

## Neurosurgery Compensation Update

Demand Still the Key Driver, but Employment Model Having Effect

By Bonnie Darves

A rapidly evolving healthcare services marketplace, health policy changes on Capitol Hill and the reshaping of medical services delivery as a by-product of health reform all are affecting physician reimbursement and by extension, compensation, directly or indirectly, and positively or negatively, depending on the specialty.

Neurosurgery, to date, however, appears relatively unaffected by the shifting and wrangling that are flattening incomes in some internal medicine sub-specialties and delivering notable boosts in primary care. The two major national compensation surveys, conducted by the Medical

The Neurosurgery Executives' Resource Value and Education Society (NERVES), which tracks the specialty more closely and in more domains than either MGMA or AMGA, found a somewhat different picture. The NERVES Socio-Economic Survey 2014 report, the most recent, saw a median compensation decline of 9.8%, to \$670,000, from its 2013 reported median of \$734,000—and a decline occurred in all three sectors: private practice, hospital-employed practice and academic practice. The latest NERVES survey, the most comprehensive one on the specialty, included 96 practices and 580 neurosurgeons.

**“Neurosurgery is still the No. 1 earning specialty—and compensation has risen more significantly than in any other specialty, in our data. That’s why I don’t really see incomes going down or things shifting dramatically ... because pure demand is driving a lot of this.”**

– Tom Dobosenski, President, AMGA Consulting Services



Group Management Association (MGMA) and the American Medical Group Association (AMGA), both reported an increase in compensation this year.

AMGA's survey (2015 report based on 2014 data) put median annual compensation at \$728,006, up from \$701,399 in the 2014 report. MGMA reported a median of \$747,066 in its 2015 report (also based on 2014 data). That's up from a median of \$710,000 posted in the 2014 report. The MGMA survey also found higher median compensation in single-specialty neurosurgery practices (\$752,141) compared to multi-specialty groups (\$737,849).

The NERVES survey also found declines in work Relative Value Units (wRVUs—one standard measure of productivity) and collections, of 7% and 9%, respectively, over the previous year. AMGA likewise reported an approximate 10% decline in median wRVUs this year, and a drop in net collections, from a median of \$907,054 in 2014 to \$790,735 in 2015 reported data.

Mike Radomski, CPA, who chairs the NERVES research committee, doesn't see these findings as particularly problematic or representative of a worrisome trend. Neurosurgery practices continue to operate in a challenging insurance

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## Neurosurgery Compensation Update

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and reimbursement environment, he notes, but the “high demand for neurosurgeons’ services,” he observes, is assurance that the market picture overall is positive.

“It’s really a continuation of what we’ve been seeing in the last few years, as practices struggle with issues such as approvals for certain spine procedures. Overall, however, I am hopeful that neurosurgery practices will be able to continue to manage successfully,” said Mr. Radomski, who is vice president of finance and CFO of the Mayfield Clinic, Inc. in Cincinnati, Ohio.

The NERVES survey suggests two reasons for his optimism—about practices’ financial viability and neurosurgeons’ compensation levels: Call pay, at a median of \$2,448 per day, increased 13% over 2013 report figures; and practices’ ancillary services and other non-direct patient care activities continue to increase. Last year, those income sources accounted for 21% of neurosurgeons’ compensation, Mr. Radomski noted.

In addition, neurosurgeons who have ownership of their practices appeared to fare better overall than their counterparts in non-ownership positions. On average, the compensation decline was 4.6% in this group, yet neurosurgeons who have practiced 15 years or longer actually saw their compensation increase by 4.1%. In addition, cranial neurosurgery specialists (those who spend 50% or more of their time doing such procedures) continue to lead in the compensation realm, at a median of \$891,000.

Following are other key findings on compensation and related factors from the NERVES survey, which included 277 private practices, 238 academic groups and 65 hospital practices:

- Hospital-employed neurosurgeons have the highest compensation, followed by private-practice neurosurgeons and academic neurosurgeons.

### REGIONAL COMPENSATION VARIATIONS PERSIST

For U.S. neurosurgeons, like their counterparts in most other specialties, where they practice continues to be a significant determinant in overall compensation levels.

Here’s how the regional median compensation data broke down in the recent AMGA and MGMA surveys:

#### AMGA

Northern .....	\$758,250
Southern .....	\$751,903
Western .....	\$700,951
Eastern .....	\$676,497

#### MGMA

Midwest .....	\$850,000
Southern .....	\$750,718
Western .....	\$736,838
Eastern .....	\$683,822

The NERVES survey found the highest compensation in the south and second highest in the Midwest, with the East and West in the third and fourth positions.

- Practice limitations on ER coverage have increased steadily, and 10% groups reported such limitations in 2014.
- Hospital-employed neurosurgeons comprised 11% of respondents in 2014, up from 2% in 2010.
- Fully 55% of practices now track their neurosurgeons’ clinical quality and outcomes data, up from 44% in 2010.
- Last year, 22% of neurosurgery practices participated in accountable care organization (ACO) shared savings programs, up from 11% in 2012.

