Neurosurgery
MARKET WATCH™

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Neurosurgery Compensation Update

Compensation Continues to Rise, but Neurosurgeons Working Hard to Maintain Earning Levels

By Bonnie Darves

Neurosurgeons seeking their first opportunity or contemplating a move to another practice, location or setting can rest assured that they'll land a well-paying position and, in many markets, have a choice of options. That's the general picture that the recent national physician compensation surveys reveal, along with another consistent finding: neurosurgeons are working harder than in the past, as evidenced by the continuing hikes in neurosurgeon productivity as tallied by work relative value units (wRVUS), which remain the key metric by which physician work is measured.

The most recent compensation surveys conducted by the Neurosurgery Executives' Resource Value and Education Society (NERVES), the Medical Group Management Association (MGMA) and the American Medical Group Management Association found median total neurosurgery compensation either stable, in the case of NERVES, or on the rise, in the case of MGMA and AMGA. Here's how those findings stacked up:

- NERVES Socio-Economic Survey 2018 Report: median neurosurgery compensation was $737,000, down slightly (1.6%) from 2017. The 25th and 75th percentile compensation amounts were $525,000 and $1,021,000, respectively.
- AMGA 2019 Medical Group Compensation and Productivity Survey: median neurosurgery compensation was $833,133, up 4% over the prior year's survey. The 20th percentile compensation was $650,000 (up 7% over last year) and 90th percentile was $950,000. The median for pediatric neurosurgeons was $750,000.
- MGMA 2018 Provider Compensation and Production Report: median neurosurgeon compensation came in at $883,020, a 7.46% over last year. The 20th and 90th percentile figures were $677,216 and $1,469,222.

It's worth noting that the national surveys have varying sample sizes and employ differing methodologies, so an apples-to-apples comparison isn't possible. Of the three, the NERVES Survey is the most comprehensive neurosurgery practice survey in the country, and this year's report included participation from 83 practices and 738 neurosurgeons. The AMGA survey included 618 neurosurgeons.

The NERVES survey found pronounced differences in neurosurgery compensation based on practice type. Private practice neurosurgeons had a median compensation of $889,000, up from $822,000 in the previous report. Hospital-employed neurosurgeons earned median compensation of $786,000, significantly down from $873,000 last year. The median compensation for academic neurosurgeons was $647,000, a slight decrease from the $664,000 tallied in the 2017 report. Starting salaries by subspecialty were $537,000 for vascular neurosurgeons, $531,000 for spine, $525,000 for cranial/skull base ($525,000) and $486,000 for pediatric neurosurgeons.

In other subspecialty compensation findings, NERVES reported that for adult services (based on greater than 75% of neurosurgeon services), spine specialists lead at a median compensation level of $820,000, followed by vascular at $793,000, cranial at $655,000 and functional at $626,000.

In the AMGA survey, the median compensation for neurosurgeons in large groups (300-plus physicians) was $790,248, followed by $646,720 in groups with 151 to 300 physicians and $737,060 in groups with 50 to 100 physicians.

Here are the surveys' key findings about neurosurgeon productivity—which increased either minimally or significantly, depending on

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Neurosurgery Compensation Update

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the survey: In the AMGA survey, median annual RVUs were 9,442. The MGMA reported median RVUs of 9,984, a 7.75% increase from 2017. NERVES reported a median RVUs increase of 2.0% from 2017. That survey also found that surgical cases were essentially flat, posting a 0.8% increase over the prior year, despite the fact that new patients were down 7.9%.

"Overall, what we're seeing is that work RVUs continue to increase, so neurosurgeons are becoming more productive regardless of the fact that compensation was slightly down compared to our previous survey," said Michael Radomski, who serves as the NERVES Survey Committee chair and is VP of finance and chief financial officer for Mayfield Brain & Spine in Cincinnati, Ohio. "At the same time, however, we're also seeing that neurosurgeons have a greater ability now to supplement their income with ancillary services and call pay." Approximately one-third of neurosurgeons have income-earning arrangements outside their primary practice facility, Mr. Radomski said.

Although neurosurgery groups, like their counterparts in other specialties, continue to experiment with incenting physicians for performance on quality and outcomes measures, the productivity-based formula remains the foundation of neurosurgeon compensation, according to Fred Horton, MHA, president of AMGA Consulting. "Work RVUs are still the dominant measures that determine neurosurgeon pay, and we don't see that changing over the next few years," Mr. Horton said, "although we're seeing a slight slowdown in neurosurgeon RVU activity."

