

ASMBS Compensation and Practice Style Survey

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Introduction

Nationally more physicians are becoming employed. This trend has been especially strong in the field of bariatric surgery. It is likely due to the significant programmatic requirements including staffing and overhead to maintain a comprehensive bariatric center of excellence. In combination with the resources to provide lifelong follow up and support for the treatment of the disease of obesity, it has become necessary for many bariatric surgeon to move into a partnership with hospitals or an employed model.

As more surgeons enter employed contracts, discussions regarding compensation usually center on national or regional benchmarks. There has been very little data about compensation of bariatric surgeons. The most commonly used sources included the MGMA and the AMGA. These groups use surveys with the hospitals and medical groups that are members. The data from these surveys has been sparse and not necessarily representative of the field of bariatric survey. For example the 2010 MGMA survey results included only 24 respondents, the 2011 AMGA report had 23 respondents. MGMA and AGMA models have been inadequate in the past and do not take into account specialized bariatric surgeons vs. general surgeons also involved in bariatrics.

As many employers seek to set the benchmarks for surgeons at the 50th percentile, there will be a continual gradual decline in compensation in the field as a whole as there are such a large percentage of surgeons now in an employed model.

This survey of ASMBS members was structured to obtain data to better describe the membership of the ASMBS. The goal was to obtain more valid data regarding compensation models, amounts, and practice environment. This would be able to be used by the membership during contract negotiations. It would be useful for new fellows starting in practice to have an idea of what the future may look like for their career. It would be useful for the leadership of the ASMBS to better understand the composition and diversity of the membership to best serve the needs of the membership.

Methods

Two separate survey instruments were developed; one for hospital based physicians and one for private practice physicians. The surveys were designed to assess practice patterns and compensation patterns among the two groups. Survey questions can be found in Appendix A.

The online survey tool SurveyMonkey (Palo Alto CA.) was used to create and administer the surveys. The surveys were delivered to all ASMBS members via an electronic mail message containing a link that would direct the member to the survey. The survey was sent a total of 3 times across the survey administration time period of March – April, 2012.

Survey responses were downloaded into Excel for preliminary analyses after which they were imported into SPSS v20 (IBM Corp. Released 2011. IBM SPSS Statistics for Windows, Version 20.0. Armonk, NY: IBM Corp). Irregularities in the data resulted in the decision to exclude 9 respondents from the compensation analyses for the hospital employed physicians.

These 9 respondents all reported an annual salary of less than \$200,000. By any national measure this income level is low enough to question its validity.

Results

Hospital Employed Surgeons

Demographics. A total of 124 hospital employed surgeons responded to the survey. The data from 7 surgeons was excluded as 4 were employed part-time and 3 were non-US residents. The respondents represented 37 states with 41% of the respondents from the Northeast, 27% from the South, 25% from the Midwest, and the remaining 7% from the West. 59% of the surgeons completed a fellowship with MIS or bariatrics.

Clinical Practice. The practice environments for the majority of the surgeons were either academic (42.6%) or multi-specialty groups (34.3%). With respect to percentage of time dedicated to bariatric surgery, 38% of the surgeons reported more than 80% of their time dedicated to bariatric surgery, 35% reported 0-50% of their time dedicated to bariatric surgery, and 27% reported 51-80% of their time dedicated to bariatric surgery.

With respect to Call requirements, all surgeons reported some bariatric call requirements. The median percentage of time the surgeons spent on bariatric call was 50%. 66% of the surgeons reported some general surgery call requirement. The median percentage of time spent on general surgery call was 14%. Only 16% of the surgeons reported having trauma call requirements. The median percentage of time on trauma call was 3%.

Surgical Experience. As can be seen below, after 5 years of practice respondents tended to move into a bariatric surgery specialty.