On a global level, the NERVES survey found that neurosurgeon recruiting has leveled off

generally. The number of practices indicating that they plan to recruit either physicians or mid-level providers has declined for the last five years, consecutively.

Interestingly, off the formal-survey grid, Doximity, the burgeoning physician social network that now tracks physician earnings, reported in January 2015 an average compensation of \$609,639 for neurosurgeons based on information submitted by its members.

### Demand still key driver

Tom Dobosenski, president of AMGA Consulting Services, in Alexandria, Va., acknowledges that the reimbursement-environment factors Mr. Radomski cites are a concern for neurosurgery practices as they try to determine appropriate compensation levels while juggling collections and expenses. At the same time, he reminds young neurosurgeons that the demand for their expertise will continue to be a primary determinant of their income levels.

“Neurosurgery it still at the upper end of the scale, and it continues to outpace all the other specialties as it relates to productivity and compensation because neurosurgeons’ procedures generate a lot of net collections or RVUs,” Mr. Dobosenski said. “Basically, compensation in many cases is still very much supply- and demand-driven, and there aren’t huge numbers of neurosurgeons out there.”

He notes that Level 1 trauma centers in particular wrestle with the paucity of neurosurgeons. “What we hear is that trauma centers need to have a minimum of two and perhaps even three neurosurgeons because there aren’t many neurosurgeons who want to be on call every night—and that even small communities tend to have at least two neurosurgeons,” he said.

The AMGA survey data over recent years supports Mr. Dobosenski’s contentions about demand’s effect on earnings. He points out

**“Over the last five years, the significant increase in neurosurgeons going to hospital employment is changing the dynamic on starting salaries, because hospitals typically offer a high starting salary to recruit neurosurgeons and get them there.”**

– Mary Cloninger, MBA, CEO, Carolina Neurosurgery & Spine Associates

that in neurosurgery, from 2009 to 2015, compensation went up 32.8%, per AMGA’s survey findings. “It’s still the No. 1 earning specialty—and compensation has risen more significantly than in any other specialty, in our data,” he said. “That’s why I don’t really

see incomes going down or things shifting dramatically, over the near term, because pure demand is driving a lot of this.” For comparison purposes, he notes that the No. 2 compensation spot on the AMGA survey is held by catheterization-lab (interventional)

cardiologists, whose median income in this year’s report was \$588,910.

**Employment trends having effect**

Mary Cloninger, MBA, CEO of Carolina Neurosurgery & Spine Associates in Charlotte, N.C., arguably the country’s largest neurosurgery group with 45 neurosurgeons, urges young neurosurgeons to view compensation trends—and their own incomes—within the context of both the services delivery marketplace and practices’ financial foundations.

Based on her two decades of experience in neurosurgery practice administration, Ms. Cloninger has witnessed many market trends that affect compensation. Yet she views the current groundswell movement toward the employed model as one that’s having a particularly skewing

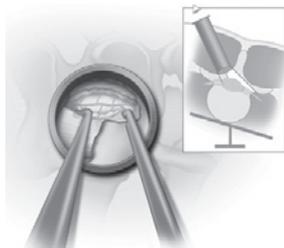
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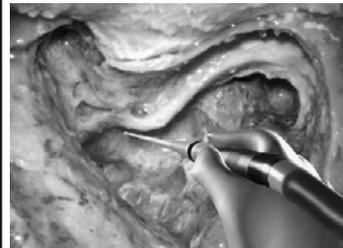


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# Walter E. Dandy Neurosurgical Society: It's All About Outcomes

Relatively new organization promotes a progressive educational agenda and has global reach

By Bonnie Darves

Medical professional organizations whose mission is to improve patient care are fairly common, but the Walter E. Dandy Neurosurgical Society (WEDNS) takes that generic concept to a far higher level, by focusing squarely—and solely—on patient outcomes. Founded in 2011 to honor one of modern neurosurgery's acknowledged forefathers, whose career and achievements during his long tenure at Johns Hopkins University School of Medicine reshaped the field, the society has also embraced a global reach.

The WEDNS education forums are designed with a very specific objective, he explains. "The cornerstone of all our meetings is straightforward: the avoidance of complications through education," Dr. Abdulrauf said, with a focus on procedures, such as aneurysm clipping, in which complications such as stroke, not uncommon, can result in very poor patient outcomes. In addition to its large meetings, the society is also developing a series of hand-on labs—one is established in China and another in St. Louis,

at everything, using a model that is, from the standpoint of improving outcomes, respectfully antiquated," said Dr. Abdulrauf, who specializes in cerebrovascular and skull base.

He further suggested that neurosurgery practice, particularly small groups, should follow suit by moving away from providing "generalist" services, where logistically feasible, and instead develop subspecialty focus areas and refer out cases not in those areas. "I think that we're at a stage in our specialty where the one- or two-person practice no longer makes sense," Dr. Abdulrauf said. "And neurosurgeons are often being put in difficult positions in hospitals developing new programs, where they're expected to do it all—which isn't good for the specialty or for patients."

