

Negotiating the Orthopedic Traumatologist Call Contract

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Objectives: To synthesize published evidence, financial models, and operational strategies related to orthopedic trauma call contract negotiation, and to present a real-world case analysis of a comprehensive contract redesign at a community hospital.

Design: Structured operational review incorporating an embedded observational case analysis.

Setting: Published orthopedic trauma, health economics, and hospital administration literature, supplemented by institutional data from a community hospital transitioning to fellowship-trained traumatologist coverage, without a trauma designation.

Intervention: A comprehensive call contract redesign comprising four interconnected components: a fair-market-value call stipend, gainsharing, co-management, and a dedicated fracture operating room.

Main Outcome Measurements: Three analytical domains: expanded financial opportunity, operational infrastructure and staffing, and performance-based compensation.

Results: Published data show that orthopedic trauma programs generate significant institutional revenue—estimated at \$3.86 billed and \$7.81 collected in hospital revenue per dollar of professional charge. Dedicated trauma ORs decrease after-hours surgery and length of stay, saving approximately \$1.13 million annually. Hospital-employed APPs cut ED time by up to 3 hours and reduce length of stay by as much as 6.5 days. Implant cost-containment strategies, including matrix pricing, sole-source contracting, and high-value implant adoption, have saved over \$4 million at a single institution. In the embedded case analysis, transitioning to fellowship-trained traumatologist coverage with a restructured contract (stipend, gainsharing, co-management, dedicated OR) improved OR efficiency, lowered length of stay, decreased implant costs, and increased surgical volume.

Conclusions: Orthopedic trauma call contracts structured around evidence-based financial models, operational infrastructure, and performance-linked compensation create measurable institutional value. A framework integrating these three domains provides a reproducible and defensible approach to call contract negotiation for orthopedic traumatologists and hospital systems.

Level of Evidence: Level IV – Structured Operational Review with Embedded Case Analysis

Key Words: Orthopedic trauma, call contract, gainsharing, co-management, trauma activation fees, fair market value, value-based care

INTRODUCTION

Negotiating orthopedic trauma call contracts has become a key part of hospital–physician alignment and surgeon compensation. A well-designed contract is no longer just about money paid to a physician for call coverage. What was once a simple financial agreement has developed into a complex tool that links reimbursement to value-based care, efficiency, and physician engagement. In modern trauma systems, well-structured call contracts support not only fair pay but also operational excellence and collaboration within the institution.

Gainsharing and co-management agreements, once innovative, are now common, providing mutual advantages by aligning hospital financial aims with physician-led quality improvement. Understanding the financial, legal, and operational principles behind these agreements is crucial for any orthopedic traumatologist entering or renegotiating a call contract. This review assesses orthopedic trauma call contracts across three operational areas: expanded financial opportunity, operational infrastructure and staffing, and performance-based compensation models.

METHODS

A structured review was conducted synthesizing published literature, economic analyses, and operational data relevant to orthopedic trauma call contract negotiations. Sources were identified through a targeted review of peer-reviewed literature on orthopedic trauma, health economics, and hospital administration, supplemented by institutional reports from the authors' practice and affiliated institutions. Findings were organized into three analytical domains: financial

expansion capabilities, operational infrastructure and staffing, and performance-based compensation models. A single-system observational case analysis of a contract redesign implemented in September 2023 at a non-trauma-designated community hospital is presented to illustrate the practical application of these principles. No patient-level identifiers were used. This study was considered exempt from institutional review board oversight because it used de-identified, aggregate institutional data and published literature.

RESULTS

There were 23 articles identified relative to potential orthopedic trauma contract negotiation. These articles were organized into three analytical domains: financial expansion capabilities, operational infrastructure and staffing, and performance-based compensation models. The principal published findings within each domain are summarized in Table 1.

