Volume 7, Number 5 May 2006

PHYSICIAN COMPENSATION REPORT

Contents

Study sheds light on benefits of disclosing docs' financial incentives to patients

Could releasing pay plan info build patient-practice relations?

Disclosing your physician compensation methods to your patients via a simple letter may lead to better-informed and more loyal patients, according to a study in the March 27 *Archives of Internal Medicine.*

During the managed-care backlash of the late 1990s, the public grew concerned that capitation reimbursement would cause conflicts of interest that could keep physicians from recommending necessary care. This concern spurred **Steven D. Pearson, MD, MSc,** the study's lead researcher and associate professor of ambulatory care and prevention at Harvard Medical School in Boston, to research the effects of disclosure.

A debate ensued about whether patients would react positively or negatively to compensation disclosure, and Pearson says he wanted to add empirical evidence to the dialogue. "I thought it would be interesting to see whether disclosure worked and to what extent it changed people's knowledge and attitude toward physicians in the group."

To help gauge patients' reactions, Pearson and his colleagues enlisted two medical groups, Harvard Vanguard Medical Associates in Boston and HealthCare Partners Medical Group in Los Angeles. The groups produced a combined sample size of 8,000 patients. Each group mailed a simple disclosure letter that outlined the compensation model of the group's physicians and was signed > p. 2

Technology and competing subspecialties cut into general surgery compensation

The juxtaposition of declining physician numbers and dips in Medicare fees usually causes physician compensation to stall. This is true enough for general surgeons. However, the growing number of surgical subspecialties and technological advances may cause these providers to become so scarce that their pay may actually begin to increase.

In 2005, trends in several compensation surveys showed general surgeons' compensation increasing by 1.41%–8.89% (see "General surgery salary trends 2004–2005" on p. 10). Compared to numerous other specialties, these pay increases are marginal.

According to the MGMA *Physician Compensation and Production Survey: 2005 report based on 2004 data,* since 1999, general surgeons have averaged increases of less than 5% per year. The average compensation for a general surgeon in 1999 was $236,572; it hit $282,504 in 2004. > p. 10

Disclosing incentives

< p. 1

by the chief medical officer to a randomly selected group of patients (see p. 5 for an excerpt of Harvard Vanguard's letter).

After approximately eight to 12 weeks, researchers surveyed patients—both those who received the disclosure letter and a control group—and found the following results:

1. Disclosure increased patients' compensation knowledge. The overall compensation knowledge level for both groups started low, Pearson says. Only 27% of patients in Boston and fewer than one in four patients in Los Angeles who didn't receive a disclosure letter were able to correctly identify how their physicians were compensated.

This percentage increased remarkably among patients who received the letter (see "Effect of disclosure on patient knowledge" below). Of those patients who remembered receiving the letter—the study distinguished between the recipients of the letter who remembered receiving it and those who didn't—48% of patients in Los Angeles and 57% in Boston correctly identified the compensation incentive.

Effect of disclosure on patient knowledge

Variable	Control patients	All patients mailed a disclosure	Patients who remembered receiving the disclosure
Boston			
A salary plus a smaller portion based on the number and complexity of patients seen*	27.1%	45.1%	56.9%
A salary with a bonus if the entire medical group has done well financially at the end of the year	43.2%	33.7%	28.0%
Fee-for-service based on the number and complexity of patients seen	18.9%	14.9%	13.2%
Capitation: A set amount per patient per month from which the physician gets to keep what is left over after medical care expenses	10.8%	6.3%	1.9%
Los Angeles			
A salary plus a smaller portion based on the number and complexity of patients seen*	23.6%	37.0%	48.4%
A salary with a bonus if the entire medical group has done well financially at the end of the year	32.4%	29.8%	28.3%
Fee-for-service based on the number and complexity of patients seen	25.0%	23.8%	19.3%
Capitation: A set amount per patient per month from which the physician gets to keep what is left over after medical care expenses	19.0%	9.4%	5.2%

* This was the correct answer.

Source: Archives of Internal Medicine, *March 27, 2006. Vol. 166, p. 626. Copyright © 2006 American Medical Association. All rights reserved. Reprinted with permission.*

2. Disclosure did not significantly affect patient trust. Opponents of physician compensation disclosure claim that by raising the question of conflict of interest, disclosure undermines the trust between a patient and his or her physician, according to the study.

