CONFIDENTIAL

aaPM&R

American Academy of
Physical Medicine and Rehabilitation

2017 PM&R Physician Compensation Survey Report

December, 2017

I. Executive Summary

A. Background

The American Academy of Physical Medicine and Rehabilitation (AAPM&R) is the national medical specialty organization representing more than 9,000 physicians who are specialists in physical medicine and rehabilitation (PM&R). PM&R physicians, also known as physiatrists, treat a wide variety of medical conditions affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. PM&R physicians evaluate and treat injuries, illnesses, and disability, and are experts in designing comprehensive, patient-centered treatment plans. Physiatrists utilize cutting-edge as well as time-tested treatments to maximize function and quality of life.

AAPM&R has partnered with ECG as the independent third-party administrator of the *2017 PM&R Physician Compensation Survey*. ECG has a long-standing history of conducting physician compensation and production surveys. In addition, ECG offers a broad range of strategic, financial, operational, and technology-related consulting services to healthcare providers. With approximately 210 consultants, ECG is a national leader in the industry, providing specialized expertise to community hospitals, academic medical centers, health systems, and medical groups.

This report represents ECG's key findings and analyses from the *2017 PM&R Physician Compensation Survey*. AAPM&R's goals for the survey included (1) establishing a comprehensive, de-identified compensation and production data set specific to PM&R physicians and (2) providing key benchmarks and data on PM&R practice characteristics, clinical activities, compensation plan structure and incentives, benefits, and other related compensation components.

B. Data Integrity

Survey data was gathered and maintained with the highest level of confidentiality and security. Individual physiatrist responses, including all submitted data, was de-identified and blinded and therefore cannot be attributed to any specific physiatrist. PM&R will only have access to the blinded data set and at no time will have access to the unblinded data set, which is maintained in strict confidence by ECG.

The survey questionnaire was developed by a work group of practicing physiatrists, with input from key AAPM&R leadership. These physiatrists provided valuable insight into the practices of AAPM&R members by identifying and defining areas of opportunity and focus for the survey. ECG worked closely with this work group to finalize the survey instrument and definitions to ensure that the survey would yield meaningful benchmarks and findings. Once finalized, a secure online survey tool was built so that all responses would be captured electronically.

A total of 9,296 physiatrists (both AAPM&R members and nonmembers) were invited to participate in the survey via email, with responses from 841 physiatrists included in this report (which equates to a 9% response rate). Physiatrists accessed their unique survey link using a randomly generated source identification number, which acted as another measure of security and further ensured confidentiality. The survey participation deadline was extended three times to encourage maximum participation among

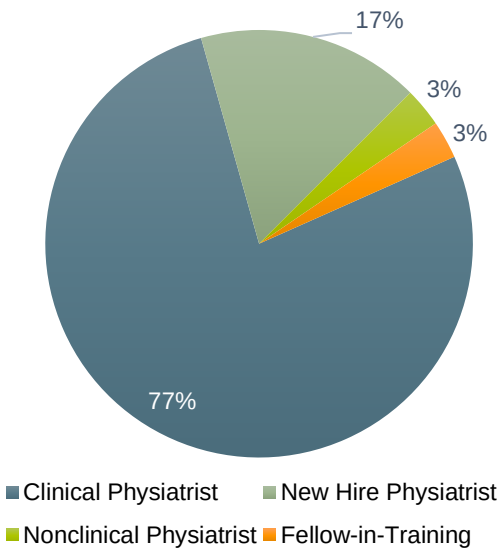
physiatrists. The calculated margin of error from the 841 responses is +/-3.2%, based on a 95.0% confidence interval. In other words, we can attest with 95.0% certainty that the results are representative of the target market within a +/-3.2% margin. An acceptable margin of error for market surveys typically falls between +/-3.0% and +/-8.0% at the 95.0% confidence interval.

Data requested in this survey represents the activities of the 12 months ending December 31, 2016. The data gathered is considered a representative sample of physiatrists; however, some drill-downs are not available to protect the identity of participants. ECG's survey methodology abides by the Statements of Antitrust Enforcement Policy in Health Care issued by the U.S. Department of Justice and the Federal Trade Commission. Specifically, every compensation and production benchmark reported by ECG has at least five physiatrists practicing in five unique organizations represented in the data set. Further, ECG ensures that no organization represents more than 25% of the sample within a reported benchmark. In order to preserve participant confidentiality, only summary statistics are reported. Further information on ECG's benchmark integrity can be found in appendix A.

C. Data Organization and Calculations

As demonstrated in figure 1.1, of the 841 physiatrists who responded to the survey, 650 (77%) categorized themselves as a clinical physiatrist, 142 (17%) reported they were a newly-hired clinical physiatrist in 2016, 25 (3%) indicated they were a nonclinical physiatrist (i.e., they did not see patients in 2016), and 24 (3%) reported they were a fellow-in-training.

