively low on-call rates of pay because they are not as likely to be called in to provide services when on-call, Mobley says.

This trend reflects the relationship between the likelihood of being called in to work and the on-call rate paid. For example, when comparing the rates paid for critical care and invasive cardiology critical care, physicians generally earn less than invasive cardiologists. However, the median unrestricted on-call hourly rate paid for critical care is \$30.93, compared to \$18.63 for invasive cardiology.

One driver might be the September 2007 OIG Advisory Opinion (07-10) that suggested physician on-call pay should relate to the amount of call coverage provided and the likelihood of a physician being called in. However, only 9% of those surveyed indicated that they made changes based on the OIG advisory opinion. (The most common modifications reported were incorporating language from the opinion into

contracts and conducting formal fair market value reviews of on-call pay levels.)

Mobley says the relatively low percentage is due to the survey being conducted in January. Based on conversations she’s had with clients, she believes the 2009 survey will reveal that the advisory opinion has had a significant effect.

Mostly, hospitals are obtaining the data they will need to respond to the opinion, Nahm says. More hospitals are now tracking the frequency of ED on-call contacts by specialty. “As data is accumulated, we expect that this data will be used to fine-tune the relative payments made to specialties,” he says.

However, Nahm reports that he’s already seeing some movement in the direction outlined by the opinion. “We have noticed some hospitals are attempting to avoid per diems or to at least add volume-based payment arrangements for ED on-call coverage,” he says.

Revisiting the social contract

Another emerging trend is the provision of on-call pay for excess-call only, which, in many ways, is a throwback to the time when on-call duty was part of the social contract—it

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Figure 3

Overall on-call pay rates

The table below shows the overall national median on-call rates paid for all physician specialties included in the study.

	All organizations		Trauma Centers		Nontrauma centers	
	Type of call		Type of call		Type of call	
	Restricted	Unrestricted	Restricted	Unrestricted	Restricted	Unrestricted
Daily stipend	\$1,600	\$600	\$1,580	\$750	ISD	\$475
Weekly stipend	ISD	\$2,403	ISD	\$2,000	ISD	\$2,452
Annual stipend	\$663,000	\$182,000	\$750,000	\$182,500	\$482,777	\$146,000
Hourly rate	\$70	\$29	\$81.50	\$30.63	\$65	\$27.40
Calculated hourly rate	\$73.27	\$23.63	\$79.17	\$29.17	\$61	\$20.83

ISD = Insufficient data

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Compensation

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was simply what physicians were expected to do. When physicians started demanding on-call pay, hospitals began throwing money at the issue, Mobley explains.

Now, as part of a more strategic approach, there's more balance. "The pendulum is swinging back, and hospitals are requesting some on-call coverage before the call pay kicks in," Mobley says.

At 21% of surveyed organizations, physicians must provide a certain number of uncompensated hours or shifts before receiving on-call pay.

The following is the breakdown:

- » Medical specialists are required to provide an average of 4.5 shifts or 108 hours of call coverage per month before receiving on-call pay. The median required numbers are 4.25 shifts or 102 hours.
- » Surgical specialists are required to provide an average of four shifts or 106 hours of call coverage per month before receiving on-call pay. The median required numbers are three shifts or 75 hours.

Subspecialty panels create challenges

The growing frequency of distinct subspecialty call panels is a trend that might be contributing to rising hospital ED on-call costs, says **Steven A. Nahm**, vice president of The Camden Group in El Segundo, CA.

For example, instead of an orthopedic general call, there might now be three call panels, one each for general, spine, and hand call. Anesthesiology might include panels for general, cardiac, and OB, and cardiovascular call might be split into cardiovascular, vascular, and thoracic.

There's the administrative hassle of more call panels, but the challenge goes deeper. It requires the ED to have a better understanding of which physician needs to be contacted and to make the decision in a crisis situation. And generally, it's costlier, since the aggregate cost of the subspecialty panels is greater than the payment for the one original call panel.