However, disclosure advocates argue the opposite—that disclosing compensation methods assuages patient concerns and increases trust.

Pearson found little evidence to solidly support either theory. Most patients who received the disclosure letters responded that the letters did not change their level of trust in their physician.

Although a sizeable minority—21% in Boston and 24% in Los Angeles—responded that the disclosure increased their trust either greatly or somewhat, Pearson says the results are not statistically significant (i.e., the sample size was not large enough to rule out chance's role in the statistical variation) and researchers cannot endorse either position based on the evidence (see "Effect of disclosure on trust and loyalty" table on p. 4).

3. Disclosure increased patient loyalty. Although researchers could not emphatically claim that disclosure increased trust, they did find evidence that compensation disclosure improved patient loyalty. They measured this by asking patients whether they would likely remain with the group in the next couple of years unless forced to change because of a move or another uncontrollable circumstance.

Sixty-seven percent of the control group in Los Angeles expressed loyalty to the practice, compared with 76% of patients who remembered receiving the letter. In Boston, because of the larger sample size, improvements in loyalty—5% higher in the disclosure group than the control group—reached statistical significance.

Should you disclose your compensation plan?

Phrases such as "capitation" or "fee for service" may mean little to most patients, but that doesn't mean that they aren't concerned about physician compensation. "Doctors often think patients have no concerns [about compensation] because they never talk about it with them, when in fact, they do harbor some concerns," Pearson says.

Patients are often just uncomfortable asking questions about financial incentives, particularly if they aren't familiar with the numerous and often complex compensation methods, he adds.

The disclosure letter may be a simple solution, if results from the study are any indication. In both Boston and Los Angeles, 70% or more of patients who remembered receiving the disclosure responded that the information was very or somewhat useful. Those patients also said they believed medical groups should routinely inform patients about how their physicians are paid.

However, just because the two groups in the study had success with compensation disclosure doesn't mean that it's necessarily right for your practice. Although Pearson is in favor of disclosure for all medical groups, he acknowledges that without further research, it's impossible to know > p. 4

Disclosing incentives

< p. 3

whether other group practices would see similar results. "[The study] was performed in only two large medical groups, and generalizability to smaller groups or to patients in other settings must remain an open question," he adds.

How can you determine whether sending a disclosure letter is worthwhile for your practice? Compensation consultants **Lindalee A. Lawrence, CCP, MBA,** president of Lawrence Associates in Wellesley, MA, and **Max Reiboldt, CPA,** managing partner and CEO at The Coker Group in Alpharetta, GA, recommend considering the size and specialty of your group because these may elicit different patient reactions.

If you have a small practice or a group that lacks the administrative capacity to develop a strategy, draft a letter, and answer follow-up questions from patients, this type of compensation disclosure may not be worth the small increase in patient loyalty, Lawrence says.

Both Harvard Vanguard Medical Associates and HealthCare Partners Medical Group are large, multispecialty groups, and a disclosure letter to patients at smaller, single-specialty practices may yield different results or cause frustration rather than add benefit, Reiboldt adds.

For example, if you're a general surgeon who typically only treats a patient once and doesn't build a long-term relationship, drafting a disclosure letter may prove a waste of time, Reiboldt says.

On the other hand, if you're a primary care physician or specialist who sees patients on an ongoing basis (e.g., oncologists, cardiologists, etc.), you may derive more benefit from a tool that increases patient awareness and loyalty.

Does how the letter is written matter?

If your practice decides to disclose its physicians' compensation incentives, be careful when wording the disclosure statement, Reiboldt says. The letters used in the study were worded in language that could help the average patient understand the basic model of compensation; deviating from this format may produce different results.

