— PRACTICE & CAREER GUIDE — EPISODE 3

How Surgeons Actually Get Paid

RVUs, salary, and the compensation structures behind the number.

COMPANION GUIDE TO SUNDAY PRACTICE ROUNDS, EP. 3

THE UNIT BEHIND ALMOST EVERYTHING

Nobody teaches compensation in residency, which is why two surgeons doing identical work can end up on very different paychecks without either one doing anything wrong. Almost all of it traces back to one unit: the RVU, or relative value unit. Medicare assigns every procedure and clinic visit a value meant to reflect the work involved, the practice expense, and the malpractice risk — and the piece that applies directly to you as the surgeon is the **work RVU**. A complex revision generates far more work RVUs than a straightforward decompression; that's the system's attempt to account for effort and complexity. Nearly every compensation structure below is built on top of this number.

THREE WAYS SURGEONS GET PAID

	Straight Salary	Production-Based	Collections-Based
How it works	Fixed pay regardless of volume	Paid per work RVU, often base + bonus	Paid on actual collections after overhead
Income predictability	Highest	Moderate	Lowest
Tracks your effort directly	No	Yes	Yes, plus overhead & payer mix
Most common setting	Academics, first 1–2 years	Hospital employment	Private practice

STRUCTURE 1

Straight Salary

Predictable, and most common in academic settings and in the first year or two of hospital employment. You get paid the same whether you do eight cases a week or fifteen. It removes income variability entirely, at the cost of any direct financial reward for higher volume or complexity.

STRUCTURE 2

Production-Based

You're paid per work RVU, usually structured as a base salary plus a bonus once you cross a defined threshold. Your income tracks your volume and case complexity directly — more cases, more complex cases, higher pay, with comparatively little regard for what happens after the visit (billing, collections, and overhead are generally the employer's problem, not yours).

STRUCTURE 3

Collections-Based

The most common structure in private practice. You're paid on what actually comes in the door after overhead is subtracted — which means payer mix matters enormously. The exact same surgery, performed identically, reimburses differently depending entirely on who's insuring the patient in front of you.

WHY IDENTICAL WORK PAYS DIFFERENTLY

1. **Structure.** Salary, production, and collections respond to volume and complexity in completely different ways — the same case mix produces different take-home pay under each.
2. **Payer mix.** A practice with a higher share of commercially insured patients will often out-earn an identical practice with a heavier Medicare or Medicaid mix, even at equal patient volume.
3. **Overhead.** Collections-based pay is only as good as the practice is lean. High collections with high overhead can net out lower than a smaller number with tight cost control.
4. **Call burden.** Call coverage — how often, how compensated, how it affects clinic and OR time the following day — is frequently absent from the headline number entirely.

QUESTIONS TO ASK ABOUT COMPENSATION

- What structure am I actually being offered — salary, production, or collections — and what happens at the transition point if there is one?
- What's the RVU conversion rate, and how does it compare to national benchmarks for the specialty?
- What's the practice's payer mix, and how does it compare to the market I'm evaluating?
- What's included in — and excluded from — the overhead calculation, if I'm on a collections-based structure?
- How is call compensated, and is it factored into the number I'm being quoted?

The Headline Number Tells You Almost Nothing

Two identical salary figures can represent very different jobs once you account for structure, payer mix, overhead, and call. Ask for the breakdown before you compare offers on the top-line number alone.

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