## Opportunities abound for young neurosurgeons

For neurosurgeons and trainees who are interested in furthering their own training or in helping the WEDNS pursue its educational mission, the society offers many avenues for involvement. WEDNS has dedicated divisions in all eight neurosurgery subspecialty areas, and because of its international scope, the society encourages young neurosurgeons from all countries—more than 15 are represented on WEDNS' executive committee alone—to pursue leadership opportunities.

"We have an open leadership structure, and there are many ways for young neurosurgeons and even trainees to get involved," Dr. Abdulrauf said. He notes that a young Brazilian neurosurgeon who co-chaired the Dubai meeting's scientific committee, Tatiana Vilasboas, MD, is up for an officer position at WEDNS. "We definitely encourage young neurosurgeons to join the society—after all, this is really for, and about their future, and the specialty's," Dr. Abdulrauf said.

For more information about the society and its programs, go to [www.wedns.org](http://www.wedns.org), or reach out to Dr. Abdulrauf at [abdulrsi@slu.edu](mailto:abdulrsi@slu.edu).



**“We wanted to create an organization for the 21st century for neurosurgery that was dedicated purely to patients’ outcomes—not just in the United States, but worldwide.”**



– Saleem Abdulrauf, MD, FACS, President, WEDNS

“We wanted to create an organization for the 21st century for neurosurgery that was dedicated purely to patients’ outcomes—not just in the United States, but worldwide,” said Saleem Abdulrauf, MD, FACS, who is president of WEDNS and chair of neurosurgery at St. Louis University in Missouri. “Our goal is to promote an outcomes-based model for the future of neurosurgery, primarily by serving as a forum for neurological surgeons to work collaboratively to enhance the education of both residents and fully-trained neurosurgeons.”

By any measure, the society is clearly succeeding. Its membership, despite its nascent status, already includes more than 750 neurosurgeons throughout the world and an estimated 2,000 neurosurgery residents, as well as a growing contingent of medical students. Its educational programs also span the globe—the annual meeting set this month (November 2015) takes place in Dubai, and the society's next Neurosurgery 101 course is in Portugal, for example. “We're expecting more than 1,000 neurosurgeons for the Dubai meeting, so we are excited that the society is becoming better known,” Dr. Abdulrauf said.

to date—that will eventually be available on other continents.

Underlying the society's educational focus is another objective, one that's emerged as somewhat controversial. Based in part on the now widely reported and accepted understanding that high-volume surgeons in high-volume institutions have better outcomes than their low-volume counterparts in facilities with relatively low annual procedure numbers, the WEDNS has called for a radical rethinking of neurosurgery training. In a recent editorial, Dr. Abdulrauf proposed a model in which neurosurgeons in training develop a subspecialty focus, and accompanying expertise, earlier on in residency.

In the proposed model, residents would spend the first four years in general neurosurgery, the fifth in research, and the remaining two years in subspecialty training at either their home institution or a different center with demonstrated recognition in the particular subspecialty area. The final written and oral examination would be focused on the neurosurgeon's chosen subspecialty. “Right now, we train people to be mediocre

## IN BRIEF

### Enhancement to U.S. BRAIN Initiative Proposed

A group of neuroscientists has proposed that the U.S. develop a national network of neurotechnology centers to enhance and accelerate the BRAIN Initiative, a two-year-old public-private research initiative whose goal is to support development and application of innovative technologies to create a more dynamic understanding of brain function.

The scientists, representing Harvard, Columbia University, UC-Berkeley, UC-San Diego and CalTech, in an article in the October issue of *Neuron*, suggest that such centers could serve as “brain observatories,” to provide a critical interdisciplinary environment to develop ambitious, complex technologies and provide individual investigators access to those technologies. The BRAIN (Brain Research through Advancing Innovative Neurotechnologies) Initiative has been lauded because of its intent to facilitate partnerships between clinical investigators and manufacturers of latest-generation stimulating and/or recording devices that are FDA-designated as Class III. Some critics, however, have claimed that the initiative is insufficiently focused.

### 3-D Spine Truss System Launched

The Frisco, Texas, company 4WEB recently launched a new 3-D posterior spine truss system encompassing 150 implants designed

to enable optimal matching for individual patients’ anatomy. The company, a forerunner in using 3-D printing in the device sector, claims the truss designs provide superior strength and promote osseous incorporation, and guide bone formation through structural mechanics rather than use of biologics.

The U.S. market launch of the system was announced at the recent meeting of the North American Spine Society. The company’s FDA-cleared systems include the ALIF Spine Truss System, the Cervical Spine Truss System and the Osteotomy Truss System. For more information, go to <http://4webmedical.com/about/>.