"It has to provide honest and meaningful infor-

Effect of disclosure on trust and loyalty

Variable	Control patients	All patients mailed a disclosure	Patients who remembered receiving the disclosure
Boston			
Trust in primary care physician to put health and well-being above costs	84.9%	83.9%	86.5%
Feel loyal to medical group and unlikely to switch groups in the next couple of years	70.2%	73.4%	74.7%
Los Angeles			
Trust in primary care physician to put health and well-being above costs	74.8%	78.6%	82.2%
Feel loyal to medical group and unlikely to switch groups in the next couple of years	66.9%	74.1%	76.0%

Source: Archives of Internal Medicine, *March 27, 2006. Vol. 166, p. 626. Copyright © 2006 American Medical Association. All rights reserved. Reprinted with permission.*

Sample disclosure letter

Below is an excerpt from the disclosure letter that Harvard Vanguard Medical Associates in Boston sent to patients:

Harvard Vanguard receives payments from the insurer of each patient who chooses to receive care at one of our practices. The money received is pooled centrally, and your primary care doctor gets a regular paycheck twice per month from Harvard Vanguard.

Approximately 70% of your doctor's pay is a simple flat salary based on how many years he or she has been in practice. The remaining 30% of each doctor's take-home pay is variable and is determined by measuring two factors:

1. The number of patients for whom the doctor is listed as the primary care provider (panel size)
2. The number and the complexity of patient visits that doctor sees

These two factors, when taken together, are meant to reflect how the doctor works to take care of his or her patients. Each doctor is compared to the other doctors in Harvard Vanguard to determine how much above or below the group's average his or her variable compensation will fall.

The number of tests, treatments, and referrals ordered by an individual doctor has no direct influence on how much money he or she will make.

The costs of expensive tests and treatments are spread across the entire patient population of Harvard Vanguard, so no individual doctor needs to feel that "the bottom line" exerts undue pressure on the care of the patient.

Source: Archives of Internal Medicine*, March 27, 2006. Vol. 166, p. 624. Copyright ©2006 American Medical Association. All rights reserved. Reprinted with permission.*

mation, but if [the letter] gets too complicated, you run the risk of confusing [patients] and making them more worried or suspicious," Lawrence says.

Patients often hold misconceptions about the costs of healthcare, so Reiboldt recommends also including in the letter information about costs. "Something patients often forget is that one of the reasons for larger fees is the high cost of doing business," he says.

There are as many ways to word a compensation letter as there are practices. Ultimately, the goal is to produce a letter that your group can endorse and that explains your compensation methods in a way that patients can understand.

Toward an era of transparency?

Compensation disclosure is just one aspect of an overall shift in healthcare toward greater transparency and openness with regard to financial matters, Lawrence says. This has been a hot topic following efforts by the Bush administration and some state governments to encourage the disclosure of prices paid for common medical procedures.

"There's a whole movement dedicated to making [financial aspects of healthcare] more transparent," Lawrence says.

However, Pearson hopes that regulators and lawmakers won't need to become involved when it comes to disclosing physician compensation. Instead, he says his research provides evidence that disclosure can add value and that groups and practices should disclose compensation incentives for their own benefit.

"I hope [the study] has enough relevance to people's real decisions that group leaders, executives, and managers will look very carefully at doing a simple disclosure on their own," Pearson says. ■

PCR *sources*

Lindalee A. Lawrence, CCP, MBA, president of Lawrence Associates, 396 Washington St., Ste. 303, Wellesley, MA 02481, 781/237-9044; *www.lawrenceassociates.com.*

Steven D. Pearson, MD, MSc, associate professor of ambulatory care and prevention, Harvard Medical School, 133 Brookline Ave., 6th Floor, Boston, MA 02215, 617/509-9904; *spearson99@yahoo.com.*

Max Reiboldt, CPA, managing partner and CEO, The Coker Group, 1000 Mansell Exchange West, Ste. 310, Alpharetta, GA 30022, 678/832-2007; *www.cokergroup.com.*

Boost compensation by ensuring that your practice gets fully reimbursed for out-of-network services

Your compensation depends as much on your practice's ability to get reimbursed by payers as it does on your skill with patients. Contracting with all payers may seem like a solution, but that wouldn't be business-savvy; however, neither is getting underreimbursed for too many out-of-network claims.

Operating out of network (i.e., without a payer contract) means that for many services, you will be flying without the reimbursement safety net of a contract, and you may have trouble getting paid. This out-of-network collection struggle happens for several reasons:

- Payers sometimes send payment directly to the patients, which often means that money will never make it back to the practice.
- Payers sometimes try to pay a provider using a fee schedule instead of the charges billed.
- Some payers try to establish a "usual, customary, and reasonable" fee schedule to represent the prevalent price in that market for a specific service. This is often the schedule payers use to pay out-of-network providers.

