COLLEGE of AMERICAN PATHOLOGISTS

Practice Management Roundtable

Topic: Exploration of Compensation Models and Workload Distribution

Date of Event: January 14, 2025

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Questions and Answers		
Question(s) Asked	**Answer**	**Responder(s)**
50%ile for RVU and salary-based pay, 75%ile, and 90th %ile	I don't have access to a current formal data set, but a good target is $70/wRVU in order to create a fair and equitable outcome for pathologists that can operate effectively in a tertiary care center that serves an accredited cancer treatment center and processes specimens for specialized surgical and medical oncologists. Frankly, highly qualified pathologists who serve in these complex practices are hard to find and require the skill sets of a good general pathologist who also has expertise and/or experience in at least two specialized organ systems. The total compensation (salary plus benefits) is derived from profits generated by all components of the Practice (PC from AP and CP, TC from AP and CP (if any), Medical Director (MD) Fee, Part A Fee, Revenues from MDX and Genetics). In order to maintain equanimity, there should be an opportunity for a pathology group to share monies from all service lines, irregardless of ownership status, which will align the interests of partners and associates. For pathologists that produce significantly above the mean wRVU of 7000 per pathologist, the $/wRVU is less ($65). For practices that produce a wRVU significantly less than 7000 per pathologist, the $/wRVU range is higher ($90). So a smaller less productive practice will have a ceiling. A larger more efficient practice will be less profitable on a per-unit basis but will have a much higher ceiling. The increased overhead in larger groups is attributable to the cost of infrastructure (LIS, couriers, space, equipment, and so on) which increases cost but also productivity, allowing busier pathologists to	Vivek Khare, MD

	maximize their earning potential. These metrics are reached only by groups whose shareholders receive their ROI as the “last cut” of the margin rather than some models (ie leveraged buyouts) in which the debt holder is paid first before the operation has the resources to manage the operation. In other words, there isn’t enough money to pay lab professionals, pathologists, and management FMV if a shareholder is “owed their cut” before the operation is fully funded. Having said all of this, the wRVU (or even a modified wRVU adjusted for complexity by organ) is not the sole determinant of profitability. It is important to look at all sources of revenue from wRVU-based and non-wRVU-based contributions to determine the best model for your practice.	
Accounting for time spent performing medical directorship duties and being able to convert that time to RVUs.	This is not easily done as the complexity and time required for each MD is variable and highly dependent on the resources the facility allocates and whether the lab is at compliance risk or not. Having said this, we tend to value time spent in MDship equivalent to time spent signing out, especially if the facility pays FMV Part A, MD Fee and the group is allowed to bill PC on CP. Anecdotally, so long as FMV rates are garnered from the facility that owns the clinical lab, it is valuable to a group to allocate time for MD duties. Having said this, we, unfortunately, see far too many circumstances in which pathology groups forego their Part A fees (pro fees on CP) out of competitive pressure or simply a lack of understanding of the true value they provide to the facility. I recommend working with Robert Tessier of HBP Consulting to learn more about this issue if you have additional questions.	Vivek Khare, MD
Anything prohibiting a group from paying employed pathologists a percentage of the global fee on collections.	I recommend seeking counsel from a compliance attorney to verify the laws in your state.	Vivek Khare, MD
The best model for caseload distribution	There is no single best model. What works for us is to allow a computer program to allocate and track productivity, using a modified wRVU methodology, and having a single arbiter of fair workload distribution in a given market; that is, one has to trust and respect the decision of the physician in charge of workload allocation. Our Regional Medical Officers take into account tangible and intangible roles (as outlined by Karim Sirgi in his presentation) we play during the	Vivek Khare, MD

