One Day a Month: How a Rural Hospital Saved Its Eye Surgery Program — Compliantly

A FAIR MARKET VALUE & PHYSICIAN COMPENSATION CASE STUDY

THE OVERVIEW

Real Need, Not Enough Volume

In many rural communities, the difference between a patient getting cataract surgery close to home and driving hours to get it comes down to one unglamorous question: can the local hospital pay a specialist fairly, sustainably, and in a way that holds up under regulatory scrutiny?

We recently worked with a county-owned critical access hospital in rural western Kansas facing a hard question, and the manner in which it was resolved shows why physician compensation valuation is rarely a matter of looking up a number in a survey.

PROJECT QUICK FACTS

- ☑ County-owned critical access hospital
- ☑ Rural western Kansas
- ☑ Cataract & refractive ophthalmology
- ☑ Itinerant PSA · single per-wRVU rate
- ☑ On site ~1 day / month
- ☑ HSG opinion: consistent with FMV & commercially reasonable

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The hospital serves a geographically dispersed rural population for whom it is the primary point of access to care across a variety of specialties and subspecialties, from primary care to cancer care to specialized eye care. Eye surgery, cataract and refractive procedures in particular, have become a headline service line in the hospital's specialty clinics. But the community could not support a full-time ophthalmologist. There wasn't enough local volume to justify one, and subspecialized surgical eye talent is scarce in that part of the country.

For years, the hospital solved this the only way it could: an itinerant, fellowship-trained cataract and refractive surgeon who traveled in from a metropolitan practice several hours away to operate roughly one day a month. On each visit the hospital "loaded up" the schedule, the surgeon alternated between clinic and the OR, performing a significant number of cataract procedures, laser procedures, and evaluations in a single concentrated day, supported by a small team of clinical technicians who traveled along with the ophthalmologist.

It worked clinically. The challenge was structural. Reimbursement pressure on cataract services, plus a desire for cleaner compliance footing, prompted the parties to restructure into a Professional Services Agreement with billing reassignment, the hospital would bill and collect for both the professional and technical components, and in exchange pay the physician's group a single rate for every work RVU generated.

THE CHALLENGE

Why the Usual Playbook Didn't Apply

Most physician-compensation FMV opinions are answered with the Market Approach: compare the proposed pay to published survey benchmarks for the specialty, and you're largely done…as long as the salary is not outside traditional thresholds. That works when a hospital pays an individual physician a salary for personally performed work.

This arrangement was different in almost every way that matters. The payment wasn't a salary to an individual, it was a per-unit rate paid to a group. It wasn't for the physician's work alone, it was for a bundle: professional services, dedicated clinical technicians, malpractice coverage, practice overhead, and administrative infrastructure, delivered itinerantly once a month. No published survey reports a clean comparable price for a bundled, traveling, per-wRVU service. Forcing it into a standard salary benchmark would have produced a number that was easy to defend but wrong and unacceptable to the practice. The group would walk away and the hospital would lose a vitally important service to the people of the community it serves.

THE APPROACH

Build It Up, Then Cross-Check It

1 A Cost-Up (cost) approach as the primary lens

Our team led with a Cost-Up (cost) approach as the primary lens. We built up the fully loaded annual cost of delivering the bundled service, physician compensation and benefits benchmarked against a weighted blend of national surveys, the technicians' compensation, professional liability coverage, management and administrative fees, and an overhead allowance, and expressed that total on a per-wRVU basis using market-level production at each percentile.

2 An independent Market Approach cross-check

Because a single method in isolation is never enough, we corroborated it with an independent Market Approach cross-check, comparing the implied compensation against national collections-to-wRVU benchmarks for ophthalmology and contextualizing it against the arrangement's own historical production.

3 The two independent methods converged

The cost build-up bracketed the proposed rate closely, and the market cross-check placed it between the 50th and 75th percentile of the national benchmark, while representing only a modest, sustainable share of the collections the services generated. We paired the FMV opinion with a commercial reasonableness analysis: for a rural critical access hospital, preserving local access to essential surgical eye care is a legitimate business purpose that stands on its own, apart from any referrals.

THE OUTCOME

Why It's a Win-Win

The elegant part of this arrangement is the efficiency and productivity. Because the hospital concentrates a month's demand into a single loaded surgical day, the surgeon produces at an exceptional level on the days of coverage, well above the benchmarked norm for a typical day. That concentration is what makes the model work for everyone: the physician earns strong compensation for a high-output day, including the time and travel it requires; the hospital sustains a profitable, essential service line under a compliant billing structure; and the community keeps local access to eye surgery it would otherwise travel hours to receive, or go without.

KEY FINDINGS

Preserving local access to essential surgical eye care is **a legitimate business purpose that stands on its own.**

THE TAKEAWAY

What This Means for Hospital Leaders

Not every physician arrangement fits neatly into a survey. Itinerant coverage, bundled services, per-unit rates, group-to-hospital payment structures, these are increasingly common in rural and access-challenged markets, and they are exactly where a lazy benchmark creates the most regulatory risk. The answer isn't to force the arrangement into a box it doesn't belong in; it's to value it rigorously on what it actually is. **Done well, fair market value work isn't a compliance tax, it's what lets a creative, community-serving arrangement actually happen, and hold up.**

ABOUT HSG ADVISORS

HSG is a growth intelligence partner for hospitals, health systems, physician groups, FQHCs, and hospital associations.

Healthcare organizations choose HSG for three reasons: an ongoing partnership rather than a transaction, a rigorous approach to how their data is governed, integrated, visualized, and reported, and advisory experience in the decisions that determine growth.

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