Overcome payer barriers

To overcome some of these reimbursement barriers, be selective about whom you contract with, says **Fredrick I. Miller,** partner and head of the healthcare practice group for the New York–based firm Garfunkel, Wild & Travis, PC. "Just as hospitals should not contract with every payer, neither should a practice."

Before you sign on the dotted line, make sure that the contract is financially worthwhile. You don't want to agree to a contract that pays you less money as a participant than you'd receive for working without a contract, cautions Miller, who has 30 years of experience representing physicians and other providers and more than 18 years of experience with contract negotiation and enforcement.

Your practice needs appropriate reimbursement to stay open, agrees **Sherri C. Staat, CMPE,** administrator at Orthopaedic Associates Medical Clinic in Visalia, CA, who offered in-the-trenches advice during the 2006 MGMA Financial Management Society–Managed Care Assembly in San Diego in March.

"Practices aren't immune to the law of economics," she says. "So before you do anything, figure out whether it's costing you more to have a contract with a payer than to operate out of network. You may be surprised at the answer."

Analyze the out-of-network payer performance, especially those that your practice frequently encounters (see "Improve reimbursement with proper market analysis" on p. 8). Compare the contract terms to what you already receive as an out-of-network provider.

Also conduct due diligence with other practices that contract with the payer to find out whether they have difficulty getting reimbursed or whether any other problems exist. After all, your time is also worth money, and if you and your staff must chase down every dollar, the contract may not be worth it in the end.

Other paths to reimbursement success

If you decide not to contract with a payer, these seven tips may help your practice—and, ultimately, your providers—get compensated for out-of-network services:

Tip #1: Check whether the payer is part of a larger network. You may be able to negotiate national network rates from payers that are part of a national network, says **Carol Carden,** principal at Tennessee-based Pershing, Yoakley & Associates. These rates are typically higher than what you would receive as an out-of-network provider.

Tip #2: Determine whether your payer contract is actually finished. If an insurance provider terminated your participation and you're within a 90-day window of the termination, determine who is responsible for paying a patient's bill. Check for provisions in the contract that addresses termination circumstances.

"If you're outside of that [contract] window but the patient is undergoing a course of treatment that started prior to the termination, then the plan con-

tract is still relevant and you can often bill the plan," says **John Kirsner,** partner at Squire, Sanders & Dempsey, LLP in Columbus, OH.

Tip #3: Don't waste your resources. As an out-of-network provider, pouring money into seeking payment from a payer often has a low success rate. So instead of being reactive, be proactive—ask the patient for a deposit up-front.

"If you anticipate a $1,500 bill, then ask for a deposit of at least $1,000 from the patient," Kirsner says. "Then this amount can be applied if the patient [or payer] does not pay. This is just one way of protecting yourself."

Tip #4: Seek full payment in advance from the patient. If deposits from patients still aren't footing the bill, ask for the entire amount up-front. "If the patient has a chronic disease, you would expect that patient to pay because [he or she] needs to come back periodically," Kirsner says. Just be mindful of your state's consumer sales practices and debt-collection laws.

"You're a healthcare provider, but that doesn't make you immune from those laws," Kirsner says. "That means if you need to put the bill into collections, it should go to a reputable collection agency. There should be a good-faith effort to get payment before you write off any bill for tax purposes."

Tip #5: Learn your state's insurance laws. This information can be especially useful to out-of-network providers. For example, your state's laws may specify that payers must send payment for services directly to providers and not to the beneficiaries. Approximately 20 states, including Ohio and Louisiana, have insurance laws that apply to out-of-network providers. "[Check] whether there's any regulatory language to support your position," says Carden.

State laws also require that you honor the assignment of benefits (AOB) (i.e., method in which the patient assigns the payment of benefits to a physician or hospital). When providers go out of network, plans often ignore AOBs and argue that without a contract, they have no commitment to you as the provider. According to Carden, the payer takes the position of, "We don't have an obligation to you. We pay our member, and then it's the member's responsibility to pay you."

In those cases, payers send payment directly to the patient. And although patients should send the money to you, there's no guarantee they will. Applicable insurance laws can strengthen your position when confronting such matters. If you practice in a state without these kinds of laws, you can still take action to get reimbursed.

