



STIPENDS FOR STROKE CALL CREATE NEW PRESSURES, DEMANDS ON NEUROLOGISTS

By Orly Avitzur, MD, MBA

ARTICLE IN BRIEF:

✓ With office disruptions, extra liability, and a rising number of uninsured patients, is ER call worth the hassle? In an effort to tip the scales their way, some hospital administrators are offering compensation for call coverage to convince neurologists that it is.

Covering the emergency room (ER), while never easy, is becoming even more demanding. The latest pressure – particularly at community hospitals without trained fellows – is coming from stroke call. With the new DRG compensating stroke centers for the administration of tissue plasminogen activator (tPA), it seems that every Good Sam, Dick, or Harry is aiming for this designation by the local state department of health or the Joint Commission on Accreditation of Healthcare Organizations.

The burden, of course, falls on neurologists, who need to respond to ER calls well before the three-hour window of opportunity expires. Even ER docs feel apologetic because *any* symptom – from dizziness to confusion – means paging a neurologist to evaluate the tPA risk-versus-benefit scenario for each and every candidate patient.

'IS ER CALL WORTH THE HASSLE?'

Risk-versus-benefit ratio discussions taking place all over the country have neurologists asking the same question: With office disruptions, extra liability, and a rising number of uninsured patients, is ER call worth the hassle? And in an effort to tip the scales their way, some hospital administrators are offering compensation for call coverage to convince neurologists that it is.

If the disenrollment from community hospital staff rosters over the past few years is any indication, there is a looming crisis, leaving a growing number of ERs with inadequate coverage. In South Florida, this predicament became dire when many doctors dropped ER call because liability insurance was no longer affordable.

"Physicians believe that most med-mal cases arise from ER call," points out Waden E. Emery III, MD, a neurologist in Fort Lauderdale. "The situation became critical last summer," said Dr. Emery, "when patients died after being transferred from Palm Beach to Broward County because neurosurgeons in Palm Beach refused to take call." When the problem was exposed in the local newspapers, hospitals in Broward began to reimburse for call – *and* for costs arising from medical malpractice cases involving patients seen in their ERs. Holy Cross Hospital, where Dr. Emery takes call about twice per month, pays him \$430 for each 24-hour call period.

HOSPITALS PAY FOR ER CALL

Most neurologists who made similar arrangements admit that it takes some



Dr. Douglas J. Redosh, and the three other neurologists in his group in Wheatridge, CO, realized a few years ago that they were being pulled in too many directions by covering three hospitals. After another neurology group in their area went on strike – and received a nice coverage compensation package as a result – Dr. Redosh and his colleagues decided to drop one hospital (even though they were then, also, offered remuneration) and negotiate payment at the others.

convincing. When doctors first approached Methodist Hospital in Houston to request remuneration for ER call, the administration refused. Eventually they came around, and now they pay all community physicians for taking call. Brian D. Loftus, MD, Deputy Chief of Neurology at Methodist, explains that the number of call days

assigned is proportionate to hospital activity: A neurologist who does 20 percent of all the admissions and in-patient consults is responsible for 20 percent of the call days, and is compensated \$250 for each day on call.

STROKE CARE AS REVENUE SOURCE

This trend is likely to snowball, especially with stroke treatment providing hospitals with an attractive new revenue source. Until recently, Medicare paid hospitals a fixed amount per patient treated for stroke, whether or not reperfusion therapy was used. The standard DRG (14) gave hospitals only between \$4,000 and \$6,000 per stroke patient. The new Medicare rule, which took effect last October, created a specific DRG (559) for acute ischemic strokes with use of a thrombolytic agent, and reimburses hospitals \$11,578 for the care. As appealing as it sounds, these figures pale against the threat of revenue losses incurred from ambulance diversions to certified stroke centers. (With the "alert" bar set low, every symptom masquerading as stroke could be a forfeited case.) To avoid this scenario and ensure robust ER coverage, on-call stipends make a lot of sense.

WHAT IS ADEQUATE REIMBURSEMENT?

But how do you determine an amount that makes it economically worthwhile? Jeffrey O. Dann, CPA, Executive Director of Dent Neurological Institute in Buffalo, admits that this is a complex issue for most office-based practices. The first step, he said, is to determine the loss of ancillary revenues for being out of the office.

An analysis revealed that his practice would incur a loss of \$610,000 annually per each full-time equivalent neurologist. "This would be the amount we would want the hospital to pay our practice if they

requested a full-time neurologist covering hospital neurology needs," explained Dann.

Until January 1, 2005, his group covered two hospitals with one full-time physician out of the office each day. The stroke inpatient service compensated them \$1,500 per week, which, along with other hospital-related revenue, was not

The new DRG (559) reimburses hospitals \$11,578 for treatment of acute ischemic strokes with a thrombolytic agent.

sufficient to cover their cost for 2005. So the group resigned from one hospital and dropped out of the acute stroke program at the other.

