Neurosurgery
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Measuring and Compensating Neurosurgeon Productivity

Relative value units (RVUs) are frequently utilized but may be overrated

By Bonnie Darves

Figuring out how hard neurosurgeons work, and adjusting their compensation and incentive or bonus payments accordingly, pales in complexity compared to the procedures neurosurgeons perform. But as healthcare cost-cutting pressures intensify and concerns about the future neurosurgery reimbursement picture increase with health reform implementation, practices must devise systems that fairly and reasonably accurately quantify physicians' productivity.

Private and academic practices are struggling to do just that, according to William Jessee, MD, the longtime president and CEO of the Medical Group Management Association (MGMA) in Englewood, Colo., who recently moved into consulting. "As practices prepare for reimbursement models requiring them to take on more financial risk, as they also cope with increasing operating costs, gauging productivity will become more important," he said.

That, in turn, means that neurosurgeons seeking an initial—or new—practice opportunity need to understand how a prospective employer measures productivity and the productivity expectations for neurosurgeons. "For neurosurgeons looking for a job, the key is to have a detailed conversation with the employer, whether it's an academic or private practice, about exactly how they'll be compensated and how productivity figures in the picture," said Robert Harbaugh, MD, treasurer of the American Association of Neurological Surgeons and director of the Penn State Hershey Neuroscience Institute. "Is there a base salary plus productivity bonus? And if so, is that bonus based on RVUs, procedure numbers, quality metrics—or a mix of all of these?"

Neurosurgeons may have a handle on procedure numbers based on their training experience, and most likely are aware of the increasing emphasis being placed on care-quality metrics by government and commercial payers. But relatively few, Dr. Harbaugh suspects, have any notion of RVUs (relative value units) and what they mean in the context of total compensation. "Overall, we do a miserable job of training our residents in what they'll encounter regarding business issues like RVUs," he said.

So why do RVUs matter? In part, it's because RVUs figure in reimbursement. An element of the Centers for Medicare and Medicaid Services (CMS) resource-based relative value scale, RVUs compute the time and skill, as well as physical and mental effort, involved in performing a medical service or procedure (see sidebar on page 2).

RVUs have been a mainstay in the Medicare physician fee schedule, which determines reimbursement, for two decades. In addition, research shows that about half of practices, both private and academic, take RVUs into account when setting neurosurgeon compensation levels and productivity expectations. For example, many employment contracts provide a guaranteed salary or income in the first year but may convert in the second and subsequent years to schemes that use physician-generated work RVUs in some manner for compensation or bonus structures.

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> – Robert Harbaugh, MD
> Director, Penn State Hershey Neuroscience Institute

That's the approach Broward Health in South Florida takes in determining overall compensation for its neurosurgeons, notes Staci Work, a physician recruiter for the health system. "The first year, we guarantee their salary so neurosurgeons can build up their practice. But the second year compensation is based primarily on RVUs and the number of patients seen," she explained.

Because that shift can occur so early in neurosurgeons' careers, it behooves them to obtain at least a basic understanding of RVUs and related trends in the specialty, Dr. Harbaugh suggests, as well as RVUs for the procedures they do. For example, in the 2010 survey conducted by the Neurosurgery Executives' Resource, Value & Education Society (NERVES) in Charlotte, N.C., the median number of annual work RVUs (WRVUs) generated by neurosurgeons was 10,662, while those in the 90th percentile generated 18,507. MGMA's 2011 physician compensation and production survey reported a median WRVU of 9,710.

The NERVES survey found considerable RVU variation between private and academic neurosurgery

IN THIS ISSUE...