Figure 1.1: Percentage of Physiatrists by Provider Category



To calculate comparable compensation and production data, we used ECG's proprietary survey methodology. In doing so, each physiatrist's total compensation was recalculated to a 1.0 total FTE, clinical compensation was recalculated to a 1.0 clinical FTE, and production data (e.g., net professional collections, work relative value units [WRVUs]) was recalculated to a 1.0 clinical FTE. Appendix B presents *2017 PM&R Physician Compensation Survey* benchmarks across all metrics and data cuts that met the minimum sample size guideline of five physiatrists in five unique organizations. Appendix C presents *2017 PM&R Physician Compensation Survey* benchmarks by clinical focus area across all metrics and data cuts that met the minimum sample size guideline.

For purposes of organizing the data and information contained within the main body of this report, we structured the findings into the following sections:

» *Clinical Physiatrist Profile:* Summarizes key findings for only those physiatrists who indicated they are actively seeing patients and were hired in their position before 2016 and who met the criteria for inclusion in the final compensation and production data set

» *Clinical Physiatrist Compensation and Production:* Reports the detailed benchmarks for only those physiatrists in the clinical physiatrist profile

» *Compensation and Benefits Plans for Clinical Physiatrists*: Reports the detailed findings related to compensation plan structure, compensation plan incentives, and benefits for only those physiatrists in the clinical physiatrist profile

» *All-Physiatrist Profile*: Summarizes key provider demographics from clinical physiatrists, new hires, fellows-in-training, and nonclinical physiatrists

» *New Hire Profile:* Summarizes starting salary data and hiring package incentives for clinical physiatrists who started in their position in 2016

» *Fellow-In-Training Profile:* Summarizes key findings for only those physiatrists who indicated they were in a fellowship training program in 2016

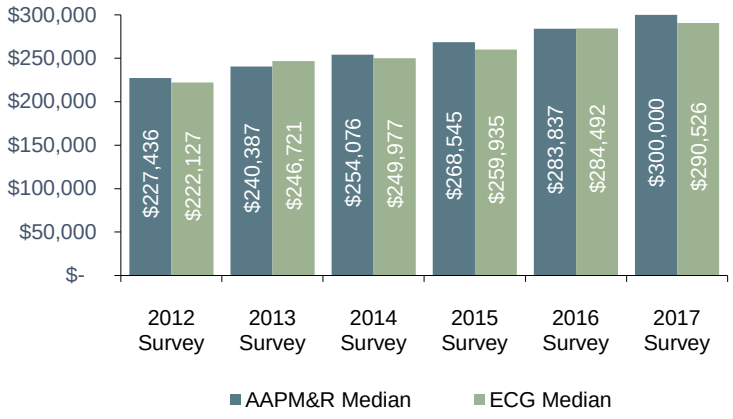
» *Nonclinical Physiatrist Profile:* Summarizes key findings for only those physiatrists who indicated they were in a 100% nonclinical role (i.e., they did not see patients) in 2016

D. Clinical Physiatrist Compensation and Production Statistics

The final clinical physiatrist data set, after data validation and the evaluation for outliers, included compensation and production information from 650 physiatrists. To our knowledge, this represents the largest national compensation and production data set uniquely addressing the needs of physiatrists available in the industry.

As demonstrated in figure 1.2, in aggregate, median compensation for PM&R physicians was $300,000 in the 2017 PM&R survey, compared to $227,436 in the 2012 PM&R survey.[1,2] This increase reflects an annual growth rate of 5.7%, which is comparable to the annual growth rate of 5.5% (over the same period) seen for PM&R physicians in ECG's *2017 Physician Compensation Survey*.[3]

Figure 1.2: Overall Trends in Median Clinical Compensation



---

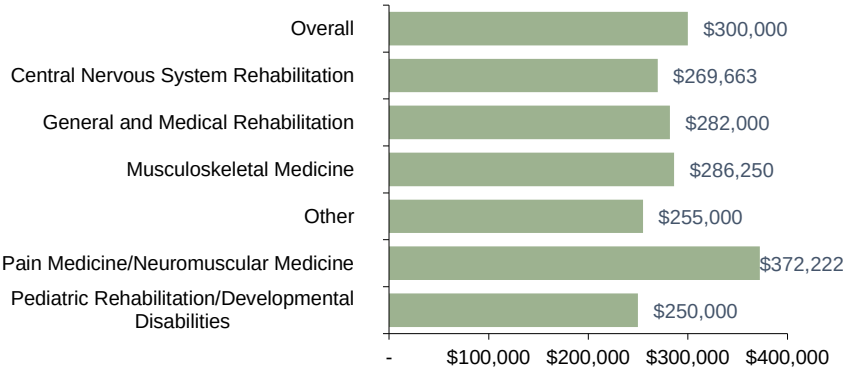
1 Any reference to the 2012 PM&R survey in this report specifically refers to the *2012 PM&R Compensation Survey Report* published by AAPM&R and conducted by Premier Research Solutions.

