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Is 75th Percentile Compensation Safe? A Look at the New Definition of FMV and Its Applicability to Survey Data

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Amidst the backdrop of an already competitive and highly regulated environment, health systems are facing challenges from the convergence of the coronavirus pandemic, the new final rules under the Stark Law and Anti-Kickback Statute (AKS), and the financial impact from the 2021 Medicare physician fee schedule (Medicare PFS). Within this context, the number of healthcare transactions is expected to rise and return to pre-pandemic levels in 2021.[1] This means compliance teams will have to manage an increasing number of transactions, including but not limited to acquisitions, professional services arrangements, and physician employment agreements. As part of the compliance process, many of these transactions will be reviewed against compensation thresholds to establish fair market value (FMV) support. Given the importance of FMV to satisfying exceptions and navigating safe harbors, the determination of these compensation thresholds is of utmost importance.[2]

To establish these FMV thresholds, many health systems have relied on compensation survey data at particular percentiles. The 75th percentile is a common threshold used. However, is a single FMV threshold at the 75th percentile relevant and comparable to all subject transactions within the health system? It depends. The anticipated increase in transaction activity coupled with new regulatory guidance presents a good opportunity for compliance teams to delve into this question and re-evaluate their FMV process. Specifically, this piece will examine the definition of FMV as stipulated in the final rule, review the applicability of survey data at the 75th percentile based on the subject transaction, and provide recommendations for the appropriate use of surveys in deriving FMV.

Redefining FMV to Be Specific to the Subject Agreement

The term fair market value has been statutorily defined in Section 1877 (h)(3) of the Social Security Act. This definition has been incorporated into the regulations[3] with various modifications through the years to increase clarity. Despite the Centers for Medicare & Medicaid Services' (CMS') attempts to clarify the definition of FMV, health systems and compliance teams have still been left with questions and ambiguity surrounding the determination of FMV and its application to transactions.

On November 20, 2020, CMS announced the new final rules under the Physician Self-Referral "Stark" Law and AKS in an attempt to modernize the regulations and remove "unnecessary obstacles" to value-based arrangements.[4] Within these rules, CMS redefined FMV to be the value in an arm's-length transaction, consistent with the general market value of the subject transaction. With respect to compensation for services, general market value is now defined as the compensation that would be paid at the time the parties enter into the service arrangement as the result of bona fide bargaining between well-informed parties that are not otherwise in a position to generate business for each other.[5]

In redefining FMV, CMS provided some useful commentary and insight into its thoughts on determining the FMV range for a transaction.

- "We continue to believe the fair market value of a transaction—and particularly, compensation for physician services—may not always align with published valuation data compilations, such as salary surveys. In other words, the rate of compensation set

forth in a salary survey may not always be identical to the worth of a particular physician's services."

- "It is not CMS policy that salary surveys necessarily provide an accurate determination of fair market value in all cases. . . . Consulting salary schedules or other hypothetical data is an appropriate starting point in the determination of fair market value, and in many cases, it may be all that is required. . . . In our view, each compensation arrangement is different and must be evaluated based on its unique factors." As an example, CMS indicated that securing a sought after physician with a unique skillset may warrant a compensation level higher than typically expected for the specialty in the particular geographic area. On the flip side, hospitals that may be in a more tenuous economic state need not feel compelled to pay higher than financially prudent simply because salary surveys would suggest such a payment.
- For these reasons, CMS declined to establish a bright line rule based on a particular survey percentile. Specifically, CMS' policy of determining appropriate compensation is not based on salary data at or below the 75th percentile, nor is it outside of FMV range for compensation set above the 75th percentile.

So, Is 75th Percentile Safe? It Depends.

The concepts of validity and reliability in statistics may help answer the question. When reviewing compensation transactions, validity pertains to the extent to which the survey data is relevant to the subject transaction and reliability reflects the consistency of the results. While survey data provides valuable information, the appropriate application to each subject transaction is crucial. The importance of reviewing each transaction in the context of its unique factors is affirmed in CMS' commentary above and consistent with the standards of valuation practice.[6]

To assess the validity and reliability of utilizing the 75th percentile as a compensation threshold for FMV, compensation data from the Medical Group Management Association (MGMA) 2020 Provider Compensation Survey[7] was analyzed. The analysis herein will review the relationship between compensation, production levels, and various transaction defining categories as reported in the survey.