### CMS Publishes Physician Payment Data

The U.S. Centers for Medicare and Medicaid Services (CMS) has released 2014 physician-industry financial data—payments that manufacturers of drugs, devices, biologicals and medical supplies make to physicians and teaching hospitals—on its Open Payments public website. The data is required as part of the Sunshine Act, one component of the Affordable Care Act (ACA).

Neurosurgeons must register to review their data, but should note that any requested corrections will not occur until CMS performs its annual review and includes any updates to data disputes and other data corrections. For more information, go to <https://www.cms.gov/openpayments/index.html>.

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## Reducing Regulatory Risk in Neurosurgery Practice

Gaining a basic grasp of regulations that could affect practice's business dealings helps



By Heather Skelton

When people ask me what I do for a living, I often say that my job is to tell physicians that their amazing new business idea would in fact be amazing in any industry except healthcare, in which case it is actually illegal and could land him or her in jail or facing millions of dollars in penalties. When I deliver this message to the unsuspecting physician, the reaction is usually disbelief.

Most people expect to recognize illegal or criminal behavior when they see it. They assume that it will feel wrong or dishonest. The physicians I counsel have no desire to cheat the system; they might just want to expand their scope of services or provide financial motivation for staff to work harder.

The difficulty is that in healthcare, we have certain federal regulations (namely the Anti-Kickback Law, Stark and False Claims Act) that prohibit certain behaviors that under other circumstances might make good business sense. We all know that you are not supposed to bill for unnecessary services or for services you didn't perform. Both are obviously wrong, and while it is baffling how many people continue to do it hoping they don't get caught,

incentivize healthcare providers to increase their utilization of Medicare dollars.

Making sure that Medicare funds are not spent improperly sounds like a positive goal, but it is very difficult to know where to draw the line in our current fee-for-service world. Therefore, we are left with a cumbersome federal regulatory structure that does not always give a clear answer as to whether something is considered illegal or not. The goal is to recognize when you might be bumping into a federal regulatory issue and to consult a professional to guide you.

The following are three categories of not-so-obvious danger zones that are important for neurosurgeons to keep in mind throughout their careers:

### Compensation

The general rule applies when it comes to compensation: if it sounds too good to be true, it probably is. We learned this lesson once again from the recent Halifax Health Medical Center (a non-profit in Florida) case, which resulted in an \$85 million settlement. The neurosurgeons in this case were paid handsomely—nearly double the 90th percentile of their specialty nationally, per survey data, although their productivity was less than the

Hindsight is 20/20, of course. You might be tempted to say to yourself that you would have recognized that this would have been inappropriate. However, the reality is that you secretly might also have been pleased that someone finally recognized the true value of your services.

An even trickier aspect to compensation is productivity bonuses. Profit sharing cannot be based on any methodology that is directly related to the volume or value of the physician's referrals. Note that these are typically not referrals outside the practice, but rather to internal ancillary services such as labs, diagnostic radiology and physical therapy, for example. Make sure that your practice's bonus structure has had a legal review, as the regulations prescribe the permitted ways to compensate physicians on these services.

### Ancillary services in neurosurgery

Unbeknownst to many physicians, there are legal requirements that must be met in order to provide certain services (designated health services, which are defined by CPT code) in your own office! As mentioned above, these include, among other things, clinical lab services, physical or occupational therapy, durable medical equipment (DME) and outpatient prescription drugs.

Fortunately, there is a widely used exception for group practices to allow the services to be provided, but there are a number of prerequisites—namely, who provides it, where it is provided and who bills for it—that must be met. If these exceptions are not met, you likely are making an impermissible self-referral. If that is deemed to have occurred, even unbeknownst to you, you might have to return the money received for each affected claim, and you might be subject to fines and penalties.

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**“There have been numerous enforcement actions against both medical device companies and physicians, and neurosurgery appears to be a particular area of focus.”**

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in all likelihood those people know that the law may eventually catch up with them.

Unfortunately, it is those “bad” people who make it tough for the rest of us. The consequence is that the federal government is very interested in having protections against business arrangements that improperly

90th percentile. They received car allowances, benefits, call pay and a guaranteed salary with no deductions for bad debt or overhead. In fact, there did not appear to a legitimate purpose for the hospital to contract with them at all other than their referrals, as the neurosurgeons maintained their own practices.

## Medical device company payments

Neurosurgeons are often asked to perform research or conduct lectures for medical device companies. These relationships are common and have many benefits, such as improving patient care and advancing technology. However, there is also a risk of abuse. The government is concerned that certain types of payments by medical device companies may improperly influence a physician to use (or overuse) those particular companies' products. There have been numerous enforcement actions against both medical device companies and physicians, and neurosurgery appears to be a particular area of focus.

If you want to avoid scrutiny, there are a few premises to keep in mind. These include:

- Do not accept anything beyond fair market value for the services you provide.
- Never request or solicit anything of value from a sales representative, such as gifts,

supplies or marketing assistance without knowing the rules of the road.