Call pay sees slight rise

Despite the growing trend toward including call pay in total compensation structures, which is driven largely by the increase in neurosurgeons pursuing employed-model positions, call pay remains a significant factor in neurosurgeon compensation. That's the case regardless of how it's calculated and accounted for, all sources reported. The NERVES survey found a median daily overall rate of $1,800, up 7.1% versus 2017 ($1,680). Interestingly, trauma call pay varies considerably by facility-level designation; the level 1 daily rate is $2,466, level 2 is $2,000 and level 3 is $1,385.

"We'd found that call pay is fairly stable generally, but our members are reporting that they're struggling to meet needs for subspecialist call—vascular, for example," Mr. Radomski said. "There's a trend to embed call pay in compensation in the employed model and, to some degree in the academic setting as well."

The AMGA reported trauma call pay on an hourly basis, at a median of $125 per hour and a weekly average rate of $108 per hour. The rates were not significantly higher for weekend vs. weekday coverage, the survey found.

One of the key issues for neurosurgeons who have heavy call schedules is trying to meet overall productivity expectations in their practices, according to Cristy Good, MPH, MBA, Senior Industry Advisor for MGMA. "Neurosurgeons often take a lot of call at level 1 trauma hospitals while still trying to balance clinical work and meet their wRVUs [target]," Ms. Good said.

Regional compensation differences hard to qualify

All the major physician surveys continue to gather data on regional compensation differences, but how meaningful that data is becomes difficult to tease out when it comes to neurosurgery. That's because searches in the specialty are generally conducted on a national basis—primarily using national medians as a starting point, according to Mr. Horton. He acknowledged, however, that AMGA continues to find physician compensation highest overall in the North region of the country (which in AMGA's case includes many states in the upper Midwest).

"What this data actually means in the market on a regional basis is hard to articulate, but in general, the highest median compensation across all specialties is in the Northern regions, we've found," Mr. Horton said.

It's worth keeping in mind that the national surveys each delineate the geographic regions differently, in terms of which states individual regions comprise. That makes it harder to compare regional findings across surveys—and neurosurgeons seeking new practice opportunities should not expect that their compensation packages will rely to any significant large extent on surveys' regional compensation figures.

The AMGA regional median neurosurgeon compensation broke down as follows: East $820,674, West $645,206, South $727,541 and North $816,088. It's interesting to note that neurosurgeon RVUs varied significantly across the regions. Median annual RVUs in the South totaled 10,626, followed by 10,225 in the East, 7,680 in the West and 8,604 in the North.

The NERVES survey, Mr. Radomski reports, found that the West continues to lag the other regions in compensation. The median there was $665,000, compared to $786,000 in the East. The Midwest and South were comparable at $738,000 and $737,000, respectively. "We struggle to analyze what the regional data means overall, because we don't have enough detail to understand what the differences mean," Mr. Radomski said. "But the West is still typically below other regions in our survey."

Last year, some sources suggested that those regional distinctions are going away from the standpoint of how the median compensation figures in what neurosurgeons are offered in compensation packages. But Ms. Good of MGMA maintains that there's value for groups in tracking such data. "We will probably always have regional differences in physician compensation due to cost of living, market characteristics and other factors, so when determining compensation, we think it's still important for groups to filter region," she said.

Even if the regional compensation differences are becoming somewhat less pronounced in recent years, some overall trends persist among certain

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Scottsdale, Arizona

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❏ November 20-23
Atlanta, Georgia

13th New York City Minimally Invasive Spine, Spinal Endoscopy, Robotics & 3D Navigation Symposium
❏ December 12-14
New York City, New York

Spine: Base to Summit 2020
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❏ February 23-27
Snowmass Village, Colorado

UPCOMING INTERNATIONAL CMES

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Messukeskus Helsinki, Finland

15th Congress of the World Federation of Interventional and Therapeutic Neuroradiology
❏ October 21-24
Naples, Italy

ISASS Annual Conference
❏ February 26-28
San Juan, Puerto Rico

Global Spine Congress
❏ May 20-23
Rio de Janeiro, Brazil

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

Why Neurosurgeons Should Change Their Reputation as End Providers for Spine Conditions

By Daniel Goldberg

Neurosurgeons have long had the reputation of being the specialist of last resort for patients with challenging-to-treat spinal conditions. The title of "neurosurgeon" is descriptive enough for patients to suspect that a visit to a neurosurgeon has only one outcome: surgery. However, neurosurgeons who want to remain successful and broaden their patient base need to diversify their reputations and make patients more aware that seeing a neurosurgeon is not an immediate route to surgery.