Financial Expansion Capabilities

Key financial reports indicated that trauma surgeons offer significant distinct advantages in a hospital's reimbursement through the ability to generate trauma activation fees.⁵ A trauma surgeon also expands the hospital's capabilities to retain cases within the institution, resulting in retained reimbursement from ancillary services to include lab tests, imaging, physical therapy, consultations, and inpatient care.³ Collectively, these indirect advantages result in significant institutional revenue estimated at \$3.86 billed and \$7.81 collected in hospital revenue per dollar of professional charge by the trauma surgeon.

Operational Infrastructure and Staffing

Previous articles also cite strategies to ensure these reimbursements are maximized both for the surgeon and hospital system. These include the use of

hospital-employed advanced practice providers (APPs)^{14,15} and dedicated daily orthopedic trauma operating rooms.⁶⁻¹³ Together, these APPs and dedicated trauma rooms helped significantly lower patient ED times, decreased time to surgery, and decreased length of stay¹⁴ while also decreasing after hours cases.⁶⁻⁸ Such clinical efficacy resulted in millions of dollars saved annually.^{13,15}

Performance-Based Compensation Models

When direct call pay falls short of surgeon expectations, additional compensation methods such as directorship pay, co-management, or gainsharing agreements were cited as opportunities to fill the gap in pay, while also fostering institutional alignment. These performance-based compensation models provide ownership opportunities for surgeons and cost-savings opportunities for hospital systems. Trauma surgeons perform orthopedic-trauma cases significantly faster than their colleagues,¹⁶ but also at a much lower implant cost.¹⁹⁻²¹ Gainsharing, as one example, rewards surgeons with a portion of the savings from specific cost-reduction efforts—such as implant standardization, increased efficiency, or shorter length of stay. A 30% surgeon share of verified savings has proven to be both effective and compliant, ensuring that hospitals and physicians benefit together from innovation and responsible management.^{17,30}

DISCUSSION

Domain 1: Expanded Financial Opportunity — Finances of Orthopedic Trauma

Trauma programs serve as the flagship entities for many hospital systems. However, during contract negotiations, hospital administrators often claim that trauma programs lose money—an argument rooted in the early 2000s, when closures of emergency departments

Table 1: Evidence Summary: Reported Operational Impact by Contract Domain.

Domain	Component	Evidence Source	Reported Impact
Financial	Hospital revenue ratio	Vallier et al. ⁴	\$3.86 billed / \$7.81 collected per \$1 professional charge
Financial	Trauma activation fees	Althausen et al. ⁵	\$77M charges/yr; \$7.4M activation fees; \$5M profit
Financial	Activation fee range	Zitek et al. ³	\$5,000–\$30,000 per admission
Infrastructure	Dedicated trauma OR	Multiple ^{6–13}	↓ after-hours cases, ↓ LOS by 2.7 days, \$1.13M/yr savings
Infrastructure	Hospital-employed APPs	Althausen et al. ¹⁴	↓ ED time by 3 hrs, ↓ time to surgery by 6 hrs
Infrastructure	Nurse practitioners	Hiza et al. ¹⁵	↓ LOS by 6.5 days, \$1M/yr savings
Compensation	Dedicated coverage	Althausen et al. ¹⁶	↑ clinic productivity 20%, ↑ surgical volume 30%
Compensation	Traumatologist efficiency	Althausen et al. ¹⁶ ; Riepen et al. ¹⁷	50% less OR time/cost; 26% faster, 52% lower implant cost
Compensation	Implant standardization	Multiple ^{19–24}	\$1.88M savings (3 yr); \$4M+ sole-source; 56–70% generic savings
Compensation	Geriatric fracture QI	Kates et al. ²⁹	33% cost reduction, \$730K/yr savings
Case Analysis	Contract redesign	Riepen et al. ³⁰	↑ OR efficiency, ↓ LOS, ↓ implant costs, ↑ volume

(EDs) and trauma centers reflected genuine financial hardship. Since then, the trauma landscape has changed significantly. Since 2009, over 200 trauma centers have opened in more than 20 states, with another 75 centers seeking designation.¹ For-profit systems now see trauma services as profitable and strategically important. As Mike Williams, President of the Abaris Group, noted in 2012, “If a hospital is not making money on trauma, it’s not structured the right way.”²

Today, hospitals generate significant revenue from trauma through activation fees, employed physician billing, imaging, laboratory tests, consultations, and inpatient care.³ The uninsured patient population is smaller than often portrayed, which further supports the program's viability.

