Emergency Physician Overhead

Contrary to common misperception emergency physicians in non-office-based clinical settings bear significant overhead expenses. These expenses include, but are not limited to, the following:

- Uncompensated and undercompensated care including that resulting from EMTALA mandates. CMS concluded that emergency physicians are not compensated for at least 55% of the time they spend treating patients.¹
- Administrative expenses including but not limited to coding, billing, collection, legal and accounting services.
- Physician management services including medical director duties, quality improvement, EMS director duties, medical staff services, and community relations.
- Personnel and payroll expenses including fringe benefits.
- Documentation expenses including employment of scribes, transcription costs, training, and supplies.
- Adoption and implementation of electronic medical record systems to improve patient care and satisfy meaningful use requirements.
- Medical equipment, materials, and supplies including depreciation.
- Office expenses including rent or mortgage expenses for office space, utilities, telephone, information services, and technical support.
- Practitioner recruitment expenses including travel, moving costs, and training.
- Professional books and journals, continuing medical education expenses, and licenses.
- Availability expenses. The emergency department must be appropriately staffed and operational 24 hours-a-day, 7 days-a-week whether any patients are present or not. Unlike other specialists that can be "on call," emergency physicians must be physically present and ready to provide care at all times. This unique practice requirement incurs significant costs which cannot be allocated to a particular patient.
- Costs associated with the preparation for and participation in planning for regional and national disasters, including travel and lodging, vaccine/immunization updates, shift coverage, community support, and adherence to federal/state mandates.
• Expenses related to the support and adherence to mandated performance and quality measures required by hospital and regulatory agencies and third party payers.
• Expenses related to compliance with mandated patient satisfaction initiatives.
• Administrative costs required for adherence to compliance regulations, e.g., patient privacy issues.

1 The December 31, 2002 Federal Register final rule regarding the 2003 physician Medicare fee schedule (67 FR 79972). Response from CMS demonstrating its continued reliance upon fee schedule determinations made in previous years.