Currently, almost two thirds of neurosurgeons work in a private practice setting or a non-hospital based practice, according to data published in *Becker's Spine Review*. At the same time, there is a continuing trend toward private-practice neurosurgeons focusing primarily on treating spinal disorders and less on cranial and brain conditions. This is likely due to not only unfavorable trends in reimbursement but also complication rates and the challenges inherent in performing skull and brain procedures in a physician-owned ASC or outpatient setting. Of the around 650,000 to 700,000 spine surgeries annually in the United States, approximately 280,000 to 300,000 are now done in the outpatient setting, according to a study published in *Spine* in 2017.

As the population continues to age, the need for spinal procedures and the number of patients seeking them—including advanced spinal-fusion approaches—are on the rise. In 2004, a total of 122,674 elective spinal fusions were performed. Over an 11-year period, that number grew 62%, to 199,140, according to a study published in the journal *Spine*. Although those cases may have been performed by a neurosurgeon, orthopedic spine surgeon or both, the trend does not appear to be slowing.

While the number of cases continues to grow it does not mean that private practice neurosurgeons can simply rely on the growth trends to garner new patients and remain profitable. This is especially true for independent neurosurgery groups, as hospital acquisitions of referring practices and the growth in hospital-employed neurosurgeons have changed the patient referral paradigm.

Despite the numerous advances in minimally invasive approaches, implants and surgical navigation, patients' fear of spine procedures has not been quelled. In fact, many patients with chronic cervical, lumbar or radicular pain still avoid seeing a neurosurgeon and first seek more conservative approaches such as chiropractic care or interventional pain treatment. This is primarily the result of anecdotal experiences from friends or family members who underwent a spinal procedure 15 to 20 years ago and had outcomes that were less than optimal. (I've learned this during my interviews with hundreds of spine surgery patients during my career.)

Establishing trust

The first step in reversing these misconceptions is using assets such as websites and external marketing materials to focus on a more "comprehensive" approach to spine care that includes both nonsurgical and surgical options. This does not mean that neurosurgeons should spend large amounts of time treating acute injuries or performing injections, but it does mean highlighting the availability of such treatment if they are able to in a multispecialty practice setting. If the neurosurgeon is not part of a multispecialty practice, it might make sense to partner with an interventional pain practice and highlight that partnership.

By doing so, patients who are researching their options for treatments will see that there are more options than solely surgical intervention. Secondarily, this benefits the neurosurgery practice, as those patients who fail conservative treatment modalities are then more qualified candidates for surgery. During the conservative phase of care, the patient establishes trust in the practice in part because surgery was not the first and only option discussed. If a surgical consult is discussed weeks or months down the road, the patient is more likely to trust that this might be the best option if more conservative modalities have failed.

Controlling the care path

Neurosurgeons should position themselves as the most knowledgeable resource for spinal conditions and must educate patients as to why a neurosurgeon should one of the first physicians they see for chronic spinal conditions. Focusing on how a neurosurgeon is the most qualified specialist to coordinate and oversee non-surgical care will also help offset the end-provider reputation that neurosurgeons have gained—however inappropriately.

Most of this positioning begins online with website content and social media platforms, as such venues today are where most patients initially turn for advice. In fact, 61% of patients use the Internet as their first source of information when researching a condition, according to the Makovsky/Kelton "Pulse of Online Search" survey.

When researching a condition as common as chronic back pain, there is a litany of information regarding exercises, holistic treatments and spine specialists that a patient must weed through. In such a haphazard setting, it's important for neurosurgeons to use their websites and other digital platforms to establish a clear voice as to why their training, expertise and treatment philosophies are the patient's best resource for treating spinal conditions.

