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American Association of Oral and Maxillofacial Surgeons

White Paper

OMS Hospital Compensation for Trauma Call

Introduction

The AAOMS Code of Professional Conduct describes the responsibility of the attending oral and maxillofacial surgeon (OMS) to provide 24-hour coverage for patients within a reasonable distance and/or response time for the administration of emergency care. It is therefore an inherent part of being an OMS to be on call. Many of the procedures performed by an OMS require the use of a hospital facility to provide care. In order to perform procedures at these facilities, there is an agreement between the provider and the hospital system. These agreements often will include the requirements for trauma call in order to maintain surgical privileges. Each of these agreements is unique and will vary between providers and hospital systems based on both parties' willingness to negotiate the terms of these contracts.

Types of Hospital Call

There are typically two types of call coverage arrangements provided by the OMS:

- Unrestricted call coverage – The OMS is allowed to remain off the hospital premises but must be available to report for duty within a specified timeframe.
- Restricted call coverage – The OMS is required to remain on the hospital premises.

Most on-call coverage arrangements for the OMS are unrestricted, and the OMS must be available by telephone. Typically, unrestricted call rates have lower compensation than restricted call rates because of the demands associated with the restricted plans, such as sleeping overnight in the hospital.

Contract Considerations

During the past decade, the hospital industry has made profound organizational changes through the formation of large hospital systems. These large hospital systems have been built through Mergers, Acquisitions and Partnerships (MAP). In recent years, MAP activity has been on the rise driven in part by the move of value-based care, economy of scale and need for greater geographical coverage. Mergers are the transactions in which separate hospitals come together under a shared license. These transactions typically occur among hospitals located near one another. Acquisitions occur when joining hospitals retain their licenses but are owned by a common governing body; these can occur among hospitals that are near or far away. The majority of recent MAP activities are based on contractual relationships that are not a merger or an acquisition but a partnership.

The reality in private practice is that fewer OMSs are willing to take hospital emergency calls or treat patients requiring hospitalization. This, in turn, is leaving more hospitals with limited or no OMS coverage. In turn, hospitals with no OMS coverage are transferring patients who need OMS care to hospitals within the network or to hospitals with whom they have a partnership agreement.

Determining the OMS on-call compensation is not an easy task. Hospital call coverage payments have increased over the years. This trend is forcing hospitals to evaluate different strategies of on-call compensation. Many hospital systems struggle to maintain OMS providers while trying to control the high cost of on-call compensation. The major factor in determining payment should be value, not cost. Their challenge is to determine the fair market value rate for OMS services relative to the wide range of other services in their system.

Types of Compensation

When structuring on-call pay arrangements, organizations are cautioned to consider regulatory issues, including the Stark Law and Anti-Kickback Statute. On-call compensation is a "financial arrangement" under Stark Law. Each of these requires that OMS compensation arrangements, including on-call pay arrangements, fall within fair market value and are commercially reasonable.

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Anti-Kickback Statute exceptions must be met. Available exceptions include:

- No intent to induce referrals.
- No intent to reward OMS/group through compensated call arrangement.
- OMS must respond consistent with the contract and the medical staff bylaws/rules and regulations.
- The Emergency Medical Treatment and Active Labor Act (EMTALA) is implicated.
- Physician at the hospital makes determination whether the on-call OMS is required to come to the hospital for specialty service.
- Ensure the OMS providing call coverage is appropriately licensed and credentialed.

Penalties for noncompliance are severe and can include fines per claim as well as treble damages for false claims. Exclusion from Medicare and Medicaid programs, intermediate sanctions and imprisonment also may result.

There are several methods of compensation for the on-call OMS:

- **Hourly rate** – The amount paid for each hour of services performed, typically based on time spent treating a patient.
- **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. This is typically based on 24/7, which equates to 168 hours per week.
- **Annual stipend** – The amount paid for annual coverage. This is typically based on the total annual hours based on 24/7 coverage equating to 8,760 hours per year (365 days x 24 hours).
- **Relative Value Units (RVU)** – The amount paid for a volume of work. This is typically based on how much work is required to treat a patient.

Factors Affecting Compensation Rates

Compensation for the OMS will depend on several factors. These factors should be discussed during the negotiation process:

- **Frequency of call** – How many times an OMS is paged and whether he or she can respond by phone as well as in person affect the call payment rate.
- **Type of unrestricted call** – Whether the OMS is required to treat the patient in the hospital or if the patient be treated in the office.
- **Payer mix** – Hospitals with poor payer mix and higher rate of uncompensated pool usually pay OMSs a higher compensation rate.
- **Likelihood of conducting inpatient consults and average case acuity.**
- **Coverage limitations** – The less OMS a hospital has access to for call coverage, the more that OMS will be paid due to scarcity.
- **Tertiary care and trauma center status.**
- **Follow-up care requirements on indigent patients** – Because the majority of these visits will be uncompensated.
- **Private physician versus employed physician** – Private OMSs usually demand more call pay due to their independence and inconvenience to their private practice.
- **OMS's ability to bill for services provided.**
- **Size of the hospital network** – Including whether the OMS will be treating patients transferred from these affiliated facilities.

Compensation Distribution

It is important from a strategic, financial and regulatory perspective to properly structure on-call payment arrangements. The majority of organizations provide on-call payments to individual OMSs. However, there are other methods for determining the distribution of these call pay funds. An on-call agreement between the OMS and the hospital will need to include how these funds are to be distributed:

- Funds are paid to the individual OMS. These funds are paid directly to the OMS for covering call and often distributed for per diem services.
- Funds are provided to the OMS group for distribution. These funds are paid directly to the OMS practice that covered call and often distributed for annual services.

- Organization-wide pool of funds distributed at the service-line level. These funds are paid to the organization in the form of a shared payment. These funds are then distributed by the organization to each provider for services rendered. Redistribution will need to be negotiated in the agreement.
- Organization-wide pool of funds distributed at the departmental level. These funds are paid to the organization in the form of a shared payment. These funds are then distributed by the organization to the provider's department for services rendered. The provider's department will redistribute the payment to the provider in accordance to departmental policy.

As healthcare reimbursement shifts from volume-based to value-based patient-focused care, new models of compensation are emerging for physicians and OMSs.

Conclusion

This issue of trauma call coverage is of national importance. The common goal of trauma call between OMSs and hospital systems is to provide care for patients in need of emergency service. Arriving at an acceptable agreement often is complicated because of the misalignment of values between the parties. These negotiations often can be divisive between the provider and the hospitals where the OMS operates. It is imperative for the OMS to understand the financial arrangements between the OMS and the facility in order to arrive at a fair compensation.

Disclaimer: The purpose of this article is educational in nature to promote awareness of a topic of mutual interest without restricting competition or exceeding legal limits imposed by state and federal antitrust laws. This article does not constitute professional advice. Only the reader's own individual advisers can provide applicable and appropriate information for his or her particular situation.

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