2 The 2012 PM&R median compensation represents full-time employee gross income (W-2 wages) from the 2012 PM&R survey. For comparison purposes, ECG used the 2012 PM&R survey data to calculate the compound annual growth rate of 5.7%.

3 ECG's *Physician Compensation Survey* has been conducted annually since 2000 and includes compensation and production data from over 25,000 physicians and advanced practice providers (APPs) in more than 100 organizations. Benchmarks are available for 100 physician specialties, including PM&R. References to data from ECG's survey are specifically for PM&R, unless otherwise noted.

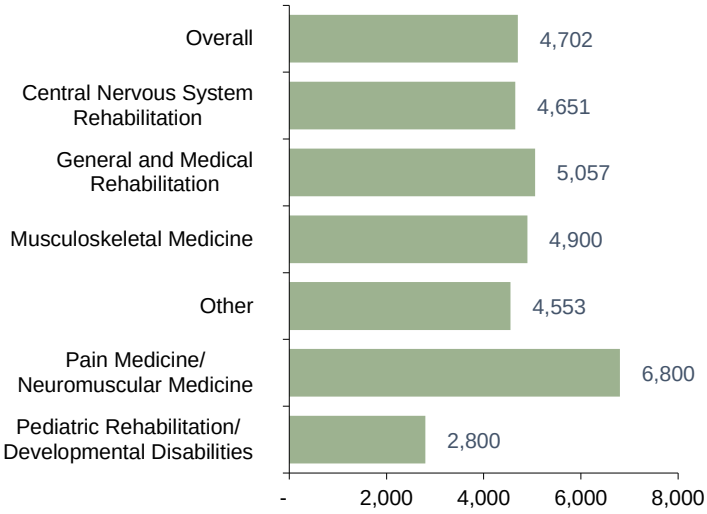
In order to further delineate compensation levels among different types of physiatrists, respondents were asked to select their area of clinical focus. As shown in figure 1.3, physiatrists practicing in pain medicine/neuromuscular medicine are earning the highest median compensation at $372,222. Pediatric rehabilitation/developmental disabilities physiatrists are earning the lowest median compensation at $250,000, which is 17% lower than the overall median compensation for physiatrists. Across the physician market, there is evidence that pediatric subspecialists are generally compensated at lower levels than their peers who treat adults in the same specialty. For example, according to ECG's *2017 Physician Compensation Survey*s, pediatric physiatrists are earning 15% less than adult physiatrists. Pediatric surgeons are typically the only subspecialists who earn more than their peers in adult surgical specialties.

Figure 1.3: Median Clinical Compensation by Clinical Focus Area



As shown in figure 1.4, in aggregate, 199 physiatrists submitted WRVU data, generating a median WRVU value of 4,702. Median WRVUs for physiatrists in ECG's *2017 Physician Compensation Survey* were calculated at 4,695, which is only 0.2% lower than self-reported WRVUs from the 2017 PM&R survey. Physiatrists practicing in pain medicine/neuromuscular medicine are generating the highest number of median WRVUs at 6,800. Pediatric rehabilitation/developmental disabilities physiatrists are generating the fewest median WRVUs at 2,800, which is 40% lower than overall median WRVUs for all physiatrists in the data set. The remaining four clinical focus areas report median WRVUs of between 4,553 (other clinical focus area) and 5,057 (general and medical rehabilitation).

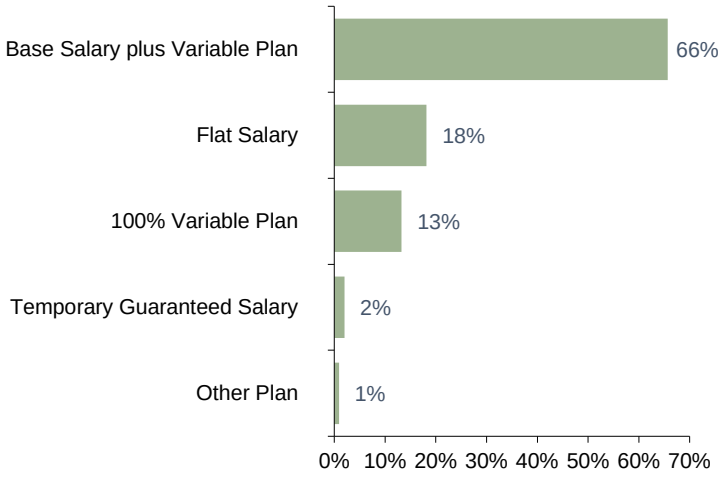
Figure 1.4: Median WRVUs by Clinical Focus Area



E. Clinical Physiatrist Compensation Plan Design

Of the 650 responding physiatrists, 513, or approximately 79%, are paid under a 100% variable plan or a base salary plus variable plan. The most prevalent compensation plan type is the base salary plus variable plan, with 66% (427) of physiatrists being compensated under this method, while 18% of physiatrists are paid under a flat salary plan (118).