Mobley says she was surprised at the high number of respondents already using this approach, and she expects more to adopt it as a way to curb rising on-call expenditures.

Use of nonphysician practitioners

During the past two years, Mobley says she has heard murmuring about using mid-level providers for on-call coverage to curb rising expenditures, and she's even seen it in a few contracts. But so far, it hasn't happened.

Although 23% of the survey participants indicated they employ physician extenders, there's very little data available about their actual use. Only nine of the 132 organizations reported data.

What is happening is that these mid-level providers are being used to reduce the burden of physicians while on-call, Nahm says.

"A typical arrangement, for example, is a hospital with orthopedic physician assistants who can admit and stabilize patients on behalf of an orthopedic surgeon," he explains. In this scenario, the surgeon is still contacted and must make a determination as to whether his or her immediate presence is required. Patients are admitted, and the physician can see the patient or perform the surgery at a later time.

On-call pay increasingly prevalent

As more sophisticated compensation strategies are emerging and rates are stabilizing, the prevalence of on-call pay continues to expand, with 28% of the survey participants indicating that they are planning to implement on-call pay for physicians who are not currently receiving it.

The most frequently cited reason for implementing on-call pay within the next six months is a shortage of physicians in certain specialties (primarily surgical specialties and neurology) who are willing to provide on-call coverage. Other reasons cited are:

- » The desire to keep services open and/or increase coverage in certain specialty areas
- » Physician threats of leaving or providing no on-call coverage
- » The desire to create equity among all physicians providing on-call coverage

Because the Emergency Medical Treatment and Active Labor Act of 1986 requires hospitals to maintain on-call

panels of physicians, many have no choice but to expand their on-call pay programs to ensure adequate physician coverage. About 86% of respondents reported providing on-call pay to nonemployed physicians with admitting privileges, whereas 54% provide on-call pay to their employed physicians. In addition:

- » 91% reported that the physician on-call pay is funded solely by the hospital, and 8% reported that the medical group is also providing some of the funding.
- » 58% of the organizations providing on-call pay to nonemployed physicians do not compensate them for providing services when called in. Generally, the physician retains the professional fees. The most common approach was a subsidy for unassigned/uninsured patients (25%), followed by subsidy for malpractice insurance and fee-for-service payment (both at 14%).

One emerging trend is backup call pay. In addition to call pay for a primary call, hospitals are compensating for backup call. So far, it's mainly happening in trauma centers, to higher volume surgical specialties.


Subsidies and guarantees

The survey found that subsidies for unassigned/uninsured patients are the most common (25%) form of payment provided to physicians for providing services when called in.

Because of the payer mix, physicians often can't collect on these patients, so hospitals provide subsidies for unassigned and uninsured patients. This guarantees the physician a reasonable

rate for coming in to serve these patients. Of those providing such subsidies:

- » 75% provide a percentage of the Medicare fee schedule. The average provided percentage is 103%; the median is 100%.
- » 25% provide a guaranteed level of payment; 50% provide the Medicaid rate, whereas 33% provide a fee-for-service payment.
- » 17% provide a payment based on wRVU.

“This approach allows the organization to tie the payments to actual services provided,” Mobley says, adding that she expects more organizations to follow suit. “If it were my hospital, I would certainly explore such an approach.” 

Editor's note: Look for more from this survey, including information about hospitalists, in a future issue of PCR.

PCR sources

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In future issues

- » Recruitment and compensation trends in urology
- » Employed physicians and on-call coverage
- » Recent OIG opinions provide additional guidance
- » Looking ahead: Experts offer predictions for 2009
- » CMS Physician Group Practice Demonstration Project

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Neurology

Low compensation continues to create challenges

Neurohospitalists identified as an emerging trend

Although neurology compensation continues to increase, neither the pay nor the rate of increase is as high as in many other specialties.

Neurologists earned a median total cash compensation of \$220,000 in 2006, a 1.76% increase from \$216,199 in 2005, according to the MGMA 2007 *Physician Compensation and Production Survey*. That remains among the lowest compensation levels of all nonprimary care specialties.

