Developing Work RVUs for Production-Based Physician Compensation Programs

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Work RVU-based production compensation programs need to be designed and administered correctly to avoid miscalculations in payment and regulatory noncompliance.

At a Glance

The following steps can be a guide when developing work relative value units (RVUs) for a productivity-based compensation program:

- Challenge stock billing systems.
- Ensure that all procedure codes are captured.
- Understand procedure code bundling.
- Exclude procedures not performed by the physician.
- Consider clinical time spent performing activities that have no assigned work RVUs.

As an increasing number of physicians choose hospital employment over private practice, health systems are facing the associated financial, regulatory, and operational challenges that come with the employment of physicians. Of the many variables that affect this relationship, the physician compensation plan is one of the most important for health systems. Consequently, the compensation plan often presents the greatest set of challenges to the hospital and employed physician relationship.

To compensate physicians in a method considered “fair,” many health systems have implemented compensation plans that tie total compensation to the level of clinical work produced. To this end, one of the most common means of measuring clinical work performed is the work relative value unit (RVU).

Production-based compensation plans that use physician work RVUs as the main factor in calculating compensation have increased in usage in recent years. The number of production-based compensation plans that relied on work RVUs as a factor in determining compensation was just over 40 percent in 2005, and increased to more than 60 percent in 2010, according to American Medical Group Association survey data. Consequently, when the Centers for Medicare & Medicaid Services (CMS) released the 2011 physician fee schedule, it recognized the need for long-term work RVU stability and did not modify work RVUs because of their use in physician compensation programs (MGMA Washington Connection, Jan. 5, 2011).

Fair Market Value, Financial Projections, and Physician Trust

Health systems that participate in federal health programs must ensure that financial arrangements with physicians meet the requirements of the federal Stark Law, anti-kickback statutes, and associated regulations. At their core, these regulations prohibit physicians from being paid for patient referrals to a hospital. In addition, federally tax-exempt healthcare entities must also ensure that physician compensation arrangements comply with IRS private inurement and excess benefit regulations. A crucial component to the determination of whether a physician’s compensation is compliant with these legal and regulatory parameters is that it must reflect fair market value. Essentially, a physician or other provider of medical services cannot be paid for the provision of medical services at a rate that is greater than the fair market value of those services.

For example, under a work RVU compensation program, one potential issue that might cause a regulator to view the financial terms of a physician compensation arrangement to be outside the bounds of fair market value is if the compensation terms were based on clinical services that were not actually performed by the physician. Another potential fair market value issue is if a physician is compensated for ongoing clinical services that he or she does not personally perform. Each of these issues could arise if there are errors in the development of work RVUs.

In addition to regulatory requirements and the impact work RVUs may have on meeting these requirements, a work RVU analysis also can affect financial projections and physician practice profitability. A work RVU projection that is either understated or overstated because of an error in the calculation can result in actual compensation that is materially different from the compensation agreement’s original intent, consequently affecting the practice’s profitability.

Finally, issues associated with the operation of a work RVU compensation program, particularly when surprises occur, can be harmful to relations between the employer health system and physicians. Physicians enter into employment agreements and accept financial terms based on expectations developed during the employment negotiation. If, due to the failure to account for nuances in the work RVU activity and the associated compensation calculation, actual physician compensation does not meet these expectations, the trust between the health system and the physician can be damaged. Health systems invest substantial resources in developing physician relationships and cannot afford to operate a physician compensation program without assurance of accurate and predictable results.

Because of the significant impact work RVUs can have in regulatory, financial, and relational matters, it is critical that valuators and physician organization financial managers understand work RVU development and compilation for physician compensation calculations. The following five steps, although not an exhaustive list, can be used as guiding principles when developing work RVUs for a productivity-based compensation program.

Challenge stock billing systems. A system that accurately captures and calculates work RVUs is the cornerstone of any work RVU productivity-based compensation program. Many physician practices have billing systems that can calculate and track work RVUs. The ability of such systems to provide accurate and meaningful work RVU figures should be examined with a critical eye.

Work RVU credits should mirror payment practices. Unless specifically programmed, stock billing systems generally do not consider procedure code modifiers when calculating work RVUs, although modifiers can significantly affect payment. For example, if a surgeon bills a procedure with a “51” modifier (denoting more than one procedure performed by the physician during the same operative session), the payment rate is generally 50 percent of the total allowed payment amount.

To the extent payment is adjusted due to modifiers, compensation (by way of the work RVU development) should also be adjusted. These adjustments should be modifier-specific and reflect the payment policy that the majority of a practice’s payers employ to address modifier adjustments. One approach is to
follow the Medicare fiscal intermediary's policy regarding modifier reimbursement, because many commercial payers look to Medicare in setting these policies.

As shown in the exhibit below, payment adjustment factors due to modifiers can range from 0 to 1.5, meaning the associated work RVU for these procedures can be zero to 1.5 times the work RVU listed in the physician fee schedule. A system that does not consider these factors in the calculation of work RVUs can create a significant misalignment between compensation (based on work RVUs) and practice revenue streams.

**Exhibit 1**

Another common problem found in stock billing systems is the use of an incorrect fee schedule. Many systems come preloaded with the current CMS fee schedule and relative value file as of the system implementation date, and these schedules often are not updated on a regular basis. It is important to ensure that the correct year’s relative value files are loaded into the system and to ensure the correct year’s work RVU value is being used for each procedure performed.