Figure 1.5: Percentage of Clinical Physiatrists by Type of Compensation Plan



Each of the 513 physiatrists who indicated they are paid under a 100% variable plan or a base salary plus variable plan was asked to provide a breakdown of the percentage of their total compensation that was considered fixed versus variable, and 354 physiatrists were able to provide this data. For these physiatrists, on average, 43.8% of total compensation is variable. The percentage of total compensation that is fixed averaged 56.2%.

Based on the data from the 354 physiatrists who provided a fixed-versus-variable breakdown of their total compensation, a variety of indicators used to calculate variable compensation were identified. As shown in table 1.1, 37% of physiatrists indicated that WRVUs are used, making it the most common measure in variable compensation plans. Across all physiatrists providing this data, on average, 13.2% of total compensation is derived from WRVU production. While the proportion of physiatrists reporting that quality measures are used in their plan was 20%, the percentage of total compensation tied to quality metrics averaged just 1.0%.

Table 1.1: Performance Indicators in Variable Compensation Plans of Clinical Physiatrists

Indicator	Percentage of Clinical Physiatrists Utilizing Indicator	Average Percentage of Total Compensation
WRVUs	37%	13.2%
Revenue Less Expenses	23%	12.3%
Quality	20%	1.0%
Net Professional Collections	17%	7.6%
Other Nonproduction-Based Indicators	13%	0.7%
Other Production-Based Indicators	12%	1.2%
Organization Profitability	12%	1.6%
Education/Academic RVUs	9%	0.4%
Total RVUs (TRVUs)	8%	3.1%
APP Supervision Stipend	4%	0.4%
Provider Profitability	4%	0.8%
Gross Professional Charges	3%	1.5%
TOTAL		**43.8%**

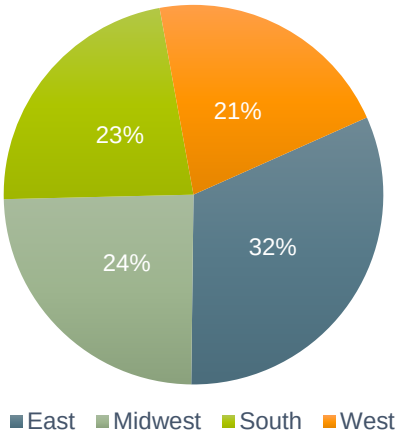
A total of 293 (83%) physiatrists report having either one or two indicators used in their variable compensation plan, while 61 (17%) report having three or more indicators. Thus, on average, 1.6 indicators are used in variable compensation plans.

F. All-Physiatrist Demographics

In aggregate, 91% of the 841 physiatrists reported they are members of AAPM&R, and 9% are nonmembers. The average age of the responding physiatrist is 44.9 years, and a majority (63%) of the responding physiatrists are male, while 36% are female (1% indicated they would rather not report their gender). The average number of years of experience is 12.0 years (including those that finished their residency in 2016).

As demonstrated in figure 1.6, the distribution of responding physiatrists by region is well balanced, with the largest proportion (32%) practicing in the East region. The Midwest region represents 24% of physiatrists, the South region represents 23%, and the West region contains the remaining 21% of physiatrists in the survey.

Figure 1.6: Percentage of Physiatrists by Region



Less than half (43%) of the responding physiatrists reported they have completed or are completing a fellowship. Of these physiatrists, the average number of fellowships is 1.2 per physiatrist. The most common fellowships were programs in spine/interventional spine (non-ACGME-approved), reported by 23.1% of responding physiatrists; pain medicine (ACGME-approved) reported by 22.5%; and sports medicine (ACGME-approved) reported by 20.0% of physiatrists.

* * * * * *

If you have any questions about this report, please contact Angie Collins at 314-726-2323 or via email at acollins@ecgmc.com. Questions for AAPM&R can be directed to the Academy by calling 847-737-6000 or emailing info@aapmr.org.

aaPM&R

American Academy of
Physical Medicine and Rehabilitation

Physicians Adding Quality to Life™

9700 W. Bryn Mawr Avenue, Suite 200
Rosemont, IL 60018-5701
phone 877/AAPMR 99
info@aapmr.org
www.aapmr.org