Surgeons must also understand the extent of their impact on hospital revenue. Vallier et al. showed that for every dollar of professional charge, hospitals billed \$3.86 and collected \$7.81 in net revenue through facility, imaging, and ancillary services.⁴ Even after adjusting for inflation and changes in payer dynamics, the core idea remains: orthopedic traumatologists generate substantial institutional profit that greatly surpasses, and is not reflected in, their individual collections. Hospitals can only access this revenue stream by maintaining trauma site verification with skilled orthopedic trauma surgeons.

Trauma Activation Fees

Trauma activation fees, introduced in the mid-2000s, are a significant but often overlooked source of revenue for hospitals with a trauma designation. These fees—ranging from \$5,000 to \$30,000 per admission—are charged by hospitals to cover the cost of mobilizing trauma teams when patients arrive. Originally meant to offset expenses for uninsured care and overhead, activation fees have grown into a notable income stream, and their amounts are often set somewhat arbitrarily.

In a 2009 JBJS study, trauma patients with orthopedic injuries generated \$77 million in total charges over one year, including \$7.4 million in activation fees, \$15.7 million in radiology, and \$3.4 million in laboratory services—resulting in over \$5 million in profit, excluding physician billing.⁵ These figures have only grown in the years since.

Hospitals claiming they cannot afford adequate call stipends often miss this point. Even a small increase in trauma activation fees can fully cover surgeon and anesthesia stipends while maintaining profitability and consistent trauma coverage.

Domain 2: Operational Infrastructure and Staffing

A high-performing trauma program depends on clear infrastructure and staffing models that support both clinical excellence and system efficiency. To ensure accountability and alignment with hospital performance goals, these resources should be explicitly outlined in the call contract. If not specified, a new administrator could

eliminate essential personnel and systems designed to deliver the highest quality of care with just a click or keystroke.

Core requirements include a dedicated trauma operating room (OR) with reliable anesthesia coverage, immediate access to fluoroscopy and essential implants, and a skilled support team experienced in trauma workflows. Additionally, advanced practice provider (APP) support plays a critical role in facilitating timely patient care, coordinating documentation, and enhancing continuity for follow-up management.

These operational standards not only meet American College of Surgeons (ACS) verification criteria but also lead to measurable improvements in throughput, patient outcomes, and surgeon satisfaction—highlighting the importance of investing in trauma program infrastructure.

Dedicated Trauma OR

A dedicated orthopedic trauma OR is crucial for both patient safety and program efficiency. Published evidence shows that dedicated trauma ORs decrease surgical delays, reduce nighttime surgeries, and lower complication rates.^{6–8} Additional research indicates shorter operative times, less blood loss and mortality, and higher elective case volume.^{7,9}

Subsequent analyses confirm that dedicated trauma ORs enhance perioperative efficiency while remaining financially net-positive, with reductions in after-hours procedures and operational disruptions.^{10–12} Establishing a weekend trauma room has also been shown to decrease hospital length of stay (LOS) by 2.7 days, shorten wait times, and reduce Monday case backlog—saving \$1.13 million annually in direct variable costs.¹³

A dedicated OR represents one of the most effective, evidence-based investments a hospital can make to support its trauma surgeons and enhance system

efficiency.^{10,11} These data support its inclusion as a core contractual element.

Hospital-Employed Advanced Practice Provider (APP)

Advanced Practice Providers (APPs) are essential to an effective trauma service. Their roles go well beyond simple support—they directly influence patient flow, adherence to protocols, and hospital cost-saving efforts.

