On-Call Duties Usually Mean Additional Pay

BY MARY ELLEN SCHNEIDER

Nearly two-thirds of physicians receive additional pay for providing emergency department on-call services in the hospital, a survey from the Medical Group Management Association shows.

The survey of more than 2,500 physicians in group and solo practices and other health care providers found that 38% of respondents did not receive additional compensation for on-call coverage, while 62% received some type of added payment. Of those who received additional payment, the most common method of payment was a daily stipend.

But the survey's findings prompted a skeptical response from some emergency medicine experts.

This is the first year that the Medical Group Management Association (MGMA) has surveyed physicians and other health care providers about on-call compensation levels.

"Historically, on-call duties have been sporadically compensated by hospitals. However, we're seeing more hospitals compensating physicians, and we're seeing hospitals paying more," Jeffrey Milburn, a consultant with the MGMA Health Care Consulting Group, said in a statement.

For those who get paid for on-call coverage, more than two-thirds were paid only by the hospital. About 16% received added pay from their medical group only, and another 16% received some type of added pay from both the hospital and the medical group.

Neurological surgeons had the highest median daily rate for providing on-call coverage, about $2,000 a day. Near the top of the pay scale were neurologists ($1,500), cardiovascular surgeons ($1,600), internists ($1,050), and anesthesiologists ($800).

Among the specialists earning lower median daily rates for on-call compensation were psychiatry ($500), general surgery ($500) gastroenterology ($500), ophthalmology ($300), and family medicine without obstetrics ($300), according to the MGMA survey data.

The survey also found that for most specialties, physicians working in multispecialty group practices received higher on-call compensation than did those in single-specialty practices.

Regional pay variations also were seen. For example, orthopedic specialists received higher compensation in the East, while general surgeons were paid at a higher rate in the Midwest than in other areas of the country.

The task force recommended the adoption of a compensation model for physicians who provide on-call coverage in the emergency department. It also supported various ways that hospitals in the same region could work together to provide on-call coverage. ■

APA, AMA Object to New Rule

ID Theft *from page 1*

professionals to develop and implement a written identity-theft prevention and detection program to protect consumers. Specifically, the rule calls for organizations to conduct a risk assessment to determine their vulnerability to identity theft. Next, they must develop and implement a written identity-theft program to identify, detect, and respond to those risks.

As part of the plan, organizations must specify how they will detect the "red flags" alerting them to potential identity theft. The program also must include how the organization will respond once a red flag is detected.

While identify theft is most commonly associated with financial transactions, there is increasing concern about identity theft in the health care sector, according to the FTC. For example, medical identity theft can occur when a patient seeks care using the name or insurance information of another person.

For most physicians working in settings with a low risk for fraud, an identity-theft program could be simple, according to the FTC.

For example, staff at the practice could check a photo identification at the time services are sought.

Another part of a basic program would be to develop steps to take in the event that someone's identity has been misused. That might include not collecting debt from the "true consumer" and not reporting the debt on the con-