First, national compensation data will be reviewed utilizing a pay to production plotter that illustrates each physician's compensation along with their respective productivity in terms of Work Relative Value Units (wRVUs) and professional collections.[8] Rather than reviewing compensation or productivity metrics in isolation, this graphical representation will show physicians at the same compensation level yet generating widely variable production levels.

Second, compensation data will be isolated based on the following factors: (1) compensation term, (2) geographic region, (3) service area population size, and (4) use of advanced practice providers. Compensation levels within each of these categories were then compared against each other as well as against the national data set. The greater the variability found through parsing out the data into different subsets, the less relevant a universal 75th percentile threshold is in determining FMV for a specific transaction.

Compensation to Production Plotter—Variances in wRVUs and Professional Collections

Production performance has been a widely accepted correlate to physician compensation. In fact, most physician compensation plans contain a production-based component.[9] Even as health systems begin to shift their compensation design away from production toward value-based arrangements, production performance will continue to be a material driver in physician compensation. To what extent does a physician's wRVUs or professional collections drive compensation in the surveys?

To answer this question, note Figures 1 through 3.[10] These figures illustrate physician compensation to wRVU production on a plotter graph for family medicine, non-invasive cardiology, and general surgery.

Figure 1: 2019 Family Medicine (without OB) compensation and work RVU production plotter

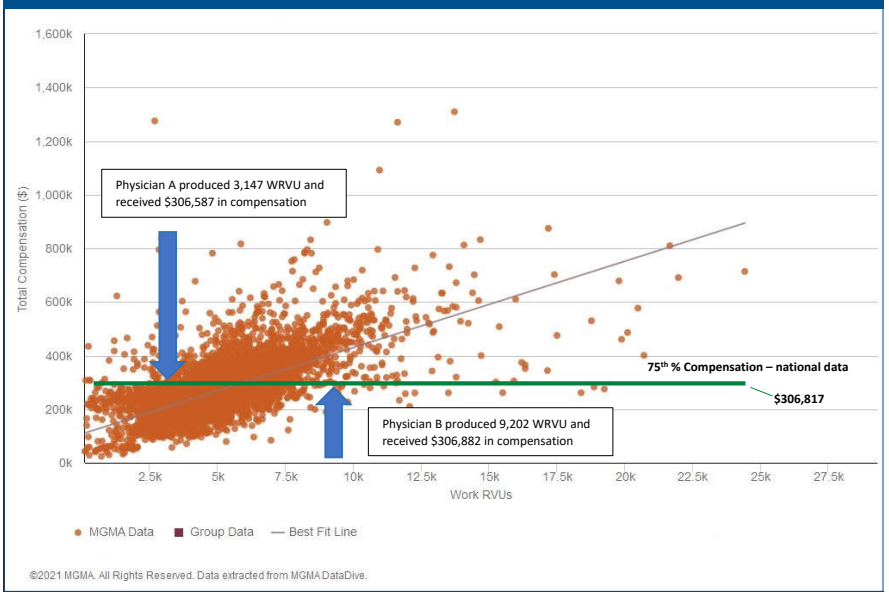


Figure 2: 2019 Cardiology: Non-Invasive compensation and work RVU production plotter