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Neurosurgery
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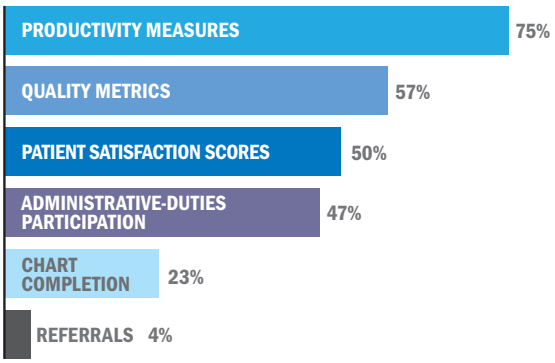
Physician Incentive Payments:

What Guides Healthcare Organizations



In ways that hospitals, health systems and other employing entities incentivize physicians for their efforts—patient care and otherwise—productivity is still a mainstay. But things are shifting, as the graph above illustrates. A new report by HealthLeaders Media suggests that organizations are trying to strike a balance in their incentive structures, to reward doctors for the important services they provide outside the clinical realm. Based on its survey of 316 healthcare leaders, the publication found that organizations now take many factors into account when devising incentive-payment structures.

Source: Physician Compensation: Shifting Incentives, HealthLeaders Intelligence Report, October 2011

Candidate Profile

Who: Perry Hoeltzell, MD, Ph.D.

New position: Private practice neurosurgeon, affiliated with El Centro Regional Medical Center, El Centro, California.

Practice and research interests: Enjoys "just about anything in neurosurgery," but especially microdiscectomies, and complicated cranial and spine tumors. The latter expertise has earned him multiple "top doctor" designations over the years.

Why he chose the job: After many years in a large metropolitan area, I look forward to practicing in a smaller, friendlier community where I can get to know the people—and where I know my services are needed. Patient interactions have always been my favorite part of the job.

What neurosurgery has taught him as a person: It is a true gift to help a patient who has been in pain for many years become pain free. I also learned a lot about myself—and what my patients go experience--"on the other side of the table" several years ago, when I underwent an anterior discectomy with fusion following a bad collision.

Advice to young neurosurgeons: Don't lose sight of what we learned in medical school: That we don't treat MRIs or CTs; we treat patients. Never underestimate the importance of a careful physical and neurological examination. And remember that even a simple procedure, such as putting in a shunt, can be challenging.

Measuring and Compensating Productivity

(continued from Page 1)

practices. The median annual WRVU for physician-owned practices was 12,211, compared to 10,132 for academic practices, for instance. Substantial variation also emerged among U.S. geographic regions. Neurosurgeons in the South posted median annual WRVUs of 12,465, while in the West the median was 9,138.

For illustration purposes, following are a few WRVUs from the CMS fee schedule for neurosurgeons:

- Percutaneous vertebroplasty, 1 body—8.65
- Laminectomy for electrode implantation—10.92
- Revision or replacement of cranial nerve neurostimulator electrode array—11.00
- Implantation or replacement of intrathecal or epidural drug-infusion device—5.00

The RVU may be useful for benchmarking and general comparison purposes, but some neurosurgeons, including Dr. Harbaugh, caution that the metric, as a standalone, isn't sufficient to quantify and qualify physician productivity. One reason is that the RVUs vary so significantly from one procedure to the next.

"In my department, we have pediatric neurosurgeons and peripheral-nerve neurosurgeons who are very busy and do a lot of cases, but their RVUs aren't great because they perform a lot of low-RVU cases," Dr. Harbaugh said. "For example, a pediatric neurosurgeon who does 300 cases won't make nearly the number of RVUs a tumor surgeon will make."

That RVU disparity among procedure types is a key reason that Michael Brisman, MD, CEO of the 18-neurosurgeon group Neurological Surgery P.C., in New York's Long Island region, pays scant attention to RVUs. "We keep track of how many RVUs our neurosurgeons generate, but they're mostly irrevelant to me. I'm more focused on how many cases people do and how much revenue they generate," he said, "because it's the profit that determines our incomes."

Dr. Harbaugh concurs that RVUs, despite their use as the predominant productivity benchmark, are becoming less meaningful in academic centers too, especially as the disparities between academic and private-practice compensation decrease. "When I try to determine compensation for my faculty, RVUs are one thing I consider, but they're not the guiding force," he said. "Of course, if you have two people doing the same kind of cases and one makes 9,000 RVUs and the other makes 16,000, you know that [second] one is doing a lot more. But it's important to look at other metrics, too, before making comparisons."