Contrast that \$220,000 with the \$348,706 earned by dermatologists or the \$406,345 by gastroenterologists during 2006.

The smaller compensation—and lower increases—are nothing new, notes **Neil A. Busis, MD**, a fellow of the American Academy of Neurology, chief of the division of neurology and director of the neurodiagnostic laboratory at University of Pittsburgh Medical Center Shadyside and president of the Pittsburgh Neurology Center.

Busis cites MGMA data showing that neurology compensation rose 36.38% between 1996 and 2006. In the same period, dermatology rose 91.83%, gastroenterology rose 81.1%, and radiology went up 65.74%. Family practice increased only 23.85%.

The lower pay rate relates directly to the type of work neurologists do, Busis explains.

Specialists such as cardiologists or gastroenterologists generate income from high-paying procedures; most neurologists' revenue comes from E/M services, which tend to be reimbursed at a lower level than the procedural work done by other specialties.

“Diagnostic and therapeutic procedures are rewarded disproportionately more than evaluation and management services. Volume of E/M services has increased, but there has been a greater relative increase in procedures,” Busis says.

John B. Phifer, senior search consultant at CompHealth in Salt Lake City, citing 2006 data, notes that a pulmonary/critical care physician will generate, on average, \$1.3 million annually for a hospital; a neurologist will generate less than half of that. In particular, dermatology and gastroenterology generate

enormous profits, Phifer says. “Groups of neurologists are competing with multispecialty groups who may choose to grow faster in other specialties,” he adds.

Busis notes the following two trends:

- » E/M compensation increased in the past few years. However, Congress applied a work adjustor in the Medicare fee schedule that largely negated the gains in reimbursement for E/M services.
- » The professional component RVUs for the most commonly done neurology procedures (e.g., EMG and nerve-conduction studies) decreased dramatically in recent years. There is a stronger incentive than ever not to provide these services in hospitals. In the office, the neurologist gets reimbursed the global amount (professional plus technical components), but in the hospital, the neurologist receives only the professional component.

“Neurologists lag in income and percent increase in income because we are primarily a cognitive specialty, and there is a disproportionate reward in the current reimbursement environment for specialties that do procedures,” Busis says.

The disparity is reflected in locum tenens work, although perhaps not as sharply.

“Our daily rate for neurologists is about 15% lower than the average rate of all of our specialties,” reports Phifer's colleague **Alisa Weeks**, manager of the subspecialties team at the CompHealth locum tenens division.

However, Weeks says the average is driven up by the high pay rates of surgical specialties, so compared to most others, the neurology rate is about the same or higher. (For more on locum tenens trends, see “Neurology and locum tenens” on p. 8.)

Shortages and recruiting

As the U.S. population ages and the prevalence of stroke and neurodegenerative diseases increases, there might not be enough neurologists to meet the demand. All of the consulted

experts say there is a shortage of neurologists—and it’s only expected to get worse.

For example, the demand for locum tenens neurologists has steadily increased every year, “and we are hearing the same thing from our major competitors,” Weeks says.

There are several reasons for the shortage, such as more neurologists taking fellowships. But that only delays entry into the field by one or two years. There are other, more systemic reasons.

“Medical students increasingly pick areas of medicine due to favorable lifestyle and reimbursement considerations,” Busis says. And they are not opting for neurology.

But the problem isn’t universal. “Recruiting is lumpy-bumpy, with some [geographic] areas having great trouble attracting qualified candidates and others having less trouble,” Busis says.

Location is a primary consideration, as are other lifestyle issues and, of course, reimbursement. He cites a 2007 New York state residency training outcomes survey that supports his observation. In that survey, the reason most often cited “for difficulty finding a practice position” was “a lack of jobs in desired locations” (49%).

That corresponds with the experience of recruiters. The severity of the shortage varies by region, says **Todd Dillon**, senior search consultant in the physician search division at St. Louis-based Cejka Search. “I have a very hard time getting

neurologists in the Midwest,” Dillon says, adding that location might be the most significant challenge he faces in terms of their recruitment.