Tip #6: Voice your concerns with your state's medical society or association. "These issues affect all providers," Carden says. "Providers typically have a lobbying presence already, so they would be good advocates." Even if your state doesn't have applicable laws on the books, ask your attorney to check out case law in your state. It's possible that this same issue has come up before, and another case may offer a precedent-setting decision.

Tip #7: Launch an ad campaign. If you're the dominant practice or a large provider in your area, use your size to your advantage—although do so only as a last resort. Payers in the area will likely not want to see you go out of network, so make them work for your business.

Launch an advertising or public relations campaign via local media to apply pressure on the plan to negotiate a fair contract with you, Carden says. But don't do this lightly. "You really have to have a lot at stake to resort to this kind of option," she says.

Be careful not to overstep any bounds in such a campaign, Kirsner adds. "You might see such an ad campaign if a very large health plan kicked a large hospital out of its network, for example," he says.

He suggests checking the veracity of the facts given and presenting the information to the public in a straightforward way. With preparation and by applying the above tips, you should be able to keep your practice from losing out-of-network profit. ■

PCR *sources*

Carol Carden, principal, Pershing, Yoakley & Associates, One Perkins Place, 525 Portland St., Knoxville, TN 37919, 865/673-0844; *ccarden@pyapc.com.*

John Kirsner, partner, Squire, Sanders & Dempsey, 1300 Huntington Center, 41 South High Street, Columbus, OH 43215, 614/365-2722; *jkirsner@ssd.com.*

Fredrick I. Miller, partner, head of the healthcare practice group, Garfunkel, Wild & Travis, PC, 111 Great Neck Rd., Great Neck, NY 11021, 516/393-2200; *www.gwtlaw.com.*

Sherri C. Staat, CMPE, administrator, Orthopaedic Associates Medical Clinic, Inc., 325 South Willis Street, Visalia, CA 93291, 559/625-0551; *www.bonesurgeons.com.*

Improve reimbursement with proper market analysis

Whether you contract with a third-party payer or operate out of network, your practice needs to know what other similarly sized providers charge for services to know what is a reasonable amount to charge for your services. By finding out these going rates and charging similar prices, you stand a better chance of receiving more reimbursement from out-of-network payers. Plus, as consumer-directed healthcare takes root, you won't have to worry about patients leaving due to overpriced services at your practice. To help you properly analyze the market, **Kay Stanley, FACMPE,** associate partner of The Coker Group in Alpharetta, GA, offers simple advice.

The term 'business plan' often intimidates physicians and managers, but unless you need it to search for capital, your plan can be a simple outline to keep you focused on important practice issues and goals.

Before evaluating your existing managed-care agreements or entering into new ones, arm yourself with information about your practice. Determine the cost of your procedures so you know the threshold of reimbursement needed from any present or future contract to make your practice profitable.

The process of studying your market and practice is also known as a market analysis. To accomplish this analysis, take the following three steps:

Step #1: Assess the local market. Your local chamber of commerce and hospital marketing department can be good resources to use when gathering community data. Collect statistics by demographic group (e.g., gender, age, race, income, education, employer, etc.) and by

- population density and distribution by locale
- anticipated trends in population growth or decline by locale
- major employers
- major health insurers
- annual healthcare expenditures

Step #2: Assess your practice market. Gather a minimum of 12 months of practice-utilization data. Obtain the following information for several demographic groups (e.g., age, gender, ZIP code, and, if available, race, employer, income, and educational level):

- Number of active patients seen in the past two years, by payer mix.
- Office visits/procedures per year.
- Average visits/procedures per activepatient/year.
- Frequency of diagnoses per demographic group.
- CPT frequency by demographic group.
- Average cost per visit/procedure. To calculate this, divide practice expenses by hours worked to arrive at an average cost per hour. Then divide average cost per hour by the number of visits/procedures per hour to arrive at the average cost of each visit/procedure.

Step #3: Create a business plan. This is the most important step. The term "business plan" often intimidates physicians and managers, but unless you need it to search for capital, your plan can be a simple outline to keep you focused on important practice issues and goals.