While some orthopedic surgeons use their own physician assistants, trauma programs often work best when APPs are employed by the hospital. This provides consistent coverage, continuity, and seamless integration into ED and general surgery trauma workflows.

Althausen et al. demonstrated that hospital-employed PAs at a Level II trauma center reduced ED time by nearly 3 hours, improved time to surgery by 6 hours, shortened operative times, and enhanced compliance with postoperative protocols.¹⁴ Although their direct billings did not cover their salaries, the cost savings from improved efficiency and fewer complications more than offset the expenses. Similarly, Hiza et al. found that nurse practitioners at a Level I trauma center reduced LOS by 6.5 days and saved over \$1 million annually.¹⁵

These findings indicate that APPs are not a financial burden—they are an investment in quality, safety, and throughput that directly benefits the hospital's bottom line and boosts physician productivity.

Domain 3: Performance-Linked Compensation — Call Stipends

The call stipend remains the fundamental element of trauma call contract negotiations. It compensates surgeons for their availability, expertise, and the loss of elective practice opportunities while on call. Some administrators have rephrased it as a “call

subsidy,” suggesting financial aid rather than earned pay—a distinction worth challenging during negotiations.

Current call pay rates vary widely, typically ranging from \$500 to \$5,000 per 24-hour period, depending on trauma level designation, call volume, and geographic market. Hospitals with lower call volume may warrant higher stipends since lower case volume limits the surgeon’s ability to generate procedural revenue, but these stipends must still fall within fair market value (FMV) ranges.

Surgeons should refer to national benchmarks from the Orthopaedic Trauma Association (OTA), Medical Group Management Association (MGMA), and/or the OrthoForum to determine FMV for their region and call intensity. Importantly, all payments must be FMV-compliant to avoid violating the AKS or Stark Law. Hospital representatives often cite the 50th percentile as the safest benchmark. However, FMV is a range (0–100th percentile), and compensation at the 75th or even 95th percentile remains compliant if supported by documentation of call intensity, volume, and market conditions.

When direct call pay falls short of expectations, additional compensation methods such as directorship pay, co-management, or gainsharing agreements can fill the gap while fostering institutional alignment.

Directorship Pay

Surgeons who oversee trauma programs should never provide administrative expertise without fair compensation. Program leadership requires significant, ongoing effort—including establishing protocols, managing quality initiatives, conducting morbidity and mortality (M&M) conferences, and coordinating across departments such as the OR, nursing, and rehabilitation services.

Directorship pay acknowledges this administrative task and compensates physicians for the

significant value they bring to the institution. Typical rates range from \$300 to \$500 per hour, often with a cap on a set number of reimbursable hours each month. To stay compliant with AKS and FMV standards, hours must be accurately recorded and submitted monthly for reimbursement.

Including directorship pay in the call contract formalizes this leadership role and ensures hospital accountability. It also aligns the surgeon’s incentives with hospital performance metrics—creating a true partnership that supports both quality and efficiency.

Demonstrating Value in Exchange for Compensation

Hospitals expect a measurable return on investment for trauma call coverage. Orthopedic traumatologists meet—and often surpass—these expectations by advancing institutional priorities such as improving efficiency, controlling costs, and achieving better quality outcomes. Therefore, modern call contracts should acknowledge this value rather than just compensate for availability.

Fellowship-trained traumatologists provide dedicated call coverage that enhances patient access and care coordination while decreasing delays in treatment. Their leadership in OR workflow optimization directly boosts operative efficiency. Orthopedic trauma surgeons also oversee cost-containment initiatives, including implant pricing strategies that lead to significant savings. Additionally, they guide quality-improvement efforts and program development that are vital for ACS trauma verification and performance benchmarking.

Each of these impact areas provides clear institutional benefits—such as increased throughput, reduced costs, and better patient outcomes—strengthening the case for higher call stipends, trauma program director compensation, and inclusion in gainsharing or co-management arrangements.