Phifer says another recruiting challenge facing practices is finding the best fit (e.g., movement disorder patients, epilepsy, and stroke), “so as not to duplicate what the department or group already has a handle on in their service area.”

Crafting packages

Groups and hospitals in less-than-prime locations are being forced to create attractive compensation packages, Dillon says.

Dillon and Phifer say successful packages not only offer competitive salaries, but they also include:

- » The best possible call coverage
- » Student loan reimbursement
- » A signing bonus
- » A retention bonus

“The record was broken [with] a total package of \$510,000 for one fellowship-trained neurologist . . . with a director title and no direct reports,” Phifer says.

One emerging trend is to get the physicians’ contracts signed well in advance, Dillon says, adding that one practice has

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Neurology compensation trends, 2004–2007

Survey	2007 median*	2006 median*	2005 median*	2004 median*	% change 2006–2007	% change 2004–2007
AMGA	\$222,998	\$211,995	\$201,241	\$190,076	5.19%	17.32%
HCS (salary only)	\$162,814	\$159,979	\$153,017	\$146,953	1.77%	10.79%
MGMA	\$220,000	\$216,199	\$211,094	\$190,973	1.76%	15.2%
SCA	\$200,629	\$194,497	\$200,000	\$170,074	3.15%	17.97%

+ Survey results are based on the previous year’s data.

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Neurology

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already signed on a surgeon who won't complete his fellowship until 2010. He expects this approach to become more common in neurology.

If a practice can pay up front and subsidize the residency or fellowship, it may be able to secure the neurologists it needs.

Such contracts include provisions that require the prospect to repay the money if he or she ends up not coming to work for the practice.

Employment model emerges

Busis says he is seeing a move away from private practice. "In my opinion, more and more recent graduates want to be employed rather than start a private practice. Shift work is more amenable to their anticipated lifestyle, with the ability to better put your work behind you and out of your mind when you go home for the day," he says, adding that employment provides regular hours with less administrative hassle.

Neurologists, perhaps even more so than most other specialties, have been frustrated by the time spent doing hospital consults, Dillon says, adding that neurologists are often

called in when other providers are stumped. As a result, the calls are often a waste of time. He says he knows of some who are doing strictly outpatient work. The neurohospitalist is emerging, Dillon says. Hospitals are willing to pay a premium to have an in-house neurologist.

Phifer says the trend has not yet caught fire. Not only is the job demanding, but covering stroke patients without a stroke fellowship carries significantly more liability.

But Phifer says he expects to see more. "I think as hospitalists for primary care did catch on, the neurohospitalist should follow suit," he adds.

A paper published earlier this year in *Neurology* concluded that the same pressures that spawned the growth of medicine and pediatric hospitalists will drive the neurohospitalist trend: "Given the tremendous growth in the number of medical hospitalists over the past decade, we predict that neurology hospitalists will continue to grow in number, particularly at hospitals with high patient volume and many resources. The time for the neurology hospitalist clearly has come of age."¹

Weeks says she sees growth on the locum tenens side too. "Our neurohospitalist business is still small compared to the demand for general neurology, but we are seeing an increase," she says.

Neurology and locum tenens

Recruitment and compensation trends in the locum tenens market parallel those in the permanent market.

"We pay our neurologists a daily rate for locum tenens work. Our daily rate for neurologists is about 15% lower than the average rate of all of our specialties combined," says **Alisa Weeks**, manager of the subspecialties team at the CompHealth locum tenens division in Salt Lake City. She adds that the average is driven up by the high pay rates of surgical specialties so, compared to most other specialties, it is about the same or higher.

Weeks says the three primary neurologist recruitment challenges to do locum tenens work are finding:

- » Neurologists who are available and willing to do temporary work

- » Fellowship-trained neurologists who are comfortable doing EEG and EMG
- » Neurologists willing to take a lot of call and overtime work

And like those on the permanent side, Weeks' clients are gradually distinguishing between stroke neurology, neurohospitalists, and general neurology. "We have a handful of clients that specifically are asking for physicians that have completed a stroke fellowship and others that want strictly neurohospitalists," she says.