This outline, called a market assessment, is based on the community and practice assessment and describes market forces that will affect the practice. It includes

- current patient mix
- anticipated demographic growth/decline
- expected increases/decreases in current health plan reimbursements
- financial effect on practice of the first three items
- strengths and weaknesses of the practice (e.g., geographic coverage, range of services currently offered, special services, additional unused expertise available, competition)
- credentialing (e.g., affiliations such as IPAs; hospital privileges; board certifications; and deficiencies such as malpractice claims, impairments, and sanctions) ■

Editor's note: This excerpt was adapted from the HCPro, Inc., publication The Top 15 Financial Management Policies and Procedures for Physician Practices. *For more information, go to* www.hcmarketplace.com/prod-3411.html *or call our Customer Service Department at 800/650-6787.*

When creating a physician staffing plan, seek third party

by Michael P. Broxterman, COO

Offering your physicians an appealing level of compensation depends greatly on your practice's ability to create the right balance of staff to meet demand and generate healthy profit. Now more than ever, this financial challenge requires healthcare providers to produce a comprehensive physician staffing plan. However, creating an impartial, meaningful plan takes time and requires extensive data, which is why practices may want to consider using a third party for this process.

Physician staffing plans assess the number of physicians needed at a practice or facility, but you also may use it to analyze various practice areas, such as physician specialty mix, the productivity of your practice, or the right amount of compensation to offer a physician candidate.

Take the process outside the practice

Given the breadth of practice areas that a staffing plan can cover, it's important for the plan to be accurate and impartial. So although administrators undoubtedly know their practices best, the amount of time required to complete this tool—coupled with the potential for administrators to have some bias toward staff—don't make them the best choice to complete the task.

"Healthcare providers are some of the busiest people," says John Beckman of the Atlanta-based consulting firm Beckman & Associates. A solid staffing plan requires intense data analysis, and practice administrators may not have access to or have studied all of the necessary national-utilization statistics to do this, he says.

"Plus, staff really appreciate the use of an outside, independent, third-party consultant" because third-party planners are less inclined to have any bias, and their intermediary status allows staff to be more open, he adds.

"Often physicians won't open up as much to an in-house person as they will to someone from outside the organization," he says. "We don't know the medical staff; so when we do physician interviews, we can [impartially] listen to their needs. We can also talk to them about quality-of-care issues, pending retirements, or any other concerns."

Get into the right physician mix

For some practices, knowing when to hire a new physician, and which specialty to choose is a guessing game, but staffing plans eliminate the speculation. Beckman explains that creating the wrong specialty mix may cause several problems, such as

- a loss of income due to a physician oversupply
- a disruption in physician-to-physician referral patterns
- dissension among the medical staff due to too much competition
- failure to meet the community's service needs

All of these can be costly mistakes to a practice. Choosing the wrong mix of specialists or hiring physicians without a clearly defined need results in the community not receiving the right level of service, diminished practice revenues, and, ultimately, decreased physician compensation.

However, by generating an accurate staffing plan, the opposite results are true. To do this, a third-party planner analyzes statistics from the U.S. census, state and county demographics, regional economic profiles, institutional and ambulatory care ZIP code reports, national incidence-of-disease rates, and numerous other data to obtain the big picture on your market.

Based on this information, the staffing plan can help your practice know precisely what kind of physicians to have on staff, the quantity needed, and when to bring them on board. This better equips your practice to serve your community and more likely earn higher profits.

By working with a third-party planner to create a staffing plan, you not only save time, but you also get the correct picture of your practice's staffing needs so you can establish realistic recruiting goals and ensure that the organization remains profitable. ■

Editor's note: Broxterman is COO of Pinnacle Health Group, a leading U.S. physician-recruitment firm. Visit www.phg.com *for more information.*

General surgery salary trends 2004–2005

Compensation surveys	2005	2004	% change 2004–2005
AMGA Medical Group Compensation and Financial Survey	$294,000	$270,005	8.89%
HCS Physician Salary Survey Report	$281,395	$277,470	1.41%
MGMA Physician Salary Survey Report	$282,504	$264,375	6.86%
SCA Physician Compensation and Productivity Survey	$270,005	$254,880	5.93%

Source: Data excerpted from AMGA, Hospital and Healthcare Compensation Service, MGMA, and Sullivan Cotter & Associates compensation surveys. Reprinted with permission.