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Reputation 'Adjustment' Can Boost Marketing

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Marketing to enhance awareness of practice

In many cases, patients with chronic back or neck pain do not immediately seek care. Instead, they research their condition online and may spend weeks or months trying to self-manage their pain. It is during this time that they begin to create a digital footprint that practices can use to deliver highly engaging ads to these potential patients.

Platforms such as Google Display Ads, YouTube Ads, Facebook and Instagram have highly advanced algorithms that allow practices to connect with potential patients based on that patient's location, age, search history, websites visited and even products that they purchase. For instance, if a patient in your area searches Google for "sciatica treatment," the practice can then start showing that patient ads on various platforms and apps.

Such ads allow your practice to connect to the patient and to give your practice an opportunity to highlight the importance of seeing a neurosurgeon. This exchange also establishes awareness and trust in your practice and helps to ensure your practice is top of mind when the patient when the patient decides to seek care.

There are a plethora of digital platforms that practices can use to create awareness and acquire new patients, and understanding these platforms' role in patient acquisition is vital. Below is a brief summary of how these platforms engage and influence potential patients.

Google Adwords. On this real-time auction, practices can bid to place ads in front of patients looking for a provider or treatment via Google search. Google Ads is one of the highest ROI strategies when implemented correctly.

Google Display Ads. This platform uses patient locations, behaviors and search history to place targeted ads in front of potential patients across millions of websites. These ads are effective for creating both trust and awareness. They're most similar to traditional billboards but use targeting to deliver their messages to only a relevant audience.

YouTube Pre-Roll Ads. This platform uses patient locations, behaviors and search history to place targeted 10- to 30-second video ads in front of potential patients watching videos on YouTube and other websites. These ads create a memorable and engaging experience that helps increase brand recall and trust.

Facebook and Instagram Ads. These advertising resources use thousands of data points that include demographics, search history, interests and behaviors to place ads in front of potential patients on the Facebook and Instagram platforms. These venues are important for creating brand awareness as well as educating potential patients about your services and prompting them to further explore your website.

The most important aspects of any effective marketing initiative is to understand how much of your financial resources should be allocated to these and other platforms and to have reliable systems in place to track the efficacy of these efforts.

Daniel Goldberg is the vice president of IXVY Health and specializes in neurosurgery practice marketing, with a focus on direct-to-patient marketing. Mr. Goldberg has lectured at many of the leading healthcare and medical conferences around the country on the subjects of strategic growth and patient behaviors.

FEATURED OPPORTUNITY

Neurosurgery Opportunity in Dayton, Ohio

A hospital in Dayton is seeking a BE/BC neurosurgeon to join its three-physician employed group. The facility has a preference for candidates with interest and/or experience and fellowship training in spine, complex spine or general neurosurgery, with an interest in trauma.

The incoming candidate will have a strong referral base from the start, with a busy clinical practice including complex instrumentation, spine deformity and MIS spine. The facility's comprehensive neurosurgery team currently has physicians trained in general, spine, neuro-oncology and functional neurosurgery. The incoming neurosurgeon will work out of one facility, a very sophisticated Level I Trauma Center. The facility is also a Primary Stroke Center. The department is currently running 3-4 block ORs five days per week specifically for neurosurgery.

The incoming candidate will have an academic affiliation with an affiliated state college as well as academic appointment at an affiliated School of Medicine. The incoming candidate will also have the opportunity for support and protected time for basic science research interests, medical student and residency teaching opportunities (general surgery and orthopedic residency programs), and collaborations with engineering for device development.

The facility has state-of-the-art equipment, including Varian TrueBeam, 3T MRI, three Rosa neurosurgical robots and a Medtronic O-arm. It also has a Brethen Center for Surgical Advancement in Robotics and Minimally Invasive Surgery, Stryker and Stealth Navigation, and a 36 bed Neuro-ICU. The facility will provide a competitive compensation package and full benefit package including salary, bonus-based incentive, paid relocation and CME.

CODING CORNER

2020 Code Updates for ICD-10 Published

By Barbara Young

Code updates for ICD-10-Procedure Coding System (ICD-1-PCS) and ICD-10-Clinical Modification (ICD-10-CM) went into effect October 1, 2019. Reviewing the code changes will help neurosurgery practices avoid claim denials and prevent interruptions to their revenue cycle. The Centers for Disease Control and Prevention (CDC) releases the ICD-10-CM code updates each fall, and practices that familiarize themselves with the changes will be better able to capture the proper and most specific diagnosis codes for patients' conditions.