For the many neurosurgeons considering hospital-employed positions—AANS data shows that 40% of trainees are choosing that practice option—RVUs may figure to some extent in contracts. But in setting compensation levels hospitals are more concerned these days with the particular services neurosurgeons will provide and the volume they can generate, Dr. Harbaugh contends.

"RVUs are a poor predictor of the hospital's profit margin. The neurosurgeon who does a lot of instrumented spine operations can make an awful lot of RVUs because those are high-RVU cases," he explained. "But often the hospital pays for all that hardware that gets put into patients, so a high-RVU procedure may not be particularly profitable for the hospital. On the other hand, there are low-RVU procedures—radiosurgery, for instance—where the hospital's profit margin is huge. So as more neurosurgeons become hospital employees, RVUs will become less valuable, I think."

RVUs DEFINED

In healthcare and medicine acronyms and abbreviations abound, but few are more ubiquitously used yet less comprehensible to young physicians than the relative value unit (RVU). Devised in the early 1990s by the U.S. Health Care Financing Administration (now the Centers for Medicare and Medicaid Services, or CMS), RVUs are a component of a complex formula, utilizing CPT codes, that calculates allowable payments for physician services.

The total RVU for a specific physician service, whether it's a mid-level patient evaluation or a complex surgical procedure, is multiplied by a conversion factor and adjustment factors to come up with a dollar amount for payment. The total RVU is intended to quantify the relative work, practice expense and malpractice costs for specific physician services. The work RVU (WRVU), one component of the total RVU, has gained acceptance as a way to measure physician productivity, despite its limitations.

IN BRIEF

Neurosurgery, Device Market to Remain Strong

New research reported by Millenium Research Group (MRG) of Toronto suggests that the market for neurosurgical procedures and neurovascular treatments will remain robust, largely due to the aging population and commensurate demand.

The firm's recent data suggests that as the incidence of intracranial atherosclerosis, stroke and cerebral aneurysm increase, the U.S. market for procedure and device treatments will rise in tandem, to a predicted $240 million by 2016. That market likely will be boosted by provisions of the Patient Protection and Affordable Care Act, which is expected to improve services access and exert pressure on providers to choose devices with good safety track records, researchers noted.

Devices expected to generate substantial portions of those revenues include hydrocephalus shunts and neurovascular clips.

Neurosurgeons' Duty-hour Limit Effects Palpable

The recent additional limitations on residents' duty hours to 16-hour shifts, levied in July by the Accreditation Council on Graduate Medical Education (ACGME), are expected to have conflicting effects on neurosurgery training, according to results of a survey published in November 2011 in the journal *Neurosurgery*.

Although some training neurosurgeons admitted that the long duty hours in the past actually harmed them or their patients—8% of the 377 respondents reported personal involvement in vehicle accidents or life-threatening events, and 6% admitted to harm-causing medical errors occurring after extended shifts—72% thought the new standards would negatively affect their training. An overwhelming 83% disagreed with the imposition of 16-hour limits for PGY-1 trainees. Finally, more than one-third of respondents (36%) admitted to violating the 80-hour rule occasionally or frequently.

The survey, which had a 34% response rate, was distributed to all neurosurgery training programs in the United States and Puerto Rico.

UPCOMING U.S. NEUROSURGERY EVENTS/CMEs

2012 AANS/CNS CV Section Annual Meeting
❏ January 30-31, 2012
New Orleans, Louisiana

International Stroke Conference
❏ February 1-3, 2012
New Orleans, Louisiana

The Winter Clinics for Cranial & Spinal Surgery
❏ February 19-23, 2012
Snowmass, Colorado

2012 Annual Meeting of the AANS/CNS Section on Disorders of the Spine and Peripheral Nerves
❏ March 7-10, 2012
Orlando, Florida

Southern Neurosurgical Society
❏ March 28-31, 2012
Amelia Island, Florida

2012 American Association of Neurological Surgeons (AANS)
❏ April 14-18, 2012
Miami, Florida

Biennial Meeting of the ASSFN
❏ June 3-6, 2012
San Francisco, California

For more information regarding any of these events, or to post your upcoming CME or neurosurgery event, please contact ***info@harlequinna.com.***

LEGAL CORNER

By Roderick J. Holloman

Q: I have an opportunity to enter into a recruitment agreement with a hospital that would require I stay twice as long as the support period. The offer is reasonable and the hospital financially strong, but I've heard that it's not a good time to start a practice. Is this true?