Years in Practice	Years Bariatric Surgery		
	0-5 years	5-10 years	>10 years
0-5 years	25	0	1
5-10 years	3	20	0
10-20 years	3	15	25
>20 years	0	4	12

Characteristics of Surgeons with >80% of Time Dedicated to Bariatrics. A total of 45 physicians dedicated >80% of their time to bariatric surgery. 66% of these physicians have been in practice 10 or more years and 46% responded having been in bariatric surgery more than 10 years. 49% of the physicians reported being in a faculty practice plan and another 22% were in a multi-specialty group. 63% reported having performed >1000 bariatric surgeries. 49% of the surgeons reported a base salary plus incentive model, 31% reported a straight salary, and 20% reported a production model.

Volume. As can be seen in the table below, the majority of the hospital employed physicians (56.6%) dedicated at least 50% of their time to bariatric surgery. Approximately one-third of these physicians performed >1000 bariatric surgeries and almost half performed 150-1000 bariatric surgeries. Volume of surgeries seemed to increase as time dedicated to bariatric surgery increased however this pattern was not robust.

Time Dedicated to Bariatric Surgery	Number Surgeries Performed				
	<50	50-150	150-500	500-1000	>1000
<20%	0.8%	5.0%	0.8%	0.0%	0.8%
21-50%	1.6%	4.1%	10.7%	8.3%	2.5%
51-80%	0.8%	3.3%	6.6%	9.1%	8.3%
>80%	0.8%	1.6%	5.8%	5.8%	23.1%

Compensation. As can be seen in the table below, the mean compensation for all hospital employed physicians in 2011 was \$419,103 with retirement contributions of \$38,161. The first tier RVU was \$51 with and incentive threshold of 5,562 RVU.

Among hospital employed physicians who dedicate >80% of their time to bariatrics, the mean in 2011 was \$445,314 with retirement contributions of \$49,821. The first tier RVU was \$50 with and incentive threshold of 6,003 RVU.

All	Compensation 2011	Retirement 2011	WRVU 1 st tier	Incentive Start RVU	
Overall N=108	N=100	N=79	N=27	N=21	
Mean	\$419,103	\$38,161	51	5,562	
Std. Dev.	\$169,872	\$40,489	9	2,423	
Minimum	\$190,000	\$1,760	41	460	
Maximum	\$1,050,000	\$330,000	81	9,600	
Percentiles	20 th	\$286,110	\$16,500	42	3,110
	50 th	\$360,000	\$30,000	50	6,200
	75 th	\$497,500	\$45,000	55	7,000
	90 th	\$630,358	\$60,000	65	7,900

>80% Bariatrics	Compensation 2011	Retirement 2011	WRVU 1 st tier	Incentive Start RVU	
Overall N=41	N=35	N=28	N=12	N=8	
Mean	\$445,314	\$49,821	50	6,003	
Std. Dev.	\$173,965	\$62,004	9	2,305	
Minimum	\$225,000	\$5,000	41	580	
Maximum	\$1,000,000	\$333,000	66	8,000	
Percentiles	20 th	\$329,200	\$21,600	42	4,996
	50 th	\$400,000	\$33,500	50	6,225
	75 th	\$520,000	\$50,000	58	7,425

	90 th	\$674,000	\$91,500	65	
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Production. Production levels were calculated based on respondent's comments that incentive start levels were based on 50th percentile production RVU levels by hospitals.

Bariatric Specialists >80% time dedicated to bariatric surgery n=35			
2011			RVU
Mean comp	445,314.29		6003.75
Median	400,000		6225
20 th	329,200		5123.735
50 th	400,000		6225.681
75 th	520,000		8093.385
90 th	674,000		10490.27

All Hospital employed n=100			
2011			RVU
Mean comp	419,103.96		5562.24
Median	360000		6200
20 th	286110		4453.074
50 th	360000		6196.213
75 th	497500		8562.823
90 th	630358		10849.54

Private Practice Surgeons

Demographics. A total of 108 private practice surgeons representing 35 states responded to the survey. The respondents represented 35 states with 41% of the respondents from the Northeast, 27% from the South, 25% from the Midwest, and the remaining 7% from the West. 38% of the surgeons completed a fellowship with MIS or bariatrics.

Clinical Practice. The majority of the respondents (77%) were the owners of the practice. The legal organization of the practice was either a professional corporation (50%) or an LLC (42%). The practice models were mostly single specialties (46%) followed by solo private (32%).