Unfortunately, it would also be wise to turn down those professional football tickets, the trips to Hawaii, and the sponsored office party. Some of these things may be perfectly appropriate in the right circumstances. However, unless you want to go through the legal exercise of confirming fair market value, the existence of a legitimate need and purposes and the lack of expectations of future referrals, it might be easier (and safer) to just avoid these things altogether.

This is not to say you need to avoid relationships with medical device companies. When a good opportunity to consult, research or lecture does arise, obtain a legal review to ensure that you are within a safe harbor (permitted exceptions to the Anti-Kickback Law). Educate yourself on the rules and comply with the

terms of your contract, which often require documentation of certain elements of the safe harbor.

Ultimately, the key is to be aware of the potential for federal regulations to apply to any business arrangement you enter, even within your own practice. The stakes are high, so it is important to know when to ask for help. It is quite possible to navigate through the regulatory framework, but you must be willing to be patient, flexible and open-minded.

*Ms. Skelton is a partner with the law firm Gardner Skelton in Charlotte, N.C. She has focused her practice exclusively on the healthcare industry, and represents medical practices, individual physicians and other industry professionals. She can be reached at [heather@gardnerskelton.com](mailto:heather@gardnerskelton.com).*

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- ▶ Applicants should send letter of interest and CV to: Subu Magge, M.D., Fellowship Director, Lahey Spine Fellowship  
[Subu.N.Magge@lahey.org](mailto:Subu.N.Magge@lahey.org)



## Understanding Bonuses: Hospitals vs. Private Practices



By Katie Cole

Most neurosurgery compensation plans are a mix of salary or guarantee, and some type of bonus, usually production-based. How the bonus is determined can vary among compensation plans, sometimes considerably, so it's important to understand how you will be paid as you are negotiating your employment offer.

Private practices tend to use more traditional, fee-for-service and volume-driven bonuses, while many hospitals have an RVU-based bonus system in place. Determine an RVU (relative value unit) or wRVU (work RVU) involves calculating allowable payments for the neurosurgery services provided. However, an RVU is not necessarily a determinant of actual profit (to the practice or hospital) or volume, and procedures vary significantly for neurosurgery cases in calculating RVUs. And although RVUs reflect work effort rather than profit, it's helpful to keep in mind that spine procedures generally generate significantly more RVUs than other types of neurosurgery cases, such as peripheral nerve.

Quality metrics and patient satisfaction and surveys are also being figured in to bonuses, particularly for hospital employees. The overall trend in recent years has been to incorporate more quality and performance metrics as part of non-fixed compensation.

### Starting salaries and bonuses

The starting salary for a private practice is typically lower than for a hospital-employed position; however, the incoming neurosurgeon in a private practice typically will have a greater opportunity to receive bonuses, or a percentage of their collections, in a shorter period of time. A starting salary might be in the \$350,000 to \$550,000 range for a private practice, for a neurosurgeon coming out of training.

Traditional private practices tend to base bonuses heavily on the neurosurgeon's individual volume. Because RVUs vary tremendously depending on the type of neurosurgery case,

private practices look at revenue generated from cases and volume, based on profit for the practice. A neurosurgeon in a traditional private practice will most likely have a one-to-two-year salary or guaranteed income. But after the guarantee period is over, the neurosurgeon works on a model that involves a combination of paying fixed overhead costs while collecting on the profit and revenue of his/her individual case mix once overhead obligations have been met.

Hospital-employed neurosurgery compensation plans typically base compensation on Medical Group Management Association (MGMA) survey benchmarks, with RVU-based incentives incorporated. Some plans can have caps based

will most likely be in the \$500,000 range, and one with three to seven years' experience could be in excess of \$750,000), relocation assistance, tail insurance (typically 100% coverage), malpractice insurance (typically 100% coverage) and a sign-on bonus. The RVU or Incremental Operating Expenses can be determined by pro forma, fluctuating between \$40,000 and \$65,000 per month. Some hospitals also pay for call, in addition to salary.

Hospitals are more likely to use the RVU-based model, as it takes the business side out of the equation for an employed neurosurgeon; administration or management focuses on overhead, profitability and payer-mix, while

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**“The overall trend in recent years has been to incorporate more quality and performance metrics as part of non-fixed compensation.”**

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on MGMA or American Medical Group Association guidelines. However, caps are becoming less common, as they provide no additional financial incentive for a high-volume neurosurgeon to continue to produce, once the cap has been met. Reimbursement from government and commercial payers is changing, and hospitals in turn are basing bonuses on quality measures, including patient satisfaction, outcomes and patient-survey performance.

The majority of a typical neurosurgeon's compensation will be based on a combination of salary and RVU-based bonus, with approximately 10% based on quality incentives, and an additional small percentage based on any administrative duties.

### Typical plan structure

An example of a hospital-employed neurosurgeon compensation plan might be structured as follows: a salary set based on MGMA median compensation (depending on experience—a neurosurgeon out of training

the employed neurosurgeon can prioritize patient care. RVUs are also easier to use when comparing neurosurgeons in different locations with different payer mixes.