	course of a practice year so that focus is on much more than wRVU alone.	
Can you comment on salary-based versus productivity-based models?	One has to use what works in your market to recruit and retain pathologists. This will vary by region and there is no single best answer.	Vivek Khare, MD
Determine sub-specialty RVU goals (especially head & neck), and value/salary benefits of 15+ years of experience.	Experience is valuable; however, the type of experience matters more than simply time spent in the trenches. Was this experience at tertiary centers dealing with specialist surgeons and oncologists at accredited cancer treatment centers or was this in the rural markets with more mundane/bread-and-butter specimens and generalist clinicians? Was the training at an institution that exposed the resident to a variety of practice styles and cultures or was it at a low volume single institution training that lacked "hot seat" experience? There are numerous variables on top of experience- communication skills, relationship building, leadership potential, problem-solving, demeanor under duress, recovery from failure, grit, and so on, that will also impact one's value to a particular group.	Vivek Khare, MD
Discuss benchmarks, base pay, incentives, compensation for effort, variable pay /wRVU	See the presentation from DPG. Base pay is variable by region, but $70/wRVU is a good starting point.	Vivek Khare, MD
Does slide and block count aka case complexity factor in any compensation models?	Slide and block count are variable given the thoroughness of the prosector. Therefore, we do not focus on slide and block count alone, rather we modify the wRVU to allow for slide and block count. Regardless of what we do in our Group, what matters is how well you are able to work with the people in your own group. In other words, there is no cookie-cutter approach that will work.	Vivek Khare, MD
Ensuring equal workload in surgical pathology mixed subspecialty practice model (>1 subsp/each person) where wRVUs are monitored	We use software that utilizes a modified wRVU calculation that has been agreed upon by our pathologists. The Regional Medical Officers in different regions of our state monitor the data and allocate cases to ensure equality and equanimity.	Vivek Khare, MD
Evaluating the administrative workload relative to 88305 "clicks".	See above.	Vivek Khare, MD
How can we optimize equal workload when the lab is centrally located but pathologists are spread across hospitals?	At our lab, we use a combination of digital slide reading with physical glass slides that are couriered to various sites. Ultimately, we delegate the equalization of workload to a proprietary software and appoint Regional	Vivek Khare, MD

	Medical Officers who are charged with the responsibility of workload equalization.	
How can you expect more income over the last 29+ years when Medicare has devalued our services over the same time frame?	You have to ask your facilities to pay you FMV in Part A, MD fee, and AP TC fees. It is our anecdotal experience that few groups negotiate true FMV rates and fewer negotiate annual recurring cost of living adjustments. I recommend working with a consultant like Robert Tessier of HBP Consulting.	Vivek Khare, MD
How difficult is it for the individual anatomic pathologist to get credentialed with insurance under his LLC and bill them PC only?	I do not know the answer to this. We do billing through the practice entity which bills on behalf of all pathologists.	Vivek Khare, MD
How do the RVUs of subspecialty services such as GI, GU, thoracic, and breast compare?	Biopsies taken from these organs can vary widely in complexity and yet have exactly the same CPT and/or RVU designation. For example, a breast biopsy with a complex architecture has the same CPT/RVU designation as a hyperplastic polyp of the colon. In the lecture that I gave at the annual CAP meeting on workload distribution, I stated: "equal RVUs for unequal specimens" …	Karim Sirgi, MD, MBA, FCAP
How many biopsy slides a pathologist can ready in a day	This is too variable to itemize into one succinct answer and is highly dependent on case complexity, training, and work ethic.	Vivek Khare, MD
How payment models affect mental health	Pathology is a stressful enterprise. The healthcare field in general does not acknowledge the toll our profession takes on our physical and mental states. Like clinical specialties, a pathologist should optimize their stress management which begins first and foremost with a life that balances nutrition and exercise. It is also important to work with colleagues who have personal integrity, high intellect, and high energy, of which personal integrity is the most important attribute.	Vivek Khare, MD
How to fairly compensate pathologists	Not an answer that can be given that will cut across each participating practice in the webinar. Having said this, we recommend seeking outside consultation to determine FMV and then do your best to negotiate appropriate Part A, MD fee, and AP TC fee to ensure FMV compensation for your associates.	Vivek Khare, MD
How to implement this in Epic Beaker	We have built our own AP LIS as we have yet to find a commercial LIS that is suitable for our practice size and complexity.	Vivek Khare, MD
Optimal measurement of workloads across different	In our Practice, partners within a given market share the monies and workload equally for their	Vivek Khare, MD

divisions (heme, surg path, blood banking/transfusion, CLIA), comp models	PC efforts. Partners between markets can see regional variances based on efficiency, productivity, and focus on work-life balance versus focus on production.	
What Anatomic Pathology workload distribution tools are available?	We have programmed our own workload allocation software that is a component of our AP LIS. We have no experience with a suitable commercial product.	Vivek Khare, MD
What are reasonable volume/workload expectations per pathologist in derm path, GI, and general outpatient surg path?	There is a wide bell curve among pathologists in terms of their workload and compensation expectations. There is no single cookie-cutter approach that will answer this question satisfactorily.	Vivek Khare, MD