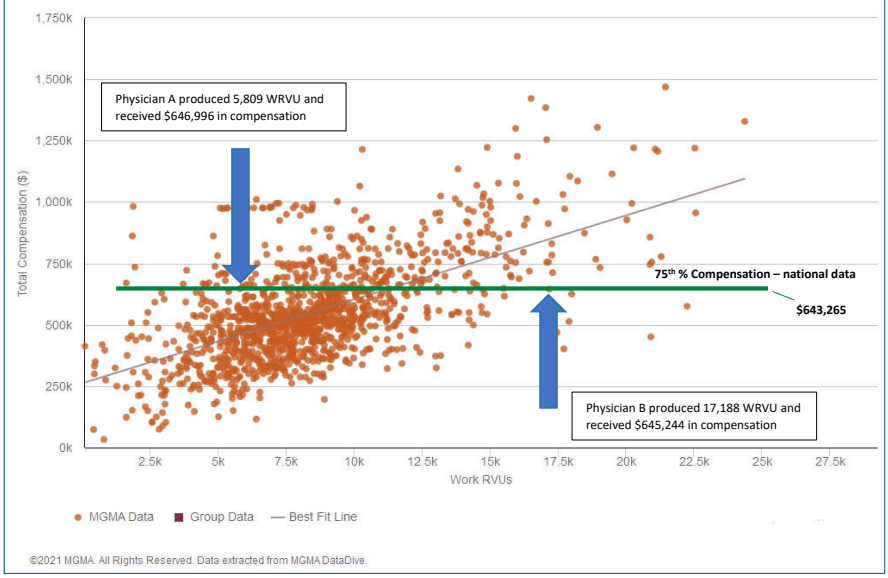
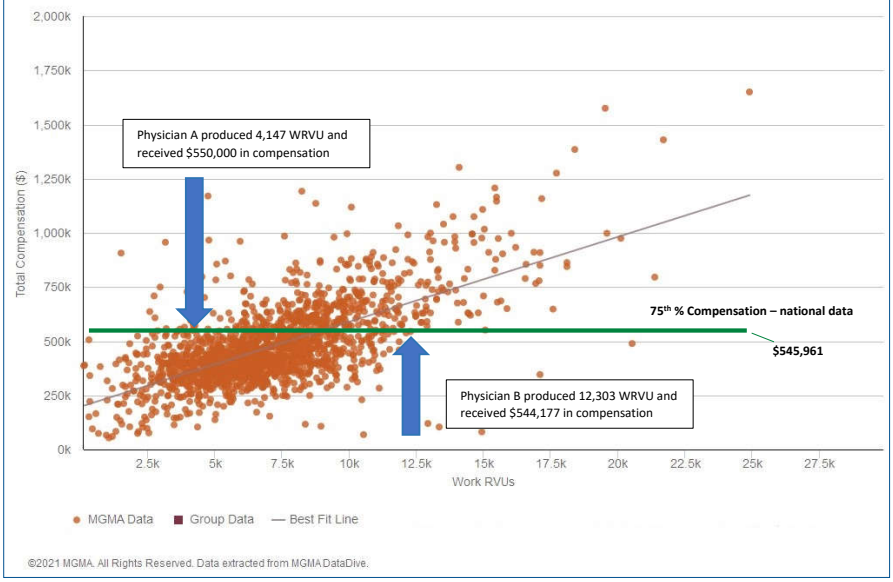


Figure 3: 2019 Surgery: General compensation and work RVU production plotter



Each point represents a specific physician's compensation and their corresponding wRVUs.[11] Note the variability in wRVU production across the graphs for each specialty along with a line corresponding to 75th percentile compensation. Specifically, the figures highlight a particular data point as Physician A and a second data point as Physician B.[12] Table 1 provides the variance in terms of wRVU production for each physician within each specialty. The difference in level of production between Physician A and Physician B is significant with Physician B generating approximately three times that of Physician A, yet both are compensated at approximately the 75th percentile.

Table 1: 75th percentile compensation based on wRVU production			
Physician Specialty	**Physician A wRVU Production[1]**	**Physician B wRVU Production[2]**	**Variance**
Family Medicine	3,147	9,202	6,055
Non-Invasive Cardiology	5,809	17,188	11,379
General Surgery	4,147	12,303	8,156

Note: 1. Represents 1 standard deviation below from the best-fit line generated by the linear regression.
2. Represents 1 standard deviation above from the best-fit line generated by the linear regression.

Table 2: 75th percentile compensation based on professional collections			
Physician Specialty	**Physician A Professional Collections[1]**	**Physician B Professional Collections[2]**	**Variance**
Family Medicine	$188,265	$1,023,588	$835,323
Non-Invasive Cardiology	$322,083	$1,527,521	$1,205,438
General Surgery	$295,235	$1,156,975	$861,740

Note: 1. Represents 1 standard deviation below from the best-fit line generated by the linear regression.
2. Represents 1 standard deviation above from the best-fit line generated by the linear regression.