Typically, the base salary will be higher and start higher at a hospital, in an employed opportunity, than in private practice. However, private-practice bonus structures tend to be more aggressive, and typically neurosurgeons can earn more significant bonuses in a shorter period of time in private practices, based on their individual volume. Bonuses are almost always related in some way to volume and productivity, although there are many ways to measure productivity and profit. These terms and measuring systems can be confusing and need to be negotiated during the employment agreement, as they will be in place during the terms of the agreed-on employment contract.

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*Ms. Cole, a Denver resident, is publisher of Neurosurgery Market Watch.*

## NEUROSURGERY LEGAL CORNER



By Roderick J. Holloman

**Q: I have tried to access compensation survey data but cannot find geographically specific data available without purchasing the entire survey or a subscription to a service. Is there any way to obtain this data without charge?**

**A:** Presumably, you will work with either a neurosurgery-experienced advisor or a reputable healthcare attorney as you start to review employment offers. Either should be able to provide the data for your reference, but note that some attorneys or advisors might require that you become a client to obtain the information because that individual has to pay for access to the data. Others might provide the information at no charge in hope that you'll retain their services. It's best to ask first, if that's primarily what you're seeking. If you are still in training, your neurosurgery department chair likely will have access to compensation data for the specialty.

**Q: How should I go about trying to determine whether the compensation I am being offered is fair?**

**A:** In evaluating compensation offers, you should consider first the geographic area where you will practice, as reimbursement rates vary widely by market. The next consideration should be the type and volume of procedures you will perform and the number patients you

are expected to see in your clinic. With these considerations in place, you would then compare the compensation offered against compensation data published by reputable sources such as the Medical Group Management Association (MGMA), the American Medical Group Association (AGMA) and Sullivan, Cotter and Associates. However, I caution neurosurgeons against strictly using national compensation data when negotiating their compensation. Doing so would be akin to negotiating the purchase of a home in a specific zip code based on the national average for a home of comparable square feet.

**Q: I am being offered a wRVU-based compensation structure by a medium-sized private practice in the Southeast. Are there any significant potential drawbacks that I need to be aware of?**

**A:** There aren't necessarily any drawbacks, although you should be cognizant of the fact that you cannot control how many patients will seek care at the practice or which services these patients will require.

As such, it's important to obtain data on both average per-surgeon case numbers and procedure volumes over recent years in the specialty.

Also, you would want to make sure that the wRVU targets are reasonable for the community and practice setting, and also be

familiar with the value per wRVU generated (commonly referred to as a conversion factor). The conversion factor is comparable to an hourly wage for a person paid by the hour.

In a wRVU model, you face (and share, with your prospective colleagues) the risk that your practice will not be as productive as planned (i.e., will not generate as much revenue as planned or projected).

In evaluating wRVU-based compensation models, you would be prudent to obtain the average number of wRVUs generated by neurosurgeons in what would be your department—or, if you would be the first neurosurgeon hired in recent history, the average wRVUs generated by neurosurgeons serving the same patient population. You would reduce the latter by 20% to factor/adjust for market-share considerations. In any event, in a purely wRVU model, you should ensure that you receive a minimum compensation guarantee for the first two years of your employment, which will provide some assurance of fair earnings as you establish your practice.

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## CONTRIBUTORS WANTED!

Neurosurgery Market Watch welcomes submissions of articles of potential interest to practicing neurosurgeons. We are particularly interested in opinion articles about how trends occurring in the neurosurgery marketplace or in the health policy arena might affect the practice environment.

To discuss a potential idea, please contact Bonnie Darves at **425-822-7409** or [bonnie@darves.net](mailto:bonnie@darves.net)

## Neurosurgery Compensation Update

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effect on neurosurgeon compensation—at least from the standpoint of income expectations.

“Over the last five years, the significant increase in neurosurgeons going to hospital employment is changing the dynamic on starting salaries,” she said, “because hospitals typically offer a high starting salary to recruit neurosurgeons and get them there.” Then, a year or two later, many hospital employers convert the neurosurgeons to a production basis.

“They’re told that they have to generate their compensation based on wRVUs, and that if they don’t meet the quota, their salaries will go down. This is what many young neurosurgeons don’t realize when they see that private practices don’t pay what hospitals do in starting compensation,” said Ms. Cloninger. She noted

that she frequently hears of such situations—and concerns—from other NERVES members and neurosurgery practice administrators.

For instance, in her group, neurosurgeons start on the lower end of the national surveys’ compensation range but have considerable upside earnings potential in future years if they take an ownership position.