So far, pay rates haven't varied much among general and stroke neurologists and neurohospitalists, but that will change, Weeks says. "I think that we will see pay rates increase as the demand goes up in these areas," she adds.

One reason is that many general hospitalists don't receive much neurology training. She notes another change that could increase demand for neurohospitalists: the change in reimbursement for tissue plasminogen activator (tPA). In 2006, Medicare began reimbursing for administration of tPA to stroke patients.

If given within three hours, this drug can dramatically improve the recovery of a stroke patient. Having a neurohospitalist on staff increases the likelihood that it can be administered in a timely manner.

More specialization

Given the aging population and the aforementioned liability concerns, it's little surprise that another growth area is stroke neurology.

"Although neurologists, neurohospitalists, and stroke specialists can give intravenous tPA to stroke patients, stroke specialists may, if they have the proper training and credentials, provide more invasive services—angiography, intra-arterial tPA, stenting, etc.—that cannot be provided by general neurologists or neurohospitalists," Busis says.

Phifer and Dillon say they believe it makes sense, in terms of compensation, to distinguish between neurohospitalists and other neurologists and between stroke neurology and general neurology.

But it's too soon to have reliable numbers on each to report. It might also be too soon to identify salary breakdowns among these groups. Part of that is due to overlap: The neurohospitalist still does general neurology.

And there's a shortage of stroke neurologists, Phifer says. Too few are graduating each year to form its own specialty. "The pay differential should be more," he says. "It takes a while to become a fully operational stroke center, but when any hospital does reach that goal, those places will be able to compensate more."

Overall, Busis says he expects greater specialization. "There is increasing specialization in neurology and more neuroscience service lines in hospitals. These will feed off each other, creating a market for neurology subspecialists, perhaps at the expense of general neurologists," he says, adding that the question of what increasing specialization will mean for neurology, and especially for general neurologists, remains unanswered.

Looking ahead

Several other issues loom for the profession, Busis says, including:

- » Will disincentives for cognitive specialties such as neurology be addressed by payers and policymakers?
- » Will incentives to do more procedures and tests be addressed by payers and policymakers?
- » How will reimbursement issues, administrative overhead/burdens, and quality issues/reporting (expecting 24/7 on-call and inpatient service, especially for stroke patients) affect the private practice of neurology and the role of private practitioners in a mixed practice environment (i.e., private practice and employed physicians in the same hospital)?

"Finally, and most importantly, what impact will the increasing importance of specialization, practice location, physician lifestyle, and reimbursement have on the care of patients with neurologic conditions?" Busis says. ■

Editor's note: Busis addressed these and many other issues in a recent HealthLeaders Media Webcast, "Service Line Strategies Workshop 2008: Neurosciences." For details, visit www.healthleadersmedia.com/webcasts.cfm?id=6606.

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CMS issues draft of new telehealth codes

Gradually, but inexorably, CMS is expanding telehealth coverage. Most recently, CMS has proposed three new HCPCS codes that will allow providers to bill for telehealth-delivered follow-up inpatient consultations. These codes are intended for use by physicians or nonphysician providers who are consulted by the patient's attending physician but are not available for a face-to-face encounter. The fee would be equivalent to the payment for a comparable face-to-face follow-up visit. The codes, which take effect November 1 pending approval, are as follows:

» **GXXI4: Follow-up inpatient consultation, limited.**

Practitioners would typically spend 15 minutes communicating with the patient.

» **GXXI5: Follow-up inpatient consultation, intermediate.** Practitioners would typically spend 25 minutes communicating with the patient.

» **GXXI6: Follow-up inpatient consultation, complex.**

Practitioners would typically spend 35 minutes or more communicating with the patient.