Table 3: 75th percentile compensation based on compensation terms				
Physician Specialty	**100% Salary Compensation**	**50% or more Salary plus Quality Bonus**	**100% Production Compensation**	**Total Physician Sample**
Family Medicine	$283,648 (n=2,105)	$296,169 (n=1,364)	$310,417 (n=844)	$306,817 (n=8,848)
Non-Invasive Cardiology	$585,250 (n=394)	$635,267 (n=294)	$620,031 (n=67)	$643,265 (n=1,642)
General Surgery	$500,001 (n=447)	$574,209 (n=321)	$584,908 (n=134)	$545,961 (n=2,078)

Similar data can be found when using professional collections as the productivity metric versus wRVUs. In Table 2, notice the wide range of professional collections under each specialty for those physicians compensated at approximately the 75th percentile.

This production level variance would suggest that there are potentially unique circumstances, specific agreement terms, and/or particular physician characteristics for each of those subject transactions that impact value and yield 75th percentile compensation. The next sections will explore other differentiating metrics like compensation terms, geographic region, service area population size, and use of advanced practice providers (APPs).

Compensation Terms—Salary vs. Production-Based

Compensation terms can vary widely amongst physician transactions and will continue along this trend with the increase in value-based arrangements. However, for the purpose of this analysis, we are using the following compensation term categories set by MGMA: 100% salary compensation, 50% or more salary plus quality bonus, and 100% production compensation.[13]

Table 3 reflects the 75th percentile physician compensation based on compensation terms.

Table 4: 75th Percentile compensation based on geographic region					
Physician Specialty	**Eastern**	**Midwest**	**Southern**	**Western**	**Total Physician Sample**
Family Medicine	$288,939 (n=1,212)	$301,059 (n=3,028)	$323,338 (n=2,151)	$310,332 (n=2,457)	$306,817 (n=8,848)
Non-Invasive Cardiology	$571,493 (n=571)	$665,111 (n=468)	$720,455 (n=369)	$585,250 (n=234)	$643,265 (n=1,642)
General Surgery	$482,000 (n=367)	$593,738 (n=660)	$559,159 (n=582)	$518,294 (n=469)	$545,961 (n=2,078)

Table 5: 75th Percentile compensation based on service area population size					
Physician Specialty	**Nonmetropolitan Area: 49,999 or fewer**	**Metropolitan Area: 50,000 to 249,999 in population**	**Metropolitan Area: 250,000 to 999,999 in population**	**Metropolitan Area: 1,00,000 or more in population**	**Total Physician Sample**
Family Medicine	$299,708 (n=320)	$306,888 (n=1,028)	$319,863 (n=2,135)	$303,803 (n=5,195)	$306,817 (n=8,848)
Non-Invasive Cardiology	$559,208 (n=28)	$625,256 (n=224)	$629,192 (n=421)	$662,977 (n=949)	$643,265 (n=1,642)
General Surgery	$516,586 (n=108)	$557,401 (n=368)	$565,795 (n=484)	$538,616 (n=1,050)	$545,961 (n=2,078)

Table 6: 75th Percentile compensation based on use of advanced practice providers				
Physician Specialty	**Physician only**	**Fewer than 1 APP per Physician**	**1 or More APPs per Physician**	**Total Physician Sample**
Family Medicine	$284,747 (n=431)	$309,444 (n=7,477)	$303,661 (n=637)	$306,817 (n=8,848)
Non-Invasive Cardiology	$549,976 (n=80)	$663,391 (n=1,313)	$592,875 (n=190)	$643,265 (n=1,642)
General Surgery	$537,941 (n=224)	$552,655 (n=1,588)	$558,216 (n=180)	$545,961 (n=2,078)

Table 3 illustrates a significant variance as you move along the continuum from 100% salary compensation to 100% production compensation, with physicians who are salaried receiving between 5% and 15% less than their counterparts whose compensation are based on production only.

In isolation, the variances shown on Table 3 would suggest that the specific compensation terms for the subject transaction shapes the resultant compensation at the 75th percentile. In other words, health systems may need to consider compensation terms and their impact on their overall FMV analysis for the subject transaction.