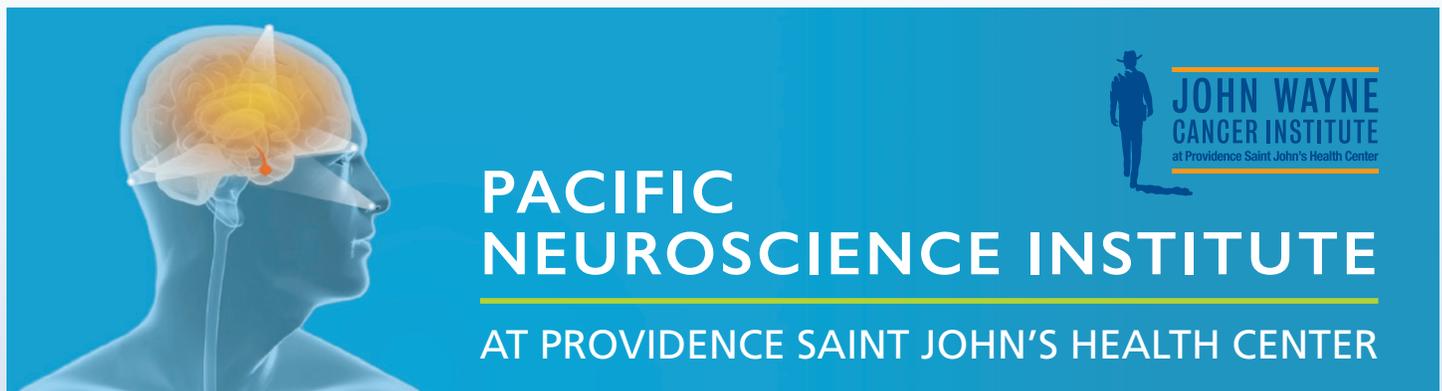
“I think that’s the case with many private practices, but young neurosurgeons might not understand that,” she said.

While Ms. Cloninger acknowledges that the employed model likely is a good fit for many neurosurgeons starting out—particularly those who have little or no interest in managing or even navigating the day-to-day operations tasks or sweating the practice’s finances—she

encourages neurosurgeons to ensure that they look beyond the compensation numbers when they evaluate opportunities.

They should understand the market for their services in any region they’re considering, and the financial position of any private or hospital-employed group they’re considering. These two factors are particularly important in the case of newly established programs, she observes, because both will affect future potential compensation levels and the practice’s long-term viability.

“I think it’s important for young neurosurgeons looking for their first opportunity to make sure that they thoroughly investigate the options—that they know the environment they’re going into and are comfortable with that environment,” she said.



**PACIFIC  
NEUROSCIENCE INSTITUTE**  
AT PROVIDENCE SAINT JOHN'S HEALTH CENTER

### FELLOWSHIP IN MINIMALLY INVASIVE NEUROSURGERY

The Pacific Neuroscience Institute (PNI) at Providence Saint John’s Health Center offers a 1-year fellowship in minimally invasive surgery for brain, pituitary and skull base tumors. This clinical training program is focused on endonasal and keyhole surgical approaches, neuro-endoscopy, pituitary tumor management and multimodality neuro-oncology treatments. The fellowship emphasizes operative and peri-operative patient management as well as translational clinical research. It is integrated into the John Wayne Cancer Institute Surgical Oncology Fellowship.

Qualified applicants must have completed training in an ACGME-accredited neurosurgical residency program and be eligible for a California medical license.

For fellowship inquiries, please contact:

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## UPCOMING U.S. NEUROSURGERY EVENTS/CMEs

### Goodman Oral Board Review Course

☐ November 8-11  
Houston, Texas

### AOSpine Course-MIS and Navigation

☐ November 20-21  
Phoenix, Arizona

### International Dementia with Lewy Bodies Conference 2015

☐ December 1-4  
Fort Lauderdale, Florida

### 43rd CSRS Annual Meeting

☐ December 3-5  
San Diego, California

### 44th Annual Meeting of the AANS/CNS Section on Pediatric Neurological Surgery

☐ December 8-11  
Seattle, Washington

### NANS 19th Annual Meeting

☐ December 10-13  
Las Vegas, Nevada

### Minimally Invasive Spine Surgery and Navigation: Hands-On Symposium

☐ December 17-19  
New York, New York

### Spine: Base to Summit

☐ January 28-31  
Beaver Creek, Colorado

### Washington Neuroradiology and Neuropathology Review

☐ January 30-February 4  
Vienna, Virginia

### Coding and Reimbursement Challenges in Neurosurgery

☐ February 4-6  
San Diego, California

### 6th Spine Deformity Solutions Course (for Attendings) with Scoliosis Research Society

☐ February 4-6  
Las Vegas, Nevada

### MOC Preparation and Neurosurgical Update

☐ February 19-21  
San Antonio, Texas

## UPCOMING INTERNATIONAL CMEs

### WFITN

☐ November 9-13  
Gold Coast, Australia

### XXIIth Brussels International Spine Symposium

☐ November 20-21  
Brussels, Belgium

### 1st Dandy Quadrennial Meeting Walter E. Dancy Neurosurgical Society

☐ November 20-22  
Dubai, UAE

### UK Stroke Forum 2015

☐ December 1-3  
Liverpool, UK

### Global Spine Congress

☐ April 13-16  
Dubai, UAE

► For more information regarding any of these events, or to post your upcoming CME or neurosurgery event, please contact [info@harlequinna.com](mailto:info@harlequinna.com).

