Payment, RVUs, and How We're Valued — Perspective of a Young Physician

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As a recent graduate working in a non-incentivized practice environment, I have developed an interest in Relative Value Unit (RVU) based compensation plans. This interest, quite simply, has come from the fact that I have a reasonably strong work ethic, which I feel is a valuable asset in a practitioner. With this desire to work, see patients, and care for the critically ill, I have seen personal satisfaction in carrying a high average ESI level and number of patients per hour, but the satisfaction does indeed end there.

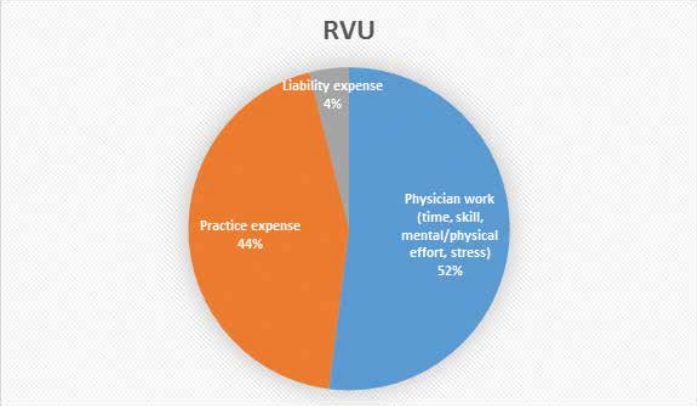
While a sense of pride and accomplishment is a great motivator, let's face it — feeling appropriately and fairly compensated for the work you do and the effort you give leads to longevity and physician retention. This may be in part why the RVU incentivized compensation plan has become so popular.

From the years 2007 to 2010, the Medical Group Management Association (MGMA) saw a near doubling of the number of physicians whose compensation and/or productivity assessments were tied to RVUs (from 34% to 61%).[1] Sadly, despite how common this form of compensation and evaluation is, it is poorly understood by many practicing physicians. Here is a simplified explanation:

As with most things in medicine, the Centers for Medicare and Medicaid Services (CMS) sets the standard. This is no different for RVUs. CMS outlines thousands of services in its physician fee schedule and creates a relative value for each specific service. This list is updated annually in the Current Procedure Terminology (CPT) book. The component pieces of an RVU are **physician work, practice expense, and malpractice coverage.** The physician work is further subdivided into components of **time, skill, mental and/or physical effort, and stress**. Practice expense represents any overhead costs to running the practice or department (nonclinical labor, space, etc). The final piece, malpractice coverage or professional liability insurance, is simply the premiums to remain insured.

Taking all of the above into account, CMS creates a relative value to the service or procedure we complete. Each component piece is not equal, however, and the value of each is probably best visualized graphically: See Image 1.

After the following components of a service are calculated, an adjustment is made with regard to the relative cost of living and business in the region where the services was completed; this has been coined the geographical practice cost index (GPCI). Finally, a conversion factor (CF) is applied, which is a dollar amount predetermined each year by Congress. This collective tallying process, called the Resource-based Relative Value Scale (RBRVS), is used by CMS to reimburse for physician services.



*Note: relative % value of each component an estimate only.

CMS has been using the RBRVS system for reimbursement since 1992. Physician compensation being tied to RVU production, however, is a more recent phenomenon, especially in Emergency Medicine. It is important to recognize that the formula for compensation is not the same as RBRVS and the modifications within it will differ from practice to practice. A multitude of pros and cons exist for RVU-based compensation plans and will vary in level of influence depending on how strongly the RVU returns dictates a physician's take home. The more consistent pros include incentivizing productivity, improving returns per patient, and increasing earnings for high performance physicians. The argument can then be made that this improves satisfaction and therefore retention of this type of physician. The cons include the potential creation of a competitive work environment, deterring citizenship, and an increasing draw to higher utilization.

As a self-proclaimed high performance physician, the idea of RVU based compensation intrigues me, but I am wary of the effects it may have on community. I love my job and am happy with the collegial, laid back work environment I walk into each day. On the other side of that coin, our workhorse physicians will at times be palpably irritated at the disparity in effort without a difference in compensation. To me, the balance lies in a carefully crafted salary plus incentives plan. In it, the plodding physician maintains his or her security in their paycheck while the nose to the grindstone doc fairly earns their salary plus some. The delicate dance therefore lies in creating that perfect incentive to entice some without slighting others.

References:

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