Dedicated Coverage by Traumatologists

Dedicated trauma coverage during day and night by fellowship-trained orthopedic traumatologists greatly enhances hospital performance and surgeon satisfaction.

Althausen et al. demonstrated that when traumatologists provided dedicated daytime call coverage (7 AM–5 PM), elective surgeons' clinic productivity increased by 20%, surgical case volume by 30%, and practice revenue by 20%.¹⁶ Elective surgeons also took fewer call shifts and had more vacation time—highlighting the system-wide efficiency gained through subspecialized trauma coverage.

For hospitals, dedicated orthopedic trauma coverage allows for efficient and reliable daytime OR use and cuts down on costly, high-risk surgeries after hours performed by exhausted elective surgeons. Moreover, the ability to promote leading positions as “call-free” attracts and keeps subspecialists, further boosting the hospital's competitiveness.

OR Efficiency

Fellowship-trained traumatologists consistently outperform general orthopedic surgeons in operative efficiency. In an analysis of the 20 most common fracture procedures, Althausen et al. reported that trauma specialists completed 18 of them in half the operative time and at half the cost compared with non-fellowship-trained surgeons.¹⁶ In a similar study, Riepen et al. demonstrated that fellowship-trained orthopedic traumatologists taking pediatric call at a regional, Level 2 trauma center completed 12 common pediatric fracture cases 26% faster and with 52% lower implant-related costs than their pediatric fellowship-trained counterparts.¹⁷

This efficiency directly results in less anesthesia used, fewer complications, and increased OR throughput—important quality and financial indicators in hospital operations. A dedicated orthopedic trauma service led by

experienced traumatologists is therefore both a clinical and economic necessity, not an optional expense.

OR Cost Containment

Trauma surgeons also reduce costs by standardization and collaboration. Gurnea et al. outlined the total savings possible when all surgeons in a department agree on standardized packs, drapes, sutures, and soft goods.¹⁸ By removing variability and waste, departments can achieve significant reductions in direct supply costs—regardless of implant savings.

When surgeons collaborate effectively with supply chain teams, the resulting efficiencies often qualify as measurable cost-saving initiatives, supporting eligibility for co-management or gainsharing bonuses. By leading these efforts, orthopedic traumatologists demonstrate financial stewardship that justifies increased compensation models and enhances negotiating leverage.

Implant Pricing Control

Implant pricing remains a key lever for reducing costs in orthopedic trauma. Three impactful strategies—Matrix Pricing, Sole-Source Contracting, and using High-Value (Generic) Implants—have shown significant savings while achieving the same clinical results.

Matrix Pricing sets fixed prices across vendors, reducing variability and encouraging transparent competition. Healy et al. first demonstrated its success in arthroplasty, and Althausen et al. later reported \$1.88 million in savings over three years for trauma implants and \$165,000 in a single year for hemiarthroplasty.^{19–21}

Sole-Source Contracting further enhances vendor alignment, typically achieving 75–80% compliance and multimillion-dollar annual savings. One community-based trauma program saved over \$4 million on implant costs while maintaining flexibility to use generics when clinically suitable.²²

High-Value (Generic) Implants offer additional options, providing comparable performance at significantly lower costs—70% savings with cannulated screws, 56% savings with locking plates, and major reductions in the price of cephalomedullary nails.^{23–25}

By leading these initiatives, orthopedic traumatologists act as responsible financial stewards, generating measurable cost savings that support improved compensation models and increase negotiating power within hospital systems.

Quality Improvement

Quality improvement (QI) initiatives are essential for both hospital accreditation and value-based reimbursement. Orthopedic traumatologists play a vital role in leading these programs, and their involvement should be explicitly acknowledged in call contracts.

The foundation of QI in trauma care is the Morbidity and Mortality (M&M) conference, which fosters transparency, responsibility, and ongoing learning—key elements for American College of Surgeons (ACS) trauma verification.^{25,26} Surgeons who organize and lead these efforts deliver measurable institutional value and should be appropriately compensated by administration.