NEGOTIATING BETTER SOLUTIONS

Douglas J. Redosh, MD, and the three other neurologists in his group in Wheatridge, CO, realized a few years ago that they were being pulled in too many directions by covering three hospitals. After another neurology group in their area went on strike – and received a nice coverage compensation package as a result – Dr. Redosh and his colleagues decided to drop one hospital (even though they were then, also, offered

remuneration) and negotiate payment at the others.

"At first we were met with deaf ears," said Dr. Redosh, who admits it took a change in administration to hear them out. Ultimately, they too, threatened a strike, and succeeded in working out an arrangement in which everyone would win. The hospital would get a stroke center; they would become its medical directors, and they would receive compensation for being directors as well as for call coverage.

Dr. Redosh pointed out that they got more than a financial reward from the deal: The hospital built a new neurological care unit, and worked out better neurosurgical coverage. Best yet, he feels more professionally fulfilled. "Creating a stroke center, developing staff in-service programs, and doing more training, has been a rejuvenating experience," he said. His advice to other neurologists: "Keep pushing and don't take no for an answer."

USING A HOSPITALIST MODEL

Dr. Redosh's group, like others, has used the hospitalist model to cover stroke calls – one member of the group is parked at the hospital, enabling the others to continue their office hours uninterrupted. The same is true for Roy C. Katzin, MD, and his five-person neurology group in Boca Raton, FL, where he serves as stroke director at two hospitals. His region had 15 neurologists sharing call until a few years ago when more than half dropped from hospital staffs to pursue concierge practices.

"Because the pressure was tremendous," he explained, "we agreed upon a payment schedule and we are now compensated \$400 per 24-hour call period at our nonprofit hospital." The group has just worked out a stipend arrangement for tPA call at their other (for-profit) hospital. The administration agreed after a surgical group threatened to leave

AAN POSITION PAPER ON 'ON-CALL REIMBURSEMENT' SHAPES POLICY

Declining reimbursement and a crisis number of uninsured patients in Oregon have been threatening the economic survival of many medical practices causing many specialists, including neurologists, to leave hospital work entirely. When it was down to every other night call after the third neurologist in her group left, Kathleen M. Fitzgerald, MD, concluded that she could no longer continue at this pace. Already, every tPA call meant canceling clinic time to run to the hospital.

The former Palatucci Advocacy Leadership fellow and her colleague Mark O. Herring, MD, a member of the hospital's Physician Leadership Group met with hospital administrators to create a more effective system for call. They also shared the AAN position paper "On-Call Reimbursement for Neurologists," www.aan.com/professionals/On_Call_Policy.pdf. The paper advocates compensation for emergency room coverage.

They ultimately created a system by which there would be a stipend for neurology coverage on weekends, allowing other neurologists to participate in taking call. She said, "The little transitional solution we worked out with the hospital to assure coverage of ER call made me feel that it is possible to develop broader programs to guarantee access to care for neurological patients."

and was able to negotiate an agreement. As has been frequently the case, this opened the door for other specialty negotiations.

The group is currently working out a stipend arrangement for tPA call at their other (nonprofit) hospital. Dr. Katzin warns neurologists who are considering tPA coverage reimbursement that they will be busy. His calls have risen considerably since the hospital initiated stroke alerts.

FACTORS FOR DETERMINING THE PER-DIEM RATE

"Not all call is created equal," said Fred Lara, a principal at HealthCare Appraisers, Inc, a firm that helps hospitals develop a per-diem rate for on-call specialty rate structures. "The burden of stroke call, in which there is a time-sensitive need for the neurologist to see the patient, is higher than average," he said. This is one of several factors that his company takes into account when it calculates payment values for hospitals. Other factors include:

- typical compensation for the specialty (for example, neurosurgeons earn more than neurologists),
- the frequency of call during an on-call

period (as determined by individual hospital data),

- the payer mix at the hospital (for example, if the population is indigent or uninsured as determined by individual hospital data, that makes the burden higher),
- professional medical liability risks (for example, neurosurgeons carry higher risks than neurologists),
- the number of physicians available in the call rotation (the fewer in number, the higher the burden).

"We have received many more requests to put a value on stroke call in the last twelve to eighteen months," said Lara, "and everyone is best served by making sure that on-call compensation is consistent with fair market value." Lara pointed out that many specialists have moved towards outpatient treatment for which hospital affiliation is no longer needed. "This places administrators in a difficult position when it comes to emergency room coverage," he noted. Sullivan Cotter and Associates, which published its first annual physician on-call compensation study in 2005, found that stipends for neurologists range from \$141/day (25th percentile) to \$539/per day (75th percentile). Stroke coverage, said Lara, would fall close to the upper end of that spectrum, assuming a fair number of calls. *



Dr. Brian D. Loftus said that at Methodist Hospital in Houston the number of call days assigned is proportionate to hospital activity: A neurologist who does 20 percent of all the admissions and in-patient consults is responsible for 20 percent of the call days, and is compensated \$250 for each day on call.

Next month's "In Practice" column will discuss the medico-legal risks of tPA administration and growing case law.