With respect to percentage of time dedicated to bariatric surgery, 35% of the surgeons reported more than 80% of their time dedicated to bariatric surgery, 33% reported 0-50% of their

time dedicated to bariatric surgery, and 25% reported 51-80% of their time dedicated to bariatric surgery.

Surgical Experience. As can be seen below, private practice respondents tended to move directly into a bariatric surgery specialty.

Years in Practice	Years Bariatric Surgery		
	0-5 years	5-10 years	>10 years
0-5 years	22	2	0
5-10 years	5	15	0
10-20 years	1	8	21
>20 years	0	8	25

Characteristics of private Practice Surgeons with >80% of Time Dedicated to Bariatrics. A total of 38 physicians dedicated >80% of their time to bariatric surgery. 76% of these physicians have been in practice 10 or more years and 63% responded having been in bariatric surgery more than 10 years. 45% of the physicians reported being in a single specialty group practice and another 42% were in a solo private practice. 74% reported having performed >1000 bariatric surgeries. 29% of the surgeons reported an individual compensation model with revenue and expense allocation by partner, 11% reported an equal sharing of practice profits and 24% reported a mixed model with a percentage of profit shared equally and a percentage shared based on production.

Volume. As can be seen in the table below 66.7% private practice physicians dedicated at least 50% of their time to bariatric surgery. Approximately 90% of these physicians performed >1000 bariatric surgeries.

Time Dedicated to Bariatric Surgery	Number Surgeries Performed				
	<50	50-150	150-500	500-1000	>1000
<20%	2.0%	0.9%	4.6%	0.9%	0.0%
21-50%	0.9%	3.7%	6.5%	6.5%	7.4%
51-80%	1.8%	0.9%	4.6%	14.8%	9.3%
>80%	0.0%	0.9%	0.9%	7.4%	25.9%

Compensation.

As can be seen in the table below, the mean compensation for all private practice physicians in 2011 was \$465,632 with retirement contributions of \$47,486.

	Compensation 2010	Compensation 2011	Retirement 2010	Retirement 2011
Overall N=108	N=22	N=102	N=70	N=72
Mean	\$329,272	\$465,632	\$51,542	\$47,486

Std. Dev.		\$90,723	\$289,169	\$70,627	\$40,491
Minimum		\$200,000	\$200,000	\$5,000	\$5,000
Maximum		\$500,000	\$2,200,000	\$600,000	\$300,000
Percentiles	20 th	\$245,600	\$253,741	\$25,000	\$24,600
	50 th	\$315,000	\$420,000	\$44,000	\$44,000
	75 th	\$370,000	\$532,375	\$50,000	\$49,000
	90 th	\$494,000	\$735,000	\$69,000	\$70,700

The table below reports the compensation of all hospital employed and private practice physicians for 2011. In addition, the private practice physicians are stratified into owner and non-owner. This table reveals private practice physicians who are owners have the highest compensation, followed by hospital employed physicians, followed by private practice physicians who are non-owners.

		Hospital Employed	Private Practice owner	Private Practice Non-Owner
		N=108	N=83	N=25
Mean		\$419,103	\$509,297	\$315,652
Std. Dev.		\$169,872	\$309,466	\$118,228
Minimum		\$190,000	\$50,000	\$200,000
Maximum		\$1,050,000	\$2,200,000	\$700,000
Percentiles	20 th	\$286,110	\$318,000	\$229,000
	50 th	\$360,000	\$490,000	\$270,000
	75 th	\$497,500	\$600,000	\$360,000
	90 th	\$630,358	\$772,000	\$480,000

Conclusions:

The membership of the ASMBS is a very diverse group. The respondents of this survey represented 37 states and all regions of the country. They also represent many different practice environments.

The subgroup of employed surgeons is more homogenous than the subgroup of private practice surgeons. The vast majority of employed surgeons are in some type of a group practice. A slight majority were in academic practice with the next largest group in multi-specialty or single specialty. More than half completed a fellowship in Minimally Invasive Surgery or Bariatric Surgery. This stood in contrast to the private practice surgeons in which only one-third completed a fellowship.