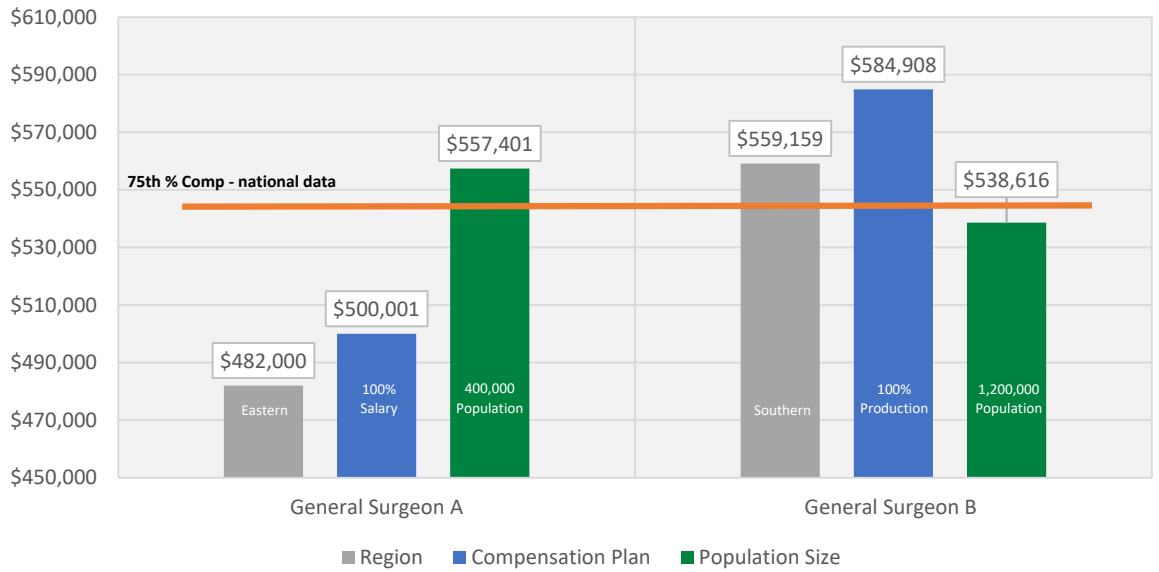
Geographic Region

The economics of physician compensation in terms of operating expenses, reimbursement, and physician supply varies by geographic location. As such, health systems utilizing the 75th percentile compensation for the purposes of determining FMV should consider adjusting the data for any differences specific to the practice's geographic location. Using national data could result in a material difference above or below the regional data. For the purposes of this analysis, the following regions were utilized based on MGMA: Eastern, Midwest, Southern, and Western.[14]

Table 4 reflects the 75th percentile physician compensation based on geographic region.

While some specialties may not have as significant of a swing across regions, others may. For instance, non-invasive cardiology shows a variance of approximately 25% from the region with the lowest compensation to the region with the highest. Caution should be taken, however, as data gets parsed even further down to the state level. Not only can the sample size drop to a level that would question its statistical significance, particular cities with higher than average compensation may begin to have a greater impact on the statewide figures (i.e. New York City MSA data versus the state of New York).

Figure 4: Comparison between 2 physician transactions and the 75th percentile MGMA compensation national data



Service Area Population Size

Determining physician compensation based on the population size in their service area is complex and multi-factorial. Challenges to recruitment, cost of living, proximity to services, etc. are but a few of the service area factors to consider when determining the FMV for a physician compensation transaction. For the purposes of this analysis, the following population sizes were utilized based on MGMA[15]: nonmetropolitan area (population of 49,999 or fewer), metropolitan area (population of 50,000 to 249,999), metropolitan area (population of 250,000 to 999,999), and metropolitan area (population of 1,000,000 or more).

Table 5 reflects the 75th percentile physician compensation based on service area population size.

The data in Table 5 does not show a significant change in physician compensation at the 75th percentile based solely on the population size, except for non-invasive cardiology. However, it should be noted that the variance is largely due to the compensation reported by only 28 physicians located in a nonmetropolitan area. A sample size at this level may not be statistically significant.