Surgery compensation

< p. 1

The many surgical subspecialties (e.g., vascular, plastic, orthopedic, urological) have in part caused the relatively slow five-year climb because they draw from patients who, at one time, may have fallen under the general-surgeon purview. As technology has evolved, interventional radiologists also have begun to glean patients who would traditionally look to the general surgeon (see "Total cash compensation comparison for surgical specialties 2004–2005" on p. 11).

So although general surgeons' pay began to stagger, during that same period, radiologists saw sharp increases in their earnings. In 1999, they earned $315,048; by 2004, they had hit a high of $406,852, according to the MGMA survey.

Assessing the effect of technology

Why the shift away from general surgery? Advances in technology (e.g., the growth of the use of minimally invasive procedures [MIP]) are partially to blame for the listless general surgeon pay climbs and, reciprocally, the boost pay for radiologists. During the past 10 years, technological strides have made it possible for physicians to perform a host of procedures through small incisions.

"The global trend is toward minimally invasive procedures," says **Edward Mun, MD,** chief of bariatric surgery at Boston-based Faulkner Hospital and assistant professor at Harvard Medical School. "In the past, surgeons took care of conditions [such as] hernias and gallbladder, but those are now treated as minimally invasive procedures. General surgeons have seen a drastic decline in many procedures they used to perform routinely."

Some procedures that used to require broad surgical expertise are now addressed by other providers or surgeons with an even greater skill set. For example, interventional radiologists are able to address complications of the disease process (e.g., the percutaneous draining of inflamed gallbladder). Also, more highly trained minimally invasive surgeons perform surgical procedures such as colectomy and appendectomy, which may require the use of a laparoscope (a thin, lighted tube), in lieu of the conventional general surgeon. Although using these MIPs benefits the patient through faster recovery, reduced pain, and lower-levels of procedural complications, they also result in financial losses for general surgeons.

Accounting for reimbursement changes

In addition to losing patients to subspecialists, general surgeons are reeling financially from the effects of poor payer mix. For example, Medicare payers represent 30.37% of the gross charges for a general surgeon; 47.60% of their reimbursements are commercial payers, according to the MGMA *Cost Survey for Single-Specialty Practices: 2005 report based on 2004 data*.

The 2005 Deficit Reduction Act managed to quell a 4.4% Medicare physician fee cut. However, the proposed 2007 cuts could present yet another blow to general surgeons' income: Not only will this affect Medicare patients, but because commercial payers often take their cues from Medicare, it could also affect the physicians' main income generators. "The overall trend is toward reductions in Medicare," Mun says. "Private insurers examine Medicare rates very carefully before they adjust their own provider compensation."

However, not all reimbursement news is bad for these doctors. CMS recently announced that it would extend coverage of bariatric surgery (the stomach/intestinal surgery used to help patients with extreme

Total cash compensation comparison for surgical specialties 2004–2005

Surgery specialty	2005	2004	% change 2004–2005
Bariatric	$250,000	n/a	n/a
Breast	$296,678	$236,125	25.64%
Cardiothoracic	$429,000	$410,000	4.63%
Colon and rectal	$367,496	$246,235	49.25%
General	$270,005	$254,880	5.93%
General orthopedic	$372,269	$350,000	6.36%
Neurosurgery	$420,357	$360,000	16.77%
Plastic/reconstructive	$281,475	$285,490	(1.41%)
Vascular	$308,133	$302,350	1.91%

Source: Sullivan Cotter & Associates 2005 Annual Physician Compensation and Productivity Survey Report. *Reprinted with permission.*

obesity lose weight) to include beneficiaries of all ages. This came with the stipulation that patients seek care at a facility certified by the American College of Surgeons or American Society for Bariatric Surgery. With bariatrics still a burgeoning subspecialty, general surgeons perform many of these operations. So the CMS announcement means that, at least temporarily, general surgeons may receive a boost in revenue.

Even before Medicare approved the benefit for all ages, the annual number of bariatric procedures (most of which bariatric or general surgeons perform) climbed from 30,000 to 300,000 per year globally during the past five years. With the expanded Medicare coverage, the number of patients will likely grow exponentially.