A: In part, yes. The reason is twofold. The payment landscape is uncertain right now but appears to be headed toward further reimbursement cuts. That would translate into less compensation per work Relative Value Unit (wRVU) for providers. In addition, the costs of sustaining a medical practice have increased in recent years. In short, an increase in costs in tandem with declining reimbursement often results in a decrease in profits.

Any physician considering such an arrangement should request the data the hospital used in reaching the conclusion that the area is medically underserved in neurosurgery, and should speak with local colleagues about patient loads and procedure volumes. At a minimum, the physician should secure the hospital's written commitment to provide two years' of financial support, inclusive of a compensation guarantee and operating expenses.

Q: I am considering an employment offer from a solo practice that has an excellent reputation. Should I hire an attorney to negotiate with the owner, or should I do so myself? Our conversations to date have been very civilized.

A: The answer depends on your comfort level and the rapport with the practice owner. While it's certainly advisable to involve a healthcare attorney in the review of the employment contract, the attorney's direct negotiation with the employer may not be necessary or even advisable, as that may disturb the rapport.

Physicians who want a little extra help with negotiations might use their attorney in a ghost-writer capacity for offer-negotiation purposes, so that they have the expertise on tap to ensure equitable terms without disrupting rapport.

Q: I am an employee of a practice now in talks with a hospital for a possible acquisition. Will my contract be null and void automatically should the hospital purchase the practice?

A: Not necessarily, as your current contract likely contains an assignment clause. Usually located near the end of the contract, such clauses stipulate that while the contract is personal to the physician and the physician cannot assign the contract, the employer can assign the contract or enable a successor to enforce the terms. In all likelihood, however, as part of the acquisition and for the sake of uniformity, you will be asked to agree to a new contract with the hospital, and those terms which will supersede the terms of the current contract.

Author's note: Roderick Holloman is the principal of The Holloman Law Group, PLLC, a national healthcare law firm. He welcomes readers' questions and can reached at *202-572-1000* or *rjholloman@hollomanlawgroup.com.*

NEUROSURGERY POSITIONS

Featured Opportunity - Southern California

Private practice in desirable area of southern California seeks a BE/ BC neurosurgeon to join the group starting out in a part-time role. This well established and reputable practice, located in a prime community within the Los Angeles metro area, currently operates two offices in southern California and is considering expansion to other locations in the region.

The incoming neurosurgeon would initially practice two days a week, with a goal of evolving the position to full-time practice, with partnership potential. The group prefers a neurosurgeon with a spine fellow or equivalent experience and has a preference for a candidate currently licensed in California. The case load is almost exclusively outpatient, non-invasive elective spine.

As this is a busy, high-volume group, the incoming neurosurgeon would not have to focus on obtaining business.

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Ohio
Kentucky
Texas

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New York *(Spine)*
Wisconsin (General, Spine)
Missouri (Spine, Endovascular)
Massachusetts
Alabama

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North Carolina

FELLOWSHIP
Texas (Spine)
Massachusetts *(Endovascular)*

PRIVA-DEMIC
Pennsylvania
Illinois
Michigan

PRIVATE PRACTICE
California
Texas
New York
Colorado
Hawaii
Illinois
Michigan

HOSPITAL GUARANTEE
Wisconsin
Indiana
California
Florida

- For more information on these positions or to inquire about hiring a neurosurgeon for a permanent position, please contact ***info@harlequinna.com.***
- If you have locums assignments available or are interested in locums positions, please contact Aaron Risen at The Surgeons Link at ***aaron@thesurgeonslink.com***

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