In addition, the compensation data alone may not tell the full story. For instance, physicians reporting in a nonmetropolitan service area reported wRVUs at approximately 10% lower than physicians in service areas with a higher population. This resulted in a higher compensation to wRVU rate for those physicians in the nonmetropolitan services area. Physicians in the nonmetropolitan service areas may also be more likely to cover a greater number of days on emergency room call or perform additional administrative services. As such, it is imperative that health systems review these nuances to the subject transaction when trying to determine FMV.

Use of Advanced Practice Providers

APPs are increasing in number within the U.S. healthcare system and are commonly used across most specialties.[16] The pandemic has resulted in expanded regulatory flexibility surrounding the use of APPs in terms of required physician supervision, reimbursement, and scope of practice.[17,18] For the purposes of this analysis, the following MGMA[19] categories were used regarding APP utilization: physician only, fewer than one APP per physician, and one or more APPs per physician.

Table 6 reflects the 75th percentile physician compensation based on use of APPs.

The data in Table 6 shows a general trend toward increased compensation for physicians in practices that utilize APPs versus those relying only on physicians. Physician transactions including compensation for APP supervision are material to determining FMV for the subject transaction. Care should be taken when considering the value of the supervision with respect to a multitude of factors including, but not limited to, the ability to stack supervision compensation on top of a physician's base guarantee as well as the impact of APP utilization on eligible wRVUs for a physician's production bonus.

Combining Multiple Factors and Impact on Physician Compensation

Tables 1-6 isolated the impact to physician compensation based on various categories separately. Many of the surveys will contain other characteristics such as years in practice, ownership type, or annual hours worked. When reviewing an actual subject transaction, the unique factors that set the transaction apart will often include multiple components that will influence the FMV results. For example, Figure 4 illustrates the 75th percentile compensation for two distinct physician transactions.

The figure highlights the 75th percentile compensation for General Surgery based on the national data. The health system employing General Surgeon A based on 100% salary is in a city located in the eastern region of the United States with a population size of 240,000. The health system employing General Surgeon B based on 100% production is in a city located in the southern region of the United States with a population size of 1,200,000. Reviewing the 75th percentile compensation based on region, compensation plan, and population size in isolation shows that the health system employing General Surgeon A may overstate FMV if they rely solely on the 75th percentile compensation from national data. Whereas the health system employing General Surgeon B may understate FMV if they rely on the national data only. As a result, this underscores the need for health systems to not solely rely on national data, but to consider the relative impact from the facts and circumstance of each subject transaction.

Recommendations for Rethinking Use of Surveys in the FMV Process

The analyses above are illustrative of the importance of understanding the appropriate application of survey data. To mitigate FMV compliance risk, it is recommended that compliance teams consider using surveys as a starting point in the analysis, contemplate using multiple surveys, and analyze factors that may impact the comparability of the survey data.

Use Surveys as a Starting Point in the Analysis

The use of surveys has been and continues to be an integral part of establishing FMV. The variances shown do not disqualify the use of survey data as a legitimate source in determining FMV but emphasize the importance of using it within the context of the subject transaction. Recall the CMS commentary regarding the importance of "evaluating each transaction based on its unique factors" along with the fact that FMV should not be set at or below a particular survey percentile.

From these comments, CMS' intention is clear in stating that a particular survey percentile does not reflect FMV. Although the Stark Law provided for a brief period an hourly rate threshold as a safe harbor for FMV, this comment provides health systems the flexibility to compensate above particular percentiles if the subject transaction warrants it through the FMV process.

The FMV process should analyze the transaction and review the survey data within the context of the subject transaction. Some unique factors to consider are as follows:

a. Compensation terms
    - » What portion of the compensation is based on salary, production, quality, emergency call, graduate medical education, etc.?

b. Provider-specific characteristics
    - » Are there factors that separate out this physician from her peers (i.e. training, skillset, and thought leadership)?

c. Position-specific requirements
    - » What is needed of the physician to fulfill the requirements of the position (i.e. hours worked, student teaching, and nights/weekends)?

d. Geographic-specific factors
    - » What are the local geographic circumstances where the physician will practice that may influence value (i.e. cost of living, housing market, school systems, and the availability of other services)?

e. Employer considerations
    - » Will the transaction include a value-based arrangement and is it commercially reasonable given the size, scope, and specialty involved?