"The number of obese patients has already increased significantly, and proportionally, general surgeons are doing more bariatric surgeries," Mun says. "Though a surgeon's main revenue stream is surgeries, bariatric surgeries require more preoperative work to see whether the patient is fit, and that generates additional revenue."

Dwindling number of docs

Bariatric surgery may offset some of the revenue lost to other doctors, but the diminishing supply of general surgeons may be the greatest compensation booster yet. "These surgeons are experiencing decreased reimbursements, and that's causing another real issue," says **Michael Fleischman, FAAHC,** consultant at Gates, Moore & Company, a Georgia-based physician practice management group. "It's becoming increasingly difficult to recruit general surgeons."

The AMA's *2006 Physician Characteristics and Distribution in the U.S.* estimates that there are 40,292 general surgeons in the United States. However, the survey also estimates that nearly half—approximately 17,835—of those surgeons are within reach of retirement (i.e., age 55 or older), losses that the number of new physicians in the field will not offset. The Association of American Medical Colleges data show only 5,320 applicants for general surgery.

"There are a whole lot of surgeons getting ready to retire and not a whole lot of younger physicians joining the specialty," Fleischman says. "Plus, many of the residents in general surgery will likely branch off into other more lucrative surgical specialties."

The AMA survey data show that in the past 30 years, although general surgeon numbers have remained relatively constant—31,562 in 1975; 38,169 in 1985; 37,502 in 2004—other surgical specialties have boomed. Since 1975, orthopedic surgeons have more than doubled from 11,379 to 23,796, and plastic surgeons have more than tripled from 2,236 to 6,852.

"In general surgery, there's not a whole lot that can be done to groom additional revenue streams," says Fleischman. "So if by pursuing another two years of education there's an opportunity to pursue a more lucrative subspecialty, these surgeons are going to take it."

Not surprisingly, the declining numbers for general surgeons make it more difficult for hospitals and practices to find doctors to hire. "We're seeing an increase in hospitals employing physicians, but this time around, they're going after the subspecialties, so there are hundreds of jobs open in general surgery," he says. Further tightening the general surgeon supply may become a veiled blessing for those who stay in the field. > p. 12

General surgery at a glance

Pay direction: Stagnant.

Physician population: 40,292 based on the AMA's *2006 Physician Characteristics and Distribution in the U.S.*

Entries to and exits from field per year: The Association of American Medical Colleges estimates approximately 5,320 applicants in this specialty. Training is three-year residency after medical school and some one- or two-year fellowships in subspecialties.

The AMA estimates that 8,189 surgeons are 65 or older.

What general surgeons do: May operate on any part of body; focus is often on abdominal operations, appendectomies, hernia repairs, hysterectomy, and gallbladder removals. Chest work includes lung and breast cancer removals. Much crossover into higher-paying surgical subspecialties (e.g., vascular, orthopedics).

Common reimbursement methods: Reimbursement rates steadily declining for approximately eight years.

Common group structures: Full range of structures and ownership.

Main professional society: American College of Surgeons, Chicago, 312/202-5000; *www.facs.org.*

Surgery compensation

< p. 11

"I think these surgeons' compensation will remain steady [in the coming years]," Fleischman says. "However, if an even greater shortage occurs, then the laws of supply and demand kick in and [general surgeons] could develop a higher pay and better reimbursement." ■

PCR *sources*

Michael Fleischman, FAAHC, consultant, Gates, Moore & Company, 3340 Peachtree Rd., Ste. 600, Atlanta, GA 30326, 404/266-9876; *www.gatesmoore.com.*

Edward Mun, MD, assistant professor, Harvard Medical School, and chief of bariatric surgery, Faulkner Hospital, 1153 Centre Street, Boston, MA 02130, 617/983-7000; *www.faulknerhospital.org.*

Group Publisher: Lauren McLeod
Executive Editor: Michele Wilson
Managing Editor: Karen Minich
Editorial Assistant: Elyas Bakhtiari

Call Karen Minich at 781/639-1872, Ext. 3778, or e-mail *kminich@hcpro.com* with story ideas for future issues of **Physician Compensation Report.**

Physician Compensation Report (ISSN:1530-342X) is published monthly by HCPro, Inc., 200 Hoods Lane, Marblehead, MA, 01945, 781/639-1872, *www.hcmarketplace.com.*