Defining what's covered

Follow-up inpatient telehealth consultations could include:

- » Monitoring progress
- » Recommending care-management modifications
- » Advising on a new plan of care in response to changes in the patient's status
- » Counseling and coordination

The practitioner who furnishes the telehealth inpatient follow-up consultation may not be the physician of record or the attending physician, and no additional E/M service could be billed for work related to the telehealth consult.

Second time's the charm

Before 2006, such follow-up telehealth inpatient consultations were approved. However, in 2006, the CPT editorial panel of the AMA deleted the codes for follow-up inpatient consultations and advised practitioners to bill for such telehealth services using the codes for subsequent hospital care. Because those codes included some services deemed inappropriate for telehealth delivery, CMS did not add them to the list of approved telehealth services for 2007.

Gradual and cautious

In the same announcement that identified the three new codes, CMS rejected proposals to add diabetes self-management training and critical-care services. Not issuing rules for these two services in draft form suggests that CMS is moving forward slowly and identifying only discrete areas in which it will reimburse for telehealth services, says **David Harlow**, principal at The Harlow Group, LLC, a healthcare law and consulting firm based in Newton, MA. "CMS is being extremely careful and slow about this," Harlow adds.

Harlow says he doesn't expect the proposed rules to have much of an effect on compensation plans, but, ultimately, expanded approval of telehealth will change the complexion of a medical practice. However, they would promote more efficient use of primary care provider resources, he says, adding that he also expects the rules to pave the way for further adoption of telehealth in the private sector. The benefits go beyond the individual patient encounter. Telehealth allows the practice to create a record that can be reviewed and deconstructed. "It opens the window into the patient encounter and provides opportunities for research and for quality assessment," he says, adding that that could raise some privacy concerns.

Looking ahead

Jonathan Linkous, executive director of the Washington, DC-based American Telemedicine Association, is pushing for more codes. "We will petition CMS for a few additional codes in December," Linkous says. "In our recent filing in response to the CMS proposals, we asked CMS to go ahead and approve several codes that are used for skilled nursing facility [SNF] visits since those facilities were just added as eligible sites for telemedicine by act of Congress," Linkous says. CMS has turned down previous SNF proposals.

Despite slow CMS adoption and privacy concerns, telehealth will become more common, so providers must be prepared. "This is coming down the pike in a big way," Harlow says. ■

PCR sources

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Ask the experts

Calculate compensation for medical directors and chiefs

Editor's note: PCR asked compensation experts to discuss how to determine the appropriate compensation for medical directors and chiefs. If you have a question for our experts, please e-mail roxanna@healthleadersmedia.com.

Maria C. Hayduk, senior manager, medical directorships, ECG Management Consultants, Inc.

The most common way of determining medical directorship compensation is to develop fair market value (FMV) benchmarks for the agreement in question. Benchmark data typically includes publicly available survey results for the specific specialty and generally are at or below the compensation level paid to clinicians for equivalent work effort. In some situations, there may not be enough publicly available data to develop a specialty-specific benchmark; therefore, it is possible to extrapolate the available data to develop a valid benchmark. In these cases, it is important to rely on an independent, third-party, industry expert in hospital/physician relationships who has knowledge of the healthcare industry and laws to develop a benchmark that is appropriate and indisputable.

Once an appropriate benchmark is determined, a range of appropriate payments can be established based on the benchmark. In general, a proposed payment should satisfy FMV if the payment is within the range of the identified benchmark, which is generally considered to be less than the 75th percentile of the survey data. Special circumstances might exist at the hospital or within the specific market that might warrant a payment that is higher than the benchmark.

Remember that medical directorship agreements must adhere to the anti-kickback statute, Stark laws, and §501(c)(3) of the Internal Revenue Code.

Max Reiboldt, CPA, managing partner and CEO, The Coker Group

Generally, medical director compensation is determined based on an hourly rate of pay commensurate with the duties and responsibilities of the position. CMS has provided two methodologies to ensure that an hourly compensation arrangement agreement for such physician personal services fits within Stark exceptions. The Stark Phase II promulgation specifically

provides that two measures of hourly physician compensation may be considered. Under the first method, the hourly rate paid to the physician must be less than or equal to the average hourly rate for ER physician services in the relevant physician market.

