Hospital On-Call Responsibilities: A Urology Group Practice Analysis

Case Study

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Statement of the Problem

Emergency Medical Treatment and Active Labor Act (EMTALA) was passed in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA). This act requires hospitals to provide emergency care regardless of the patient’s ability to pay, insurance status, citizenship, or legal status. There are no reimbursement provisions in the act. A participating hospital is defined as those that accept payment from the Department of Health and Human Services or Centers for Medicare and Medicaid Services (CMS). In reality, EMTALA applies to all hospitals in the United States, except for Shriners Hospitals for Children, Indian Health Service hospitals and Veterans Affairs. CMS guidelines require hospital emergency departments to display on-call lists in the department daily and to maintain the lists on file for five years. While individual departments of the hospital are generally responsible for management of this process, EMTALA holds the hospital ultimately responsible. This is usually accomplished through hospital bylaws. CMS rules allow hospitals flexibility from the traditional 24/7 coverage. Some say this was not always the case and report there was a practice often referred to as the “rule of three.” If there are less than 3 specialists on staff for a particular service, the hospital can provide call in that specialty intermittently, as an example, every third day. If more than 3 specialists, the hospital must include these specialists on the daily call list. CMS reports that when evaluating compliance, while they do look at the number of physicians on staff in a specific specialty as compared to coverage, they do not dictate frequencies to hospitals.
Physicians fulfilling on-call duties, in order for the hospital to be EMTALA compliant, are burdensome for the physician. According to a May 2003 American Medical Association study, emergency physicians on average provide $138,300 of EMTALA-related charity care each year. Physicians in other specialties provide, on average, about six hours per week of care mandated by EMTALA, and on average incurred about $25,000 of EMTALA-related bad debt in 2001.

In addition to EMTALA, many hospital bylaws require a physician on-call to follow up with the patient he/she saw while on-call for the emergency room, within three days in their practice. This is the circumstance for the urology practice in this case study. Because of the hospitals EMTALA requirements to see patients regardless of the ability to pay, combined with the hospital bylaws requiring the patient to be seen in the physician’s office within 3-days of discharge, adds to the financial burden of on-call services for the practice adds up. Often post emergency room discharge visits result in additional tests, procedures and extra visits over a longer period of time, and cannot be avoided because of physician malpractice liability. It is often difficult for the physician to determine when termination of post emergency care is appropriate. The physicians receive a small per diem per day to provide call 24 hours a day, seven days a week. However, this daily stipend is only a small portion of the deficit incurred by the practice and physicians. Hospitals are permitted to reimburse physicians for services provided while on-call for uninsured patients. The Office of Inspector General (OIG) Advisory opinion number 09-05 posted May 21, 2009 discusses the scenario of a payment of on-call services performed on behalf of a physician’s hospital for uninsured patients. The conclusion was: “Based on the facts certified in your request for an advisory opinion and
supplemental submissions, we conclude that while the Proposed Arrangement could potentially generate prohibited remuneration under the anti-kickback statute, if the requisite intent to induce or reward referrals of Federal health care program business were present, the OIG would not impose administrative sanctions on [name redacted] under sections 1128(b)(7) or 1128A(a)(7) of the Act (as those sections relate to the commission of acts described in section 1128B(b) of the Act) in connection with the Proposed Arrangement. This opinion is limited to the Proposed Arrangement and, therefore, we express no opinion about any ancillary agreements or arrangements disclosed or referenced in your request letter or supplemental submissions.” The urology group and its physicians do not receive any compensation for patients without insurance.

The urology group is the largest private practice in the State of Washington, located in eastern Puget Sound. The practice has urology on-call responsibilities for three hospitals, with one physician from the practice on-call every week throughout the year with the exception of three weeks. The increasing number of on-call responsibilities for the urologists is exponentially affecting financial loss. Additionally, the on-call burden is stressful for the physicians and the office. The practice frequently has to reschedule a patient, which is also costly. The analysis outlines the financial impact for providing on-call services to the local community hospital, followed by a decision to determine if active privilege status should be continued.

**Alternative Decisions Considered**

1. Notify the hospital that the group is changing its privileging status to courtesy and reducing the number of days for emergency department on-call duties.
**Pros**

A reduction in days would exponentially reduce the financial loss for hospital professional services, clinic, clinic procedures and the ambulatory surgery center.

There is a potential for increase in revenue by shortening weeks patients are waiting for an appointment. Time saved by reducing on-call days will allow more clinic slots for appointments, which generate more revenue.