Creating standardized clinical algorithms for high-risk conditions—such as open fractures, vascular injuries, pediatric infections, and unstable pelvic fractures—improves consistency, reduces delays, and enhances outcomes.^{27,28} Likewise, geriatric fracture programs have shown significant clinical and economic benefits. Kates et al. reported a 33% reduction in costs and over \$730,000 in annual savings, along with improvements in patient care metrics and osteoporosis treatment adherence.²⁹

Participation in QI initiatives not only enhances outcomes but also bolsters the negotiating leverage of

orthopedic traumatologists by directly connecting their efforts to measurable institutional benefits.⁴

Gainsharing and Co-Management

Gainsharing and co-management agreements are now well-established mechanisms for aligning hospitals and physicians. Once seen as legally risky, both models have become widely accepted after the updates to the Stark Law and AKS value-based exceptions in 2020.

Gainsharing rewards surgeons with a portion of the savings from specific cost-reduction efforts—such as implant standardization, increased efficiency, or shorter length of stay. A 30% surgeon share of verified savings has proven to be both effective and compliant, ensuring that hospitals and physicians benefit together from innovation and responsible management.^{17,30}

Co-management elevates this idea further by tying compensation directly to performance across an entire service line. For orthopedics, service line revenue can surpass \$20–40 million annually, and co-management agreements usually allocate 2–3% of this amount as incentive pay. Metrics might include lowering LOS, increasing same-day discharges, or enhancing bundle adherence.

Both structures reward measurable improvement, promote physician engagement, and reinforce the principle that trauma surgeons are not just on-call providers—they are strategic partners in institutional success.

Professional Services Agreements

Professional Services Agreements (PSAs) are a call contract format that is becoming increasingly common. They serve as an alternative to hospital employment and can take various forms. Typically, they are designed to simplify contracts by paying a single daily rate that covers the call stipend as well as payment for all clinical work. The physician agrees to cover call and follow certain standards of care and billing

compliance, while the hospital collects all revenue from clinical procedures such as E&M codes and surgeries. A daily rate without any performance metrics attached does not motivate on-call physicians to accept transfers, see additional consults, or perform extra surgeries. This arrangement may be a good option for surgeons who want to work less and still take home a reasonable salary. Some PSAs include an RVU-based bonus to incentivize additional work.

The success of a PSA for the physician clearly depends on negotiating a good rate. Hospital administrators often have no idea how much money a successful, appropriately incentivized private practice orthopedic surgeon can generate daily. As a result, the initial offer for these payments is usually quite low. Additionally, initial offers are often below fair market value, and physicians should approach negotiations with independent data on volumes, collections, and comparable contracts. To secure a good contract for both parties, the physician and hospital need to share data regarding current patient volumes, insurance coverage, and collection rates.

Unbundling services—combining a fair stipend with gainsharing, co-management, and productivity incentives—usually results in higher overall pay while aligning the interests of physicians and the institution.

Case Analysis: Contract Redesign at a Community Hospital

The following case analysis, based on a recent institutional report by Riepen et al.,³⁰ demonstrates the real-world application of the operational domains detailed above. Setting: A non-trauma-designated community hospital where orthopedic ED call coverage had been provided by non-trauma-trained orthopedic surgeons (NTTOS) for more than twenty years. In September 2023, the hospital shifted to full coverage by fellowship-trained trauma surgeons (TTOS).

Intervention: A comprehensive contract redesign that includes four interconnected components:

1) The trauma group agreed to provide 24/7 call coverage for a five-year period exclusively with TTOS. In exchange, the call stipend was increased to account for both the coverage intensity and the long-term staffing commitment.

2) A gainsharing program was implemented to motivate cost-aware implant use. The trauma team received 30% of the annual implant cost savings compared to the previous fiscal year, allocated for reducing group overhead. This promoted the use of high-value implants and supported a transition to a dual-vendor contract, pairing a standard supplier with a cost-effective alternative.