There were currently 71,932 ICD-10-CM codes previously, but effective this month there are 72,184, which includes 734 new codes and two revised codes, and 2,056 deleted codes. Many of the deletions made were to allow for the addition of more specific codes. These 2020 ICD-10-CM codes are to be used for patient encounters that occur through September 30, 2020.

The CDC posted the fiscal year (FY) 2020 ICD-10-CM final code changes in June 2019. It's worth noting that the tabular addendum requires practices and payers to understand and incorporate considerably more coding instructions than in the previous year. The CDC released 23 files for the final FY 2020 ICD-10-CM code set. The full list of updates are accessible at ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD10CM/2020/. The and the tabular addenda are at https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD10CM/2020/icd10cm_tabular_addenda_2020.pdf.

Adjusting to the annual changes often seems a daunting task, but somehow all of us in the billing industry and in physician practices manage.

Some of the changes, additions and deletions affect common neurosurgical procedures. For example, ICD-code Z45.42: "Neuropacemaker" is changed to "neurostimulator," and brain, peripheral nerve, and spinal cord have been removed, and the ICD-10 code Z96.82: "Presence of neurostimulator" is now added.

With medical billing, change is constant

The ICD-9 was replaced by a mandatory implementation of ICD-10-CM/PCS in 2015, after years-long delays. The World Health Organization (WHO) first endorsed ICD-10 in May 1990, prompting considerable uncertainty in the medical community at the time. Physicians were so concerned that the Centers for Medicare and Medicaid Services (CMS) offered lines of credit in anticipated revenue disruption for physicians and insurance payers that were not prepared to deal with the code changes.

ICD-9 codes have been used since I was first trained as a medical biller nearly two decades ago. Even though we become used to expecting other changes, this particular shift to ICD-10 sparked panic in the healthcare industry over the change to ICD-10 codes due to concerns about the costs of compliance and the anticipated loss of revenue. As things turned out, the actual transition was not nearly as difficult as any of us expected.

In fact, the move to ICD-10 has benefitted practices because the codes' structure enables physicians to code with much greater specificity than the ICD-9 codes allowed. For example, Cervical spondylosis with myelopathy in ICD-9 was coded as 721.1. Converting that code to ICD-10 created 13 different ICD-10 codes, ranging from M47.011 Anterior spinal artery comprsn synd, occipt-atlan-ax region, to M47.012 Anterior spinal artery comprsn syndromes, cervical region, to M47.013 Anterior spinal artery comprsn syndromes, cervicothor region, to name a few.

This is just one example of the changes for 2020. It's important for neurosurgery practices to review all the ICD-10 PCS guidelines and code sets annually coding is not only accurate but also that procedures are coded to the fullest specificity available. The latest updates are accessible at https://www.cms.gov/Medicare/Coding/ICD10/2020-ICD-10-CM.html.

> **"The move to ICD-10 has benefitted practices because the codes' structure enables physicians to code with much greater specificity than the ICD-9 codes allowed."**

Sources

Information included in this article was obtained through resources from the American Academy of Professional Coders (AAPC), the CDC and CMS.

Ms. Young is head of Barbara Young Medical Billing Services, a full-service medical billing, coding and collections company on Staten Island, New York, that has been in operation since 2003.

Neurosurgery
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LEGAL CORNER

In-Network vs. Out-of-Network Contracts Pose Potential Risks for Groups

By Bonnie Darves

Michael F. Schaff

In this regular series, Neurosurgery Market Watch speaks with health lawyers about a broad range of matters affecting neurosurgeons, from contractual issues related to neurosurgery employment, to compensation and performance, to business matters that affect practice finances. For this article, we spoke with Michael F. Schaff, who is chair of the Health Law practice group for Wilentz, Goldman & Spitzer, P.A. in Woodbridge, New Jersey. Mr. Schaff, who works with numerous neurosurgery groups, addresses potentially problematic areas in practice-payer agreements regarding in-network and out-of-network contracts.

Q: In the increasingly complex arena of practice-payer contracting, neurosurgery groups generally have a broad range of reimbursement agreements with various payers, and ensuring that those agreements don't disadvantage practices financially is a perennial issue for groups that requires constant due diligence. You mention that there's an emerging issue involving the way that payers and health plans treat in-network vs. out-of-network providers in the same medical practice with regard to payment rates. What's going on here?