We did notice a trend of surgeons moving into the field of bariatric surgery about 10 years ago. This coincides with the maturing of the field into a true specialty and the movement toward Centers of Excellence with an emphasis on quality. In the past 5 years, we see a trend of surgeons entering the specialty of bariatric surgery immediately as they start their practice.

When considering percent time dedicated to bariatric surgery the respondents were fairly evenly split between three groups, the bariatric specialists spending more than 80% of time on bariatrics, those focused on bariatrics with greater than 50% of time spent in bariatrics, and the group who were primarily general surgeons with some involvement in bariatrics less than 50% of the time. Two thirds of the hospital employed group spent more than 50% of their time dedicated to bariatric surgery. Only 9% spent less than 20% of their time doing bariatric surgery.

Bariatric specialists (>80% time dedicated to bariatrics) are more likely to be in academic practice (49%) and are high volume surgeons with 80% having performed more than 500 bariatric surgeries. Two thirds of this group has performed over 1000 bariatric cases. Significant portions are in group practice with very few in solo practices (10%). As a group they spend less amount of time doing non-bariatric call. Only a small percentage of bariatric surgeons as a whole participate at all in trauma call.

The most commonly used compensation model for bariatric specialists is a base salary plus incentive model (usually production incentive). The next most common model is a straight salary model with only 20% reporting a pure production only model. This trend in compensation models was seen throughout the survey.

The mean compensation for all hospital employed surgeons in 2011 was \$419, 103. The mean level of RVU where an incentive began above the base salary was 5,562 RVU's. For those who dedicate >80% of their time to bariatric surgery the mean compensation was \$445,314. The mean level of RVU at which incentive began above the base was 6,003 RVU.

There are extensive pressures for very high quality outcomes and high return on investment (ROI), especially from external stakeholders such as insurance companies and legislators. The only way to achieve these high standards of outcomes is with an extensive amount of programmatic support and follow up care. As we all understand, characteristics of a high quality program include an extensive pre-surgery education and screening, dedicated staff, access to dieticians, exercise physiologists, mental health professionals, ongoing long-term support groups, and close long-term follow up with management of outcomes using databases and continuous quality improvement. The high quality surgical procedure is just one piece of the total care of these patients.

It is likely that the large amount of programmatic work required to run a high quality program is not easily tied to a metric or RVU production number. This would argue against the use of a pure production model that would not incentivize the necessary non significant RVU generation of program development, patient education, quality improvement, and extensive follow up required for the best outcomes in this area of surgery.

For those in private practice there is even greater diversity. Many surgeons joined the bariatric surgery community later in their career. They are much less likely to have completed fellowship or specialty training in MIS or bariatrics with one-third having such training. They are more likely to be in a single specialty group or solo practice. There were fewer respondents in this group with >20 years experience in bariatric surgery. The percentage of time dedicated

to bariatric surgery was again fairly evenly split into thirds between the groups of >80%, >50%, and <50%.

Considerations for those starting out in practice or starting a bariatric practice:

Twenty five percent of the total respondents when combining the private practice and hospital employed surveys have been in practice less than 5 years. The majority (59%) are in a hospital employed setting compared with 41% in private practice. For those who are early in their bariatric experience (29% of the combined survey respondents), essentially the trend was the same with 59% in hospital employed and 41% in private practice. This is also supported by the recent trend of surgeons directly entering bariatric practice immediately at the beginning of their career.

As surgeon's years of experience in bariatric surgery increases, we see a shift toward more specialization. This may be related to a need to supplement a practice with general surgery as volume and experience increases in the early years of practice. Later there is a shift toward a practice more focused in bariatric surgery.

What practice model do they choose?

In private practice only about 10% have a specialization of >80% time dedicated to bariatric surgery during the first 5 years of their career. After 10 years in practice this increased to 76%. In a hospital employed model 26% have a specialization of >80% time dedicated to bariatric surgery during the first 5 years of their career. After 10 years in practice this increased to 50%.