3) A co-management agreement was created, giving the group one-third of verified savings from decreased LOS. This setup rewarded efficiency and linked compensation directly to hospital performance metrics.

4) The final and perhaps most critical element was the creation of a dedicated fracture “clean-up” OR reserved from 12:00 to 17:00 daily. This OR was staffed with anesthesiologists skilled in regional techniques, dedicated orthopedic scrub teams, and X-ray technologists. The trauma group agreed to maintain a daytime in-house presence to ensure continuous OR utilization, which minimized after-hours cases, improved ED-to-OR times, reduced LOS, and decreased total episode-of-care costs.

To further improve standardization and efficiency, the trauma surgeons created unified perioperative protocols—including standardized surgical trays, drapes, suture preferences, antibiotic regimens, and postoperative weight-bearing orders. Consistency across cases streamlined communication among nurses, anesthesiologists, and therapists, reducing variability and increasing throughput.

Importantly, gainsharing and co-management funds were allocated to cover overhead costs for the entire group, promoting internal alignment and encouraging subspecialty partners (adult reconstruction, hand, foot and ankle, sports) to participate in ED coverage and perioperative care. This fostered teamwork and strengthened the hospital's relationship with the broader orthopedic group.

Beyond improving efficiency, this model provided indirect benefits for hospital volume and physician engagement. Allocated OR time, anesthesia support, and skilled staff encouraged trauma surgeons to schedule elective cases during on-call days, increasing surgical throughput and patient access. Positive experiences among trauma staff also motivated non-trauma colleagues to bring elective procedures to the hospital, further boosting institutional revenue and market share. Keeping these injuries in-hospital benefits patients, their families, and the hospital. The additional revenue significantly exceeds the hospital's cost of call pay.

Implications: This initiative showed that a well-designed call contract, featuring fair stipends, gainsharing, co-management, and infrastructure support, can transform a community hospital's orthopedic service line. By aligning financial incentives with clinical efficiency and quality improvement, both surgeons and hospitals realized measurable benefits in cost control, surgeon satisfaction, and patient care.

Regulatory and Legal Constraints

Call contract negotiations must comply with federal and institutional regulations, including the Stark Law, Anti-Kickback Statute (AKS), Fair Market Value (FMV) standards, and American College of Surgeons (ACS) trauma verification criteria.

The AKS prohibits any form of payment aimed at inducing referrals for services that are reimbursed by

Medicare or Medicaid. Overpaying for call coverage or tying payment to referral volume may be a violation. Likewise, the Stark Law mandates that all compensation be commercially reasonable and in line with FMV.

Under ACS verification standards, orthopedic surgeons providing trauma call must be available exclusively to the trauma center during their shift. However, smaller or non-designated hospitals may permit simultaneous call coverage at multiple facilities if it aligns with bylaws and prioritizes patient safety.

Understanding these legal boundaries is crucial. Properly structured call contracts can fully adhere to regulations while fairly compensating surgeons for their time and hospital contributions.

CONCLUSION

The modern orthopedic trauma call contract is more than just a financial deal. It serves as a strategic framework that boosts institutional performance, aligns the interests of physicians and hospitals, and improves patient care.

Surgeons who understand the financial realities of trauma programs, the legal parameters of fair market value, and the operational needs of an efficient trauma service are better prepared to negotiate fair and sustainable contracts.

Hospitals, in turn, gain from partnering with trauma surgeons who provide measurable value through efficiency, cost control, and quality enhancement. When structured properly—with fair stipends, transparent metrics, and shared incentives—call contracts become a strong tool for value creation and long-term alignment in orthopedic trauma care. This review is limited because it relies on published literature and a single institutional case analysis, which restricts broad generalizability. The case analysis is observational and descriptive; no controlled comparator was available. Nonetheless, the integration of published evidence with real-world

operational data across specific analytical areas offers a structured, reproducible framework aligned with Level IV evidence.

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