The second method requires the hourly rate to be calculated by averaging the national compensation level for physicians within the same physician specialty listed in at least four of the six designated surveys, and then dividing this number by 2,000 hours. Therefore, to determine these hourly rates, a clear definition of the services to be provided must be established; then, using recognized benchmark surveys, determine an effective hourly rate. As such, some medical directorships and other key physician, administrative, and/or clinical positions must be relevant to the individual specialty and its typical compensation.

As for whether these compensation levels should be similar to those paid to clinicians, the principle of comparable hourly compensation applies. This is especially true when one considers that the physician could be at that level of compensation if not required to complete the duties of medical director/chief. However, having said this, the compensation for such administrative responsibilities will be no greater than a comparable rate for a clinician and, from a practical standpoint, is usually somewhat less.

Ron Seifert, senior healthcare consultant, Hay Group, Inc.

The answers vary based on an organization's perspectives about the strategy and purpose of the role. Questions to guide the thought process might include:

- » How will the organization use these positions? Are they administrative or academic leaders, clinicians operating as a managerial liaison, change agents, etc.?
- » Will you compensate them for forfeiting a portion of their clinical income?
- » Are there unique business needs that call for a special set of capabilities for which the organization is simply willing to pay more?
- » Should the pay levels reflect internal equity considerations associated with other executive roles? 🏢

Applying the group-practice exception to physician compensation

by Max Reiboldt, CPA

The Stark Law prevents an entity from billing Medicare or Medicaid for designated health services (DHS) referred by a physician wherein the entity has a financial relationship, unless that relationship is subject to a specific exception. Many services are considered DHS, including all inpatient and outpatient hospital services. The financial relationship definition includes ownership interest and compensation arrangements.

If a physician is paid a share of a group's profits for DHS, the group must be organized to meet Stark's definition of a group practice. More specifically, if a hospital entity directly employs the physicians, those physicians will not qualify as a group practice. However, the hospital may form a subsidiary to own and operate the practice and employ the physicians; the subsidiary will then qualify as a group practice; the hospital may then be able to pay physicians a profit share of DHS.

This approach is becoming much more popular as hospitals employ physicians and look for ways to provide incentives that are more closely aligned to private practice structures. Further, it is a good strategy for physicians who are negotiating their compensation and incentive pay plans for implementing hospital affiliation. The profit share must be based on the group's entire profits from DHS or the profits derived from DHS of any component of the group that consists of at least five physicians. The profits must be divided in a reasonable and verifiable manner that is not directly related to the volume or value of the physicians' referrals of DHS.

Two safe harbors are established by Stark for dividing the profits. First, they can be divided per capita (i.e., per physician in the group); second, "revenues derived from DHS may be

distributed based on the distribution of the group practice's revenues attributed to services that are not DHS payable by any federal health programs or private payer." Another consideration relative to physician compensation and Stark involves the proper quantification for personal services. A permissible method for dividing such profits is to base the pay on the number of hours in general a physician devotes to the group. CMS has provided two methods that ensure an hourly compensation arrangement agreement for a physician's personal services, such as a medical director arrangement, fit within Stark exceptions.

Under the first, the hourly rate must be less than or equal to the average hourly rate for ER physician services in the relevant market. To have a suitable physician market, at least three hospitals must be providing ER services. The second method requires the hourly rate to be calculated by averaging the national compensation level for physicians with the same physician specialty listed in at least four of six designated surveys and dividing by 2,000 hours. If neither method is available, the approximate method of valuation will depend on the nature of the transaction, its location, and other factors.

Thus, when applying the group practice exception or deriving compensation for physicians' personal services, the Stark requirements must be clearly adhered to. The good news: There are opportunities to establish these working relationships that provide not only compensation to the physician for services performed, but appropriate incentives to maximize the healthcare entity's performance and operating results. ■

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