A: It's not uncommon for neurosurgery groups, when they bring in a new surgeon, to have that physician become an in-network provider for certain health plans. This strategy is intended to help that incoming surgeon build a practice and increase patient volumes. At the same time, that practice's other neurosurgeons might actually be out-of-network (OON) providers with the same plan or payer—and those physicians are generally paid their established "usual and customary" rates. Those rates are generally considerably higher than the rates that in-network providers receive.

What we're seeing in recent years is an attempt by those plans and payers to "back door" the OON physicians into the new physician's in-network contracted rates and the corresponding participating provider agreement (PPA). Make sure that you review the PPA and the terms, conditions and rules that are on the payers' websites that are included by reference, as some plans are claiming, in essence, that because the in-network surgeon is affiliated with the larger practice, all of the other neurosurgeons associated with that in-network surgeon are obligated to accept that same lower in-network rate.

In a worst-case scenario, that payer or plan might come back to the practice a year or more later and demand repayment of the difference between the two rates on claims for all the practice's neurosurgeons that have been processed since the in-network surgeon signed the PPA.

Q: How can this happen from the contracting standpoint, and how can practices avoid getting caught up in this potentially disadvantageous situation?

A: To avoid this, you need to review the PPA and related documents very carefully to ensure that there is no "back door" opportunity that brings the OON providers subject to the PPA. This requires appropriate due diligence on the part of the practice to avoid this type of situation because the language that subjects the group to this kind of risk might not be detailed in its primary contract with the plan or payer, but rather in corollary documents or even in rules and regulations that are posted on the entity's website.

The best way to avoid this is ensure that the contract with the in-network neurosurgeon specifically states that the other neurosurgeons in the practice are not governed by the terms set between that individual neurosurgeon and the plan under the PPA. The point is that the new in-network rates are typically significantly less than the OON rates, which are a multiple of rates that the new in-network physician has agreed to, and unwittingly subjecting all physicians in the neurosurgery practice to the lower rates, which will significantly decrease practice revenues.

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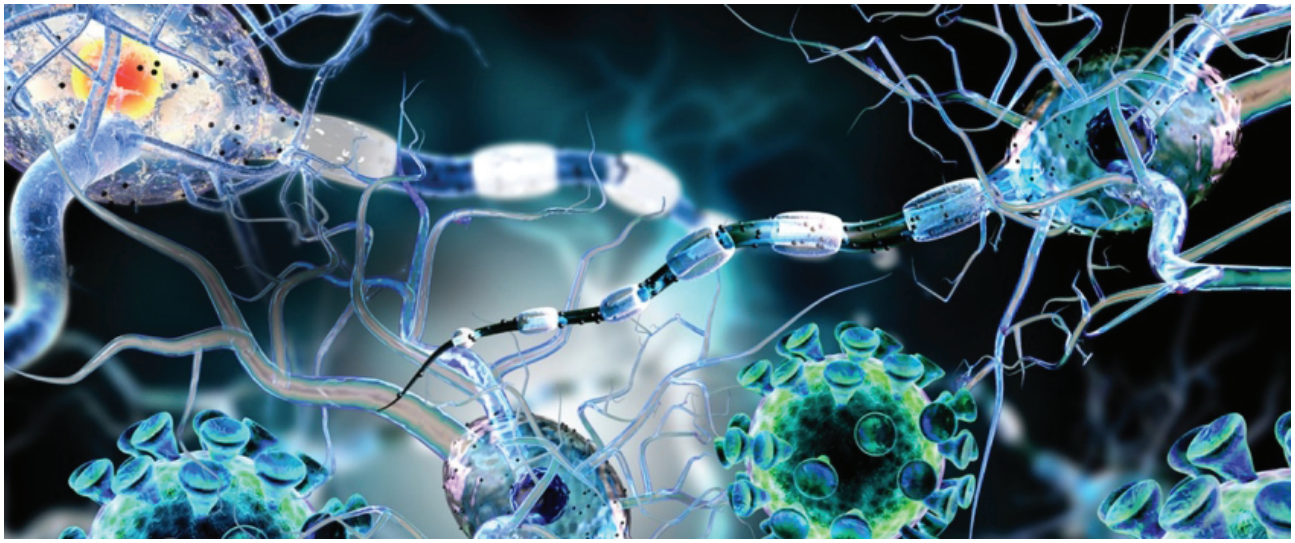