Decreasing the number of day’s on-call would directly lessen physician frustration, office disruption, patient complaints, and employee stress. Currently, the employees spend a great deal of time rescheduling patients or managing the schedule to get appropriate physician coverage.

**Cons**

Hospital-physician relationships are already stressed with competing agendas, combined with misaligned reimbursement strategies. A group of 11 urologists reducing days would increase tensions between the hospitals and physicians.

A reduction in urology on-call responsibilities could provide an opportunity for another group to provide full-time on-call services. This would introduce another competitor in the area.
The current precedence for specialists in the area is full-time call, 365 days per year. A reduction in call could place a burden on other specialists. This could negatively affect the relationships between the urologists and other specialists, reducing referrals.

2. Change all of the urologists privileging status from “active” to “courtesy” in all three hospitals. This would effectively result in no on-call obligations.

**Pros**

No on-call obligations for the urologists would positively impact the practice appreciably. The absence of an on-call obligation would allow for more patients to be seen in a timelier manner in the office, which equals more downstream revenue of office procedures, diagnostics and surgeries.

Managing the financial and stress costs of the physicians on-call responsibilities is appreciable. There is one full-time equivalent (FTE) that manages the call schedule, coordination with other providers, changing physician patient schedules and handles patient complaints each week. A loss of this responsibility would save an FTE and this stress for the physicians, patients and staff.

**Cons**
In order to meet EMTALA requirements, the hospital would need to have another group provide on-call services. This would introduce more competition for patients in the area.

A change from “active” privileges to “courtesy” privileges would eliminate any benefit the hospitals provide to the physicians. The urologists would be removed from the referral programs and the “find a physician” link on the hospital websites.

Some of the referring physicians in the area would view this decision as adversarial to them, as well as a choice to move away from the patient care team. This may negatively impact referrals.

When the urologists are on-call, there is an opportunity to provide marketing services for referring physicians, by way of patient follow up. This occasion would be lost if on-call services were eliminated.

3. Continue with the current practice and provide the same level of on-call services.

Closely monitor the trending costs, and provide this information to hospital administration.

**Pros**
The practice and its urologists and urogynecologists will continue receiving referrals through the hospital's referral service, remain on hospital directory, and stay on the website directory.

While conflicts are not uncommon between private practice physicians and the hospital, continuing to provide full-time on-call services will reduce the escalating momentum.

Continuing the same level of service will provide a continuum of the same level urology service to the patients of the practice and within the community. This will most likely continue good collegial relationships.

Providing semi-annual reports to the hospital with data specific to the physicians cost for providing care while on-call will reduce the probability of the hospital's attempt to end call pay. Monitoring and analyzing the data may allow for negotiations of increased daily stipends of call pay.

**Cons**

Providing accurate analysis specific to the financial losses for providing on-call services is time-consuming. There are many direct costs which provide the portal for a cascade of costs. This trail is difficult to find using electronic medical record data alone.
The urologist’s obligation to on-call services 24 hours per day, seven days a week is stressful for the physicians and the office. Patients do not like to be rescheduled or be seen late. The patients do not understand the urologists’ obligation to hospital call as a reason for the physician to provide their perception of “poor customer service.” As patients are financially responsible for more health care dollars, the expectation for excellent customer service without interruption is increasing.

Full-time on-call obligation is expensive for the practice. The hospital does not provide a daily stipend which would allow the physicians to block clinic for the week; however, unexpected schedule changes partnered with pre-planned expenses is not a good combination.

**Procedure Used to Select Solution**

Analyzing options was the first necessary step. The cost to provide full-time on-call services would provide the greatest detail. The cost analysis report needed to include hospital services while the physicians are on-call for patients with no insurance, combined with our inability to collect. The carry-over costs of this same group for required office visits within three days of discharge, and any procedures or visits which followed until the patient could be discharged, was included. Lost revenue opportunity cost was not included and is a limitation of the analysis (Exhibit A). The Chief Executive Officer (CEO) gathered data specific to the cost of providing call with a place of service
of the hospital. Specifically quantifying and comparing patients’ inability to pay against the per diem that was paid.

The CEO presented the data (Exhibit A), as well as the methodology to the physicians. During this meeting, assumptions were vetted and variables discussed. Several alternative options were deliberated, including the pros and cons of each choice.

A meeting commenced with hospital administration, urologists and CEO. Facts were presented outlining unpaid services provided to hospital emergency room patients, while in the emergency room because of the hospital’s EMTALA obligation and in the office as a result of hospital medical staff bylaws. The OIG Advisory opinion number 09-05 was shared with administration to inform them they are able to pay for services provided for the uninsured without triggering anti-kickback or Stark violations.