An example of a significant fee schedule update affecting physician work RVUs is CMS’s shift away from the usage of consultation codes. Effective Jan. 1, 2010, inpatient and outpatient consultation codes were no longer eligible for Medicare payment. Among other related relative value changes made, CMS increased work RVU values associated with new and established office visits and initial inpatient visits. The resulting impact of physician work RVUs related to this change can be seen across multiple physician specialties, underscoring the importance of ensuring that fee schedules are up to date when such changes occur.

The date of service should be matched with the relative value file. For example, services provided on Dec. 31, 2010, should be assigned 2010 work RVUs, regardless of when the procedure is billed. Of course, it is assumed that the correct RVU value is being used in the billing system. Nonetheless, providers should validate that work RVUs are used for the calculation (as opposed to total RVUs or some other component RVU).

Perhaps the most complex aspect of a billing system is the way it handles and notates corrected and rebilled claims. Because of this complexity, the user of a system-generated work RVU report needs to have a clear understanding of this process. The risk of not understanding the system’s correction methodology is that a physician may be assigned “double credit” for procedures that were not actually performed or billed, which can result in a significant difference in work RVUs calculated by the billing system and actual work RVUs performed by the physician.

**Exhibit 2**

Ensure that all procedure codes are captured. Providers should review work RVU reports at a procedure code level to ensure that they reflect the full range of a physician’s clinical activity. As simple as this may seem, employers commonly miscalculate historical work RVU levels given that detailed procedural data are often difficult to obtain before employment. An example of basing compensation factors on inaccurate historical information illustrates this point: Two highly utilized CPT codes were omitted from a physician’s historical work RVU report used to develop compensation terms, causing the employer to overestimate the physician’s historical earnings per work RVU generated. Compensation per work RVU was then overstated in the physician’s new employment contract, which led to a substantial increase in compensation under the new compensation program where the omitted CPT codes were correctly compiled by the new employer.

A good way to enhance trust between physicians and their employer is to allow and encourage physician review and even challenge of work RVU compilation at a procedure code level by way of monthly work RVU reports. Performing monthly reviews at this level helps to create transparency and allow problems to be identified before they become unnecessarily difficult.

Understand procedure code bundling. Many physician services are billed on a bundled basis, which means multiple patient visits are included in a single bill. Bundling, or global billing, is prevalent with surgical and obstetric specialties. In the case of obstetrical care, a physician may see a patient multiple times for antepartum care, the delivery, and subsequent postpartum visits. Depending on the payer and other factors, each visit can be billed separately or the entire episode of care can be billed globally after the delivery.

Regardless of the method used, each patient visit likely is documented in the billing system, so it is important to understand how the combination of procedure codes and modifiers are used to document these visits. Often a visit is entered into the billing system with an “NC” (no charge) modifier indicating there are no charges associated with the visit. The purpose of coding the visit this way is to record the occurrence, while signifying that the claim was not billed to the patient or insurance provider. When developing a work RVU calculation, work RVUs should not be assigned to visits with an NC modifier because they are intended to serve solely as placeholders. Work RVUs for the procedure are already represented in the global procedure code’s work RVU value and counting the work RVUs for these interim visits will cause total work RVUs to be overstated.

The example in the exhibit on page 143 illustrates how this issue can affect the work RVU calculation. In this example, a hypothetical obstetrics practice uses evaluation and management codes with NC modifiers to document each office visit. However, the practice’s billing system does not account for this modifier when assigning work RVU credit, resulting in an excess of approximately 12 work RVUs per case. Over the course of a year, a discrepancy such as this can add up to a substantial number of incorrect work RVUs credited to a physician. To remedy this discrepancy, the exhibit further illustrates how a “smoothing effect” can be employed to incrementally assign work RVU credit to each visit while ensuring that total work RVUs for the case are accurately stated.

Bundling is not limited to obstetric care, and NC claims can be entered into the system for various reasons. It is critical to understand the nature of a practice’s global billing, why a claim has been designated as NC, and how to best assign work RVU credit, if at all, for the related clinical activity.

Exclude procedures not performed by the physician. Often, a midlevel provider, such as a nurse practitioner, a physician assistant, a locum tenens physician, or a substitute physician, will bill procedures under another physician’s national provider identifier (NPI) number. When examining a physician’s productivity, providers should ensure that work RVU credit is counted only for work that was personally performed by the physician.

Procedures performed by another provider but billed under a physician’s NPI number should be noted with the appropriate procedure code modifier for the given circumstance (or otherwise noted within the billing system), and should not be counted toward the billing physician’s work RVU calculation. (The exhibit above lists the modifiers used to indicate locum and substitute physicians.)

Consider clinical time spent performing activities with no assigned work RVUs. Capturing clinical productivity may not always be as straightforward as converting CPT codes to work RVUs. A physician may perform procedures that are either not listed in the CMS relative value file or listed but assigned zero work RVUs. Essentially, if the practice receives revenue from any such activities (excluding designated health service activity), then work RVU credit can be considered for the work performed.
Work RVUs for these procedures can be assigned in various ways. One method involves determining a reasonable work RVU per unit based on effective collections for units of care provided. Another uses work RVU values from similar procedures as a proxy.

Benefits Will Result

Work RVU productivity compensation programs for employed physicians are an excellent means of employer/employee goal alignment. As illustrated in the examples in this article, such programs need to be properly designed and administered to avoid a miscalculation and the associated regulatory and physician relationship penalties that may result. Therefore, employer organizations should invest the time and resources necessary to understand how work RVUs are derived and the details that underlie clinical production data. If this investment is made, these organizations will be in a position to benefit from compliant contracts, good physician relations, and a more predictable bottom line.

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