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Neurosurgery
MARKET WATCH™

Fostering and Showcasing Positive Morale in Your Practice

By Katie Cole

When a neurosurgery group showcases its practice to a prospective neurosurgeon or clinician, it is important that the office appear efficiently run and that communication is good among employees at all levels of the organization. It's also key to ensure that there is an interview itinerary and a formal schedule for the interviewee. I have had many candidates who were turned off by a job because the practice appeared unorganized and ill prepared for the visit. In other cases, they were deterred because employee morale was clearly low or communication poor.

Many practices struggle with cultivating and sustaining employee morale, yet it's important to foster good morale in every single staff member in a neurosurgery office. Keeping each employee content has a positive impact on the morale within the entire practice and is a key determinant in employee loyalty and longevity. When morale is low, or there is poor communication between physicians and other providers and staff, the result will come across when neurosurgeons and other potential staff members visit your office in consideration of employment. Patients also notice offices that have happy, efficient employees, and they're surely aware when they're in an office with low morale.

Building a foundation for good morale within the practice that you showcase to potential employees can't be achieved overnight. Morale must be cultivated, and it's exhibited through the satisfaction of your current employees. One way to help ensure that everyone on your staff is satisfied—or if they're not, to give them a safe way to express what's bothering them--is by setting regular staff meetings. This may sound obvious, but unfortunately, there are many practices that don't hold consistent meetings or forums where everyone can openly communicate with each other on what is working and what isn't.

Weekly staff meetings can be formal or informal, and ideally should include frequent reminders about what constitutes consistent procedures for patient contact, from the beginning phone screening to the post-op follow-up and subsequent clinic visits. Even a 15- to 20-minute weekly meeting can go a long way toward ensuring that the practice is running efficiently and properly, and that employees have an opportunity to openly voice concerns or problems and propose solutions.

Another way to help build morale is to provide a formal orientation for new employees that stresses the values of the organization. Even if the incoming employee won't have a clinical practice or OR responsibilities, make sure there is a set time for training and a formal, consistent training program for all employees to learn the way that things are done and how conflicts, should they occur, are handled. Also make sure that new employees meet all or most of the care providers, particularly the ones with whom they will have frequent or regular communication.

Morale is crucial for ensuring employees' daily satisfaction as well as their loyalty and tenure, and it's a key attractor for prospective employees. That includes neurosurgeons who are looking for a practice where they can grow their practice and thrive professionally.

Ms. Cole, a Denver resident, is publisher of Neurosurgery Market Watch and Surgery PA Market Watch.

Neurosurgery Compensation Update

(continued from Page 2)

states. For instance, the Medscape Physician Compensation Report 2019, which tracks individual states, found that several states in the Southeast have made the top 10 compensation list for several years running—for neurosurgery and other specialties. Those included Oklahoma, Alabama, Arkansas, Florida, Kentucky, Tennessee and Georgia. The other three in the top 10 ranks were Nevada, Connecticut and Indiana.

Despite the stiff competition for neurosurgeons in this country, national compensation surveys still find fairly significant differences in the benefits packages that neurosurgeons receive. The AMGA survey, for example, found that at the low end of the spectrum, the 20th percentile, neurosurgeon fringe benefits had a total value of $45,241 compared to $108,411 at the 90th percentile. The median came in at $66,925.

There are also noteworthy differences among practices in when the benefits kick in for neurosurgeons, the AMGA found. While 44% of neurosurgeon survey participants were eligible for benefits immediately, 38% don't start receiving benefits until 30 days after they join the organization, and 11% must wait more than 30 days before their benefits start.

When asked what neurosurgery groups wrestle with as they try to structure fair and attractive compensation packages, all sources noted reimbursement challenges and the continuing trend toward bundled payments. All sources also cited that shifting alliances and consolidation among groups—whether that's smaller entities joining forces or large hospitals and health systems acquiring or affiliating financially with groups—poses challenges when groups they attempt to devise equitable compensation models. In the last 12 months, the NERVES survey found, 23% of groups reported that they had been approached by health systems regarding ownership—up from 18% in the 2017 report.