The hospital employed model may allow more surgeons to be bariatric specialists early in their careers. For surgeons with more than 10 years in practice there are more in the private practice environment compared with hospital employed.

Upon inspection of our data, it appears there is a definite trend toward a hospital employed model early and late in bariatric surgeons' career. During the 10-20 years of experience range there are more in private practice and the compensation is higher in private practice. This trend may be related to more security in a hospital employed environment when just starting to build a career, and less business stress later in a career. It may also be related to insecurity regarding the changing models of healthcare and reimbursement. It also appears during the traditionally highest productivity time of a career the private practice with truly market driven compensation lacking artificial ceilings may offer the greatest potential rewards.

If you are just starting in practice or wanting to move into an employed model, there are some considerations.

When comparing employed surgeons in a private practice environment to those employed in a hospital employed environment we noted a significantly higher compensation for those in a hospital employed setting. In contrast, owners in a private practice environment were likely to have a higher compensation than those in the hospital employed environment. This may be related to market pressures and more likely there has not been the creation of an

artificial ceiling of compensation that exists in an employed environment. In the employed environment there is a great deal of pressure to avoid the appearance of “overpaying” for fear of legal ramifications relating to the Stark law regarding anti-kickback. This causes many hospital employed environments to set benchmarks near the 50th percentile and adjust compensation downward if it approaches the 75th percentile. Essentially this has created an artificial ceiling of compensation for employed surgeons at a lower level than can be obtained in private practice.

When discussing compensation models it is important to understand the great diversity in practice environment. It would suggest that using a blanket benchmark of the 50th percentile for compensation for anyone performing bariatric surgery, does not take in to consideration the significant variation within the bariatric surgery community.

There is a great need for accurate longitudinal data for these distinct groups overtime to provide more valid benchmarks for these discussions.

Bariatric surgery is different from general surgery and other surgery subspecialties as there is an emphasis on a multidisciplinary approach to the life-long treatment of a chronic life-threatening disease. In general surgery, the emphasis is on correction of an acute problem with a short period of follow up care to take care of any complications from the surgery. With bariatric surgery, the understanding is the surgical procedure is a critical portion of treatment of the disease, however not the only focus of treatment. There is an emphasis on lifelong follow up and support to be most successful in the treatment of the highly complex disease.

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Appendix A

ASMBS Hospital Employed Physician Compensation and Production Survey

1. How many years have you been in practice? (If less than one year, please provide number of months.)
 - a. <1 year
 - b. 1-5 years
 - c. 5-10 years
 - d. 10-20 years
 - e. >20 years
2. Which of the following best describes your practice model?
 - a. Solo private practice
 - b. Single specialty group practice
 - c. Multi-specialty group practice
 - d. Faculty practice plan
3. How many years have you been performing bariatric surgery?
 - a. <1 year
 - b. 1-5 years
 - c. 5-10 years
 - d. 10-20 years
 - e. >20 years
4. How many bariatric surgeries have you performed?
 - a. <50
 - b. 50-150
 - c. 150-500
 - d. 500-1000
 - e. >1000
5. What is your employment status?
 - a. Full time
 - b. Part time
6. What percent of your time is dedicated to bariatric surgery?
 - a. <20%
 - b. 21-50%
 - c. 51-80%
 - d. >80%
7. In what state are you employed?
8. What is the zip code in which you are employed?
9. Did you complete a Fellowship?
 - a. MIS