## NEUROSURGERY POSITIONS

### HOSPITAL EMPLOYED

Corvallis, OR  
Bakersfield, CA  
Greenville, NC (Spine)  
Gastonia, NC  
Billings, MT  
Queens, NY  
Atlanta, GA  
Midland, MI  
Knoxville, TN (Endovascular)  
Greenville, NC (Endovascular)  
St. Cloud, MN  
Thomasville, GA  
Edison, NJ  
Midwest City, OK  
Biloxi, MS

### ACADEMIC

Morgantown, WV (*Complex Spine*)  
Toledo, OH (*DBS*)  
Albuquerque, NM (*Spine*)  
Green Bay, WI (*Endovascular*)  
Hershey, PA (*Neuro-Critical Care*)  
St. Louis, MO (*Spine*)  
Jacksonville, FL (*Trauma*)  
  
LEADERSHIP  
Greenville, NC  
*Director of Neuro-Critical Care*  
Morgantown, WV  
*Residency Program Director (Spine or Functional)*  
Johnstown, PA  
*Medical Director (Spine)*  
Charlotte, NC  
*Medical Director of Neurosciences*

### PRIVA-DEMIC

Erie, PA (*Endovascular*)  
Dayton, OH (*Spine*)  
Reading, PA (*Endovascular*)  
Reading, PA (*Complex Spine*)  
Philadelphia, PA (*Neuro-Oncology*)  
Philadelphia, PA (*Spine*)

### PRIVATE PRACTICE

Reno, NV (*Spine*)  
Cincinnati, OH  
Los Angeles, CA (*Deformity/Spine*)  
Jackson, MS  
Houston, TX (*Spine*)  
Baltimore, MD  
Albany, NY  
Dallas, TX (*Spine*)

► For more information on these positions, or if you are interested in hiring a neurosurgeon for a permanent position, please contact [info@harlequinna.com](mailto:info@harlequinna.com).  
► If you have any locums assignments available, or if you are interested in locums positions, please contact Aaron Risen at The Surgeons Link at [aaron@thesurgeonslink.com](mailto:aaron@thesurgeonslink.com).

Harlequin Recruiting  
PO Box 102166  
Denver, CO 80250

## FEATURED OPPORTUNITY

### Seeking Neurosurgeons to Join Growing Neuroscience Institute in Southwest Ohio

Premier Health/Wright State University in Dayton, Ohio, seeks four neurosurgeons with expertise in complex spine, spine, and vascular neurosurgery, as well as general neurosurgery with an interest in trauma. The Chief of the newly established Division of Neurosurgery is seeking neurosurgeon(s) who are interested in having a robust clinical practice, teaching opportunities, program building, and research and device development.

The neurosurgeons would join an existing practice of six neurosurgeons, which is a part of a rapidly growing Comprehensive Neuroscience Institute with divisions in neurosurgery, interventional neurology, neurocritical care and neurology.

The primary admitting hospital is Miami Valley Hospital, a state-of-the-art, 974-bed Level I Trauma Center and designated Primary Stroke Center. Premier Health Partners also comprises three other area hospitals, for a total of nearly 1,900 beds. The health system is affiliated with Wright State University, which offers support/protected time for basic science research interests, medical student and residency teaching opportunities, and collaboration with engineering for device development.

Miami Valley Hospital is a teaching hospital for numerous residency programs, including general

surgery, neurology and orthopedics. It offers many teaching opportunities, with the primary goal of establishing a new neurosurgery residency program.

#### Hospital & Practice Highlights:

- Busy cranial and spine clinical practice opportunity with call cover
- Miami Valley Hospital currently runs 3-4 Block ORs with neuro-team coverage 5 days per week specifically for neurosurgery
- 20 bed neuro-ICU with 24-hour neurocritical care service
- Mid-level practitioner support
- Stryker and Stealth Navigation
- Varian TrueBeam at MVH
- 3T MRI
- Epic electronic health record (EHR) system
- Academic appointment at Wright State University Boonshoft School of Medicine
- Program building and leadership opportunities, including the eventual development of a neurosurgery residency program

- Neuroscience and Engineering Collaborative Research Building currently under construction on Wright State University campus
- Protected time for research including basic science, translational and clinical. New neurosurgery lab at Wright State University (only 15 minutes from Miami Valley Hospital) with countless opportunities to conduct research and network with others
- Collaborative support from the Chair of Neurology & Brage Golding Distinguished Professor and Chair of Research in development of multi-disciplinary approach to patient care and cutting-edge research
- Synergies with engineering department create opportunities in bioengineering, biomechanics and new-instrument development
- Competitive compensation and relocation



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