Ms. Darves, editor of Neurosurgery Market Watch, is an independent medical writer and editor based in the Seattle area.

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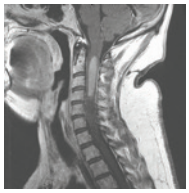
SAVE THE DATES! ADVANCED NEUROSURGERY COURSES SPRING 2020

April 16, 2020: Spine Tumor Seminar

Course Directors: Dr. Ali A. Baaj and Dr. Susan Pannullo



Now in its fourth year, this meeting brings together specialists from neurological surgery, neuro-oncology, medical and radiation oncology, neuroradiology, and pain anesthesia to share state-of-the-art treatment paradigms for patients with primary and metastatic spinal tumors. Surgical and non-surgical options, as well as leading-edge minimally invasive approaches, will be covered.

Friday, April 17, 2020: Recognition and Management of Common Neurosurgical Conditions in the Pediatric Practice

Course Directors: Jeffrey P. Greenfield, MD/PhD, and Caroline Long, MD

This one-day CME course is designed to teach or refresh pediatricians and nurse practitioners about disorders that may need further evaluation by a pediatric neurosurgeon (such as pediatric brain tumors, seizures, and inborn abnormalities of the spine, face, and head).

Sign up to be notified when registration opens:
weillcornellbrainandspine.org/continuing-medical-education
Questions? neurosurgery-cme@weill.cornell.edu

May 1-2, 2020: 5th Principles and Techniques of Complex Spinal Reconstruction

Course Directors: Dr. Ali A. Baaj and Dr. Han Jo Kim

Part didactic, part hands-on cadaveric, this two-day workshop reviews the most common techniques used in contemporary surgery for complex spine pathologies. After an afternoon of lectures from internationally renowned faculty, the course moves to the Weill Cornell Medical College Anatomy Lab for hands-on training on deformity correction and complex instrumentation techniques.

May 29-30, 2020: Minimally Invasive Cranial Neurosurgery: Recent Technical Advances, with Hands-On Symposium

Course Directors: Dr. Theodore Schwartz and Dr. Mark Souweidane

An expansion of our popular Endoscopic Endonasal Pituitary course, this event now includes robotics, keyhole craniotomies, laser therapy, and tubular retractors for a range of cranial pathologies. Featuring lectures, case presentations, and hands-on lab instruction and practice.

Neurosurgery
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NEUROSURGERY POSITIONS

GENERAL NEUROSURGERY

Phoenix, AZ: *Hospital Employed*
Macon, GA: *Private Practice*
Richland, WA: *Hospital Employed*
Brooklyn, NY: *Hospital Employed, Trauma*
Cincinnati, OH: *Private Practice*
Tucson, AZ: *Hospital Employed*
Gastonia, NC: *Hospital Employed*
Fort Wayne, IN: *Hospital Employed*
Brooklyn, NY: *Private Practice, Spine/Cranial Trauma*
Farmington, NM: *Hospital Employed, Spine/ General Neurosurgery*
Las Vegas, NV: *Private Practice, Cranial*
Dayton, OH: *Hospital Employed/Priva-demic*

PEDIATRIC NEUROSURGERY

Macon, GA: *Private Practice*
Tampa, FL: *Hospital Employed*

ENDOVASCULAR

San Antonio, TX: *Academic*
Union, NJ: *Private Practice*
Macon, GA: *Private Practice*
Fresno, CA: *Priva-demic*
Reading, PA: *Hospital Employed*

CRANIAL

Tucson, AZ: *Hospital Employed*
Phoenix, AZ: *Hospital Employed*

SPINE

Long Island, NY: *Private Practice*
Reading, PA: *Hospital Employed*
Knoxville, TN: *Hospital Employed*
Tucson, AZ: *Hospital Employed*
Union, NJ: *Private Practice*
Rapid City, SD: *Private Practice*
Philadelphia, PA: *Priva-demic*
Greenville, NC: *Academic*
Dayton, OH: *Hospital Employed/Priva-demic*
Phoenix, AZ: *Hospital Employed*

▶ For more information on these positions, or if you are interested in hiring a neurosurgeon for a permanent position, please contact ***katie.cole@harlequinna.com*** or call ***(303) 832-1866.***