Reviewing each transaction through the lens of the influencing categories above will have the greatest chance of leading to a valid and reliable FMV result.

Contemplate Using Multiple Surveys

While many health systems use one survey for their internal FMV process, the use of multiple surveys may provide a larger sample size for benchmarking as well as potentially more comparable data relevant to the subject transaction. This is consistent with CMS' statement on "[referencing] multiple, objective, independently published salary surveys [as] a prudent practice for evaluating fair market value."[20]

It is important, however, for health systems to understand some of the differences between the surveys that may involve how compensation and other metrics are defined as well as the variability regarding the characteristics of the physician respondents in terms of practice ownership, degree of academic practice, single versus multi-specialty practice, and/or practice group size. For instance, in terms of group size, 88% of the physician groups that reported to the 2020 MGMA Provider Compensation survey were comprised of ten physician FTEs or less,[21] while 74% of the physician groups that reported to the American Medical Group Association (AMGA) 2020 Medical Group Compensation and Productivity Survey[22] consisted of 151 or more physician FTEs. As for SullivanCotter's 2020 Physician Compensation and Productivity Survey Report, 62% of the respondents had an academic affiliation,[23] when compared to only approximately 20% of the respondents to MGMA in 2020.

As a result, utilizing multiple surveys appropriately may increase the applicability of the benchmark data to the subject transaction.

Analyze Factors That May Impact the Comparability of the Survey Data

Year-over-year changes to compensation, wRVUs, collections, and other metrics within the surveys do occur with varying degrees of significance. Policy changes can occur that impact some or many of the metrics reported in the surveys for a particular specialty. For instance,

a. *COVID-19 pandemic*—The challenges associated with the pandemic will have a material impact on surveys published in 2021. Specifically, patient volumes fluctuated in 2020 associated with, but not limited to, the stay at-home orders, telehealth services, and restrictions on elective surgeries. As a result, this may have a disproportionate impact on wRVUs versus physician compensation to the extent that health systems and physician practices continued to maintain the same level of physician compensation. In addition, collections reported for 2020 may also be impacted by the pandemic relief programs targeting

health systems and physician practices. All of these factors will affect benchmark metrics including total compensation, wRVUs, and collections as wells the resultant comp:wRVU and comp:collection ratios.

b. *2021 Medicare PFS*—The 2021 Medicare PFS changes will have a significant impact on the comparability to surveys this year and into next. Specifically, wRVU values for office and other outpatient services evaluation & management codes have increased by 7% to 13% amongst new patient office visit codes 99202-99205 and by 28% to 46% amongst established patient office visit codes 99212-99215.[24] For health systems utilizing the 2021 Medicare PFS, the calculated 2021 wRVUs will not be comparable to wRVUs reported in the 2021 surveys based on 2020 data. Collections will also be impacted at a lesser rate based on the 3.3% decrease to the Medicare conversion factor as well as each physician practice's procedure code volume and payor mix.[25]

c. *Specialty-specific market changes*—Other isolated changes to particular specialties have occurred through the years. Cardiology represents one example of a significant shift within a specific specialty. With the reduction in reimbursement for in-office imaging services in 2005 from the Deficit Reduction Act, a significant shift ensued away from private practice. Private practice cardiologists represented 73% of the total in 1998 before dropping to 23% just 20 years later.[26] This shift to employment resulted in a steady overall increase in cardiology compensation reported in the surveys.[27] A more recent example can be seen in the change in endoscopic sinus surgery (ESS) codes that were bundled in the 2018 Medicare PFS. This resulted in a drop in collections ranging from -7.9% to - 23.6%.[28] These examples illustrate the fact that market forces specific to certain specialties need to be accounted for year over year.

For the purposes of ensuring comparability, compliance teams may need to normalize the subject transaction data and/or benchmark against multiple survey years. The methods used to normalize the data will vary dependent on the specific circumstances impacting the benchmark data for the subject transaction.

Conclusion

Given the volume of transactions along with the continued importance of the compensation surveys, health systems will continue to utilize survey data in establishing protocols and determining their internal FMV compliance processes. In doing so, compliance teams should not only consider survey data at particular percentiles, but the FMV process itself by which each subject transaction is analyzed and benchmarked against those surveys. In short, this process should be comprehensive and consistent.