**Decision**

The hospital offered a 20% increase in the daily stipend for call as a result of the analysis and meeting. The increase does not decrease the loss rate appreciably; therefore, was not a key factor during the decision making process.

A decision to continue full-time urology call services was made by the physicians. The group was in agreement that while on-call services were expensive, stressful, and compromised the practice, it was necessary for collegial networking, their relationship
with colleagues, and as a defense strategy for competition control. However, continuing to provide this level of service requires monitoring, at least once a year; followed by a discussion to continue. In the end, financial viability allowing for maintaining the private practice was the most important goal.

**Implementation**

A system was designed to track the number of patients which had to reschedule as a result of the physicians call obligation was measured, as well as “lost” patients.

A procedure to quantify the direct cost of providing on-call services was implemented. This system quantifies practice costs specific to on-call services only.

Custom reports were written and tested to provide actual payments verses expected payments from patients which were first seen by a provider while on-call. These reports can track data for hospital services as well as subsequent office and ambulatory surgery center visits.

**Significance of Outcomes and Lessons Learned**

While historically it is traditional for physicians to take call for hospitals, the hospitals obligations can be extremely burdensome for the physician on-call, both financially and physically.
Measuring data is influential and useful when making a financial case to get paid for on-call services, maintain payments, or request increases to hospital administration.

A physician in a specialty which requires hospital on-call responsibilities will most often seek active privileges, hence, requiring on-call duties. Careful consideration regarding whether hospital’s active verses courtesy privileges is the correct path for the physician, should be carefully considered by a review of obligations via the medical staff rules and the bylaws.

**Recommendations for other Managers**

A high percentage of physicians and/or practices provide on-call services to the hospital. Historically, a physician embraced on-call, especially if new to the area; to grow his/her business. Economic conditions have necessitated ongoing analysis of time-valued medical services. Most physicians believe on-call services are a mandatory requirement of the hospital with no negotiation for pay. The CEO of the practice recommends that each manager analyze on-call services by costs verses revenue, and list pros and cons for various options, to result in improved negotiations with the hospital for paid on-call services.
Purpose: To obtain and maintain active hospital privileging status, urologists must provide call for hospitals. As a result of this call obligation, they are obligated to see all patients regardless of ability to pay. The hospital is required to comply with EMTALA rules. This rule is a burden to the physician who saw the patient on-call because it allows the patient seen in the ER to see the physician within three days of discharge. The patient receives this follow up care at the physician’s office. Many times, this results in additional tests, procedures and extra visits over a longer period of time, and cannot be avoided because of physician malpractice liability. Several of these patients have no insurance and/or an inability to pay. This analysis outlines the financial impact for providing on-call services to XXX Hospital.

Hospitals Included: XXX

Call Revenue:
For the better part of 2012, the urologists received $250 per day. During the end of 2012 the rate increased to $300 per day. The totals providing breakdown per physician is:

Doctor 1: $14,250
Doctor 2: $7,500
Doctor 3: $10,120
Doctor 4: $5,750
Doctor 5: $10,600
Doctor 6: $7,500
Total: $55,720

Costs:
Assumptions:
  a. Only XXX is included. Any services provided at other hospital POS (place of service), and at Washington Urology as a result of call at other hospital POS have been excluded.
  b. Only the physicians above are included – Bellevue physicians excluded - both revenue and costs.
  c. Costs could be underestimated because this analysis is only measuring costs for patients with $0 insurance payments.
  d. Any service with $0 charge or no RVU was not included. As an example, there are no post-ops or other services in the global period included, as well as there are no supplies, sedation, etc…
1. All revenue and cost data is for January 1, 2012 through December 31, 2012. XXX Hospital Place of Service: For services provided while on-call in XXX Hospital for patients with $0 for insurance payment.
   - Charges: $59,220
   - After contractual (expected payment): $34,929
   - Insurance payments: $0
   - Patient payments: $16,296
   - **Net Loss:** $-18,633

2. Washington Urology Place of Service: Services provided by the above physicians as a result of the hospital’s EMTALA rules for follow up. All services below were provided to patients as a result of call at XXX Hospital:
   - Charges: $470,813
   - After contractual (expected payment): $245,074
   - Insurance payments: $0
   - Patient payments: $134,343
   - **Net Loss:** $-110,731

3. Answering service and pager costs. If the physicians were not on-call, pagers and the answering service would not need to exist. These costs are listed below:
   - Average Monthly Charge: $680 x 12 = $8160
   - 1/3 calls for Overlake: $8160 * .66 = **$5385**

**2012 Net Loss Total: $-79,029**