- b. MIS with Bariatrics
 - c. Bariatrics Only
 - d. No
10. Select the method that most accurately reflects your current compensation model
- a. Straight/guaranteed salary (100% of the provider's salary via a fixed salary)
 - b. Base salary plus incentive (Payment of guaranteed base salary plus an incentive component that must be earned. May be based on one or more criteria including individual production, department/organization performance, patient satisfaction, quality measures, or other factors defined by the employer.)
 - c. Production model (Compensation based solely on WRVU productivity)
11. What is the amount of your total compensation, including salary, bonus and/or incentive payments, research stipends, honoraria, and medical directorship fees? (State the amount reported as direct compensation on Form W-2 and Form 1099)
12. What is your estimated annual retirement contribution? (Report all contributions to retirement plans including defined benefit and defined contribution plans).
13. Which of the following benefits are provided to you and paid by your employer?
- a. CME allowance
 - b. Medical Insurance: Employee only
 - c. Medical Insurance: Employee plus dependents
 - d. Disability Insurance
 - e. Life Insurance
 - f. Dental Insurance
 - g. Vision Insurance
14. If your compensation is based on WRVU production, provide the amount paid per WRVU.
15. If your incentive is based upon WRVU production, provide the threshold amount at which the incentive begins and the compensation amount per WRVU that you receive. (For example, you must produce 10,000 WRVU's before incentive compensation begins. Once you reach 10,000 WRVU's, you are compensated (X) amount for each WRVU above that threshold.)
16. What are your call requirements and compensation for the following? (Call requirement could be percent of time, number of days per week or month.)
- a. Bariatric call
 - b. General surgery call
 - c. Trauma call

ASMBS Private Practice Physician Compensation and Production Survey

1. How many years have you been in practice? (If less than one year, please provide number of months.)
 - a. <1 year
 - b. 1-5 years
 - c. 5-10 years
 - d. 10-20 years
 - e. >20 years

2. Which of the following best describes your practice model?
 - a. Solo private practice
 - b. Single specialty group practice
 - c. Multi-specialty group practice
 - d. Faculty practice plan

3. What is the legal organization of your practice?
 - a. Professional Corporation
 - b. LLC or Partnership
 - c. Not-for-profit entity
 - d. Sole Proprietorship
 - e. Partnership

4. How many years have you been performing bariatric surgery?
 - a. <1 year
 - b. 1-5 years
 - c. 5-10 years
 - d. 10-20 years
 - e. >20 years

5. How many bariatric surgeries have you performed?
 - a. <50
 - b. 50-150
 - c. 150-500
 - d. 500-1000
 - e. >1000

6. What is your position in the practice?
 - a. Employed associate (non-owner)
 - b. Owner
 - c. Independent Contractor

7. What percent of your time is dedicated to bariatric surgery?
 - a. <20%
 - b. 21-50%
 - c. 51-80%
 - d. >80%

8. In what state are you employed?

9. What is the zip code in which you are employed?
10. Did you complete a Fellowship?
 - a. MIS
 - b. MIS with Bariatrics
11. If you are an employed non-owner associate what is the amount of your total compensation? (State the amount of salary and bonus reported as compensation on Form W-2)
12. If part of your compensation includes an incentive bonus, which of the following are included in determining eligibility for the bonus payout?
 - a. Patient satisfaction
 - b. Administrative responsibilities
 - c. Quality indicators
 - d. Other
13. Assuming you are an owner in a group practice, select the method that most accurately reflects your group's current compensation model.
 - a. Equal sharing of practice profits
 - b. Mixed model with a percentage of profit shared equally and a percentage shared based on production
 - c. "Individual" model with revenue and expense allocated by partner
14. If you are a physician owner what is the amount of your total compensation, including salary and bonus payments (State the amount reported as compensation on Form W-2 as well as your share of net income as reported on Form K-1 – in the case of an LLC or S Corporation)
15. What is your estimated annual retirement contribution? (Report all contributions to retirement plans including defined benefit and defined contribution plans).
16. Which of the following benefits are provided to you and paid by your employer?
 - a. CME allowance
 - b. Medical Insurance: Employee only
 - c. Medical Insurance: Employee plus dependents
 - d. Disability Insurance
 - e. Life Insurance
 - f. Dental Insurance
 - g. Vision Insurance
17. If your compensation system includes a production element, which of the following are used to measure partner production?
 - a. Gross charges
 - b. Adjusted charges
 - c. Collections
 - d. Patient visits
 - e. Relative value units
18. What are your call requirements and compensation for the following? (Call requirement could be percent of time, number of days per week or month.)

- a. Bariatric call
- b. General surgery call
- c. Trauma call