Compliance teams should document each subject transaction's compensation terms, provider-specific characteristics, position-specific requirements, geographic-specific factors, and any other employer considerations. These unique factors will inform the quantitative analysis and result in utilizing the appropriate survey data for benchmarking purposes.

The FMV process requires consistency across transactions in order to increase the reliability and validity of the results. These steps should be written as policy identifying the steps to take in determining FMV. Any departures from the normal process should highlight the distinguishing characteristics of the physician or transaction that warrants the deviation.

So, choosing the 75th percentile compensation as the FMV compensation threshold is potentially possible, however, it needs to be contextualized by the subject agreement, supported through a relevant and comparable benchmark analysis, and documented accordingly.

Endnotes

1 Hackett, M., *Healthcare M&As down in 2020 but analysts say COVID-19 is a catalyst for future deals,* Healthcare Finance (Jan. 14, 2021), https://www.healthcarefinancenews.com/news/healthcare-mas-down-2020-analysts-say-covid-19-catalyst-future-deals.

2 We recognize the importance of establishing commercial reasonableness when evaluating value-based arrangements, however, the scope for this piece is establishing FMV and will be the focus of the analyses in this article.

3 42 C.F.R. § 411.351.

4 83 Fed. Reg. 29524.

5 42 C.F.R. § 411.351.

6 National Association of Certified Valuators and Analysts (NACVA) Professional Standards (June 1, 2017), https://s3.amazonaws.com/web.nacva.com/TL-Website/PDF/NACVA_Professional_Standards_Incl_Review_Stnds_Effective_6-1-17_Final.pdf.

7 2020 MGMA DataDive Provider Compensation based on 2019 data. This survey was chosen because of its wide use amongst health systems and the ability to breakdown data by specific categories. It is important to note that this data is based on reporting from 2019 prior to the impact of the pandemic.

8 Only physicians who reported both compensation and wRVUs/professional collections are reflected in the plotter graph.

9 2020 MGMA DataDive Provider Compensation based on 2019 data.

10 Data republished with permission. © 2021 MGMA. All rights reserved. www.mgma.com/data.

11 For this analysis, we are assuming that all reported compensation for each physician is within FMV.

12 To standardize the analysis, the physician data points chosen along the 75th percentile compensation were based on onestandard deviation above and below the best-fit line as determined by linear regression.

13 2020 MGMA DataDive Provider Compensation based on 2019 data.

14 *Id.*

15 *Id.*

16 "NP Fact Sheet," American Association of Nurse Practitioners (updated Aug. 2019), http://bit.ly/2wwCVir.

17 Fraher, E.P., Pittman, P., Frogner, B.K., et.al. "Ensuring and sustaining a pandemic workforce," New England Journal of Medicine, Vol. 382, 2181-2183 (2020).

18 Centers for Medicare & Medicaid Services, "COVID-19 emergency declaration blanket waivers for health care providers," https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf.

19 2020 MGMA DataDive Provider Compensation based on 2019 data.

20 85 Fed. Reg. 232.

21 2020 MGMA DataDive Provider Compensation – Demographics, p. 5, https://data.mgma.com/DataDive/Documents/2019%20Provider%20Compensation.pdf.

22 AMGA 2020 Medical Group Compensation and Productivity Survey based on 2019 data, AMGA Consulting, LLC.

23 SullivanCotter 2020 Physician Compensation and Productivity Survey Report. Survey data effective January 1, 2020. SullivanCotter, Inc.

24 85 Fed. Reg. 248.

25 *Id.*

26 Lewis, S.J. et al. Journal of American College of Cardiology, 69(4): 452-462 (2017,) https://www.sciencedirect.com/science/article/pii/S0735109716371157#tbl1.

27 2019 MedAxiom Cardiovascular Provider Compensation and Production Survey.

28 American Academy of Otolaryngology-Head and Neck Surgery. CY 2018 Medicare physician fee schedule (MPFS): What does it mean for you? Bulletin, (Nov. 6, 2017), https://bulletin.entnet.org/home/article/21247183/cy-2018-medicare-physician-fee-schedule-mpfs-what-does-it-mean-for-you.

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