

All Work (RVUs) and No Pay?: Eight Questions to Ask the Hospital about Its Work RVU Compensation Formula

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As more surgeons and specialists are offered hospital employment, work RVU-based compensation agreements are becoming more sophisticated and complex. In order to have a meaningful conversation with health system administrators and ensure that a compensation agreement addresses all issues pertinent to the physician's practice and specialty, physicians must familiarize themselves with the nuances of work RVU-based compensation formulas, as well as the national benchmarking standards, CPT guidelines, and reimbursement rules that impact them. The eight questions developed for this article are the result of reviewing multiple compensation agreements between physicians and hospitals and can help physicians drive the conversation with health system administrators. Engaging the services of a healthcare attorney or physician compensation expert for these conversations is advised.

KEY WORDS: Physician compensation; compensation contract; compensation agreement; hospital employment; RVU; RBRVS; work RVU; RVU formula.

As more surgeons and specialists are offered hospital employment, compensation agreements are taking on new meaning and importance. And they're changing. Hospitals have sweetened to **work** RVU-based base compensation, which is not the same as the **total** RVU that Medicare uses to calculate reimbursement. (The total RVU includes a weight for three components: physician work, practice expense, and malpractice.) Because there's more to these formulas than meets the eye, physicians need to be prepared to ask the right questions—or risk leaving money on the negotiation table.

A word to the wise: Don't assume that the RVU data the health system or employer has given you are correct. Double check the facts and the math. And **never** provide your CPT frequency report until negotiations have progressed. Wait to show your cards until you're fairly certain you can come to an agreeable deal.

1. Which work RVU and compensation benchmarking resources is the hospital using to set target levels? Is it using source data, or modifying the data in some way?

The three most commonly referenced benchmarking organizations for RVU and physician compensation are

the Medical Group Management Association (MGMA), the University Healthcare Consortium (UHC), and the American Medical Group Association (AMGA). UHC benchmarking results are distributed via the Faculty Practice Solutions Center, a cooperative endeavor between UHC and the Association of American Medical Colleges (AAMC).

Familiarize yourself with the compensation benchmarks that the health system or its advisers is using.

Data from MGMA and AMGA are commonly used for non-academic practices, while an academic center may use a combination of all three resources to reflect both its academic setting and a non-academic competitive environment. Be sure that the surveys your hospital uses reflect the most current data.

In one client example, we found that a national consultant advising the hospital employer had manipulated source data from the MGMA's *Physician Compensation*

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and *Production Survey* when presenting its proposal for physician compensation per work RVU. Instead of using the compensation per work RVU table that was computed and published by the MGMA, the consultant combined the results from one data table that reported only compensation levels and a second data table that reported only work RVUs. Because the two source tables used different sample sizes, the computed results were not statistically accurate. As a result, the published MGMA median compensation per work RVU rate was 9% higher than the incorrectly computed rate, and would have resulted in a \$50,000 compensation reduction for each physician.

Familiarize yourself with the compensation benchmarks that the health system or its advisers is using. If a physician produced 6000 work RVUs per year and was paid at a median survey rate of \$56.00 per work RVU, he or she would be compensated approximately \$339,000 (6000 work RVUs × \$56.00 per work RVU).

2. How does the work RVU formula credit physicians for modified services such as multiple and bilateral procedures, as well as for cosurgery and assistant surgery?

If the hospital's agreement is tacit on this issue, ask for details. An otolaryngology practice we worked with was given a proposal and a contract—neither of which had language that explained what the surgeons could expect.

Some hospitals discount the work RVUs for payer-assigned multiple and bilateral discount policies because they are paid less for those services by payers. Discounts are applied by payers because it's assumed that the hospital (or a practice, for that matter) doesn't incur the same level of expenses when two services are performed during one surgery.

But we would argue that there is no reduction in physician work, and that both services should be credited at 100% of the work RVU. For example, when an otolaryngologist performs bilateral ear tube placement, he or she is working on opposite sides of the body and performs the same procedure twice.

In contrast, work RVU discounts for cosurgery and assistant surgery make sense, since the work required is less than if the physician was performing the service alone or as a primary surgeon.

Ideally, the hospital's contract should specify that all billable multiple and bilateral discount services are credited at 100% of the National Physician Fee Schedule Relative Value File-assigned work RVU. (Get it here: www.cms.gov/apps/physician-fee-schedule/documentation.aspx.) If the hospital group says, "No, they aren't credited at 100%," ask what discounting formula is applied.

Point the hospital or health system to the July 2009 General Accounting Office (GAO) report *Fees Could Better Reflect Efficiencies Achieved When Services Are Provided Together*.¹ The report acknowledges that the current multiple physician payment reduction (MPPR) formula applied by

the Centers for Medicare & Medicaid Services (CMS) for Medicare claims reflects duplication in practice expenses, not physician work:

*CMS has a long-standing policy called multiple procedure payment reduction (MPPR) to avoid duplicate payments for portions of practice expenses that are incurred only once when two or more surgical services are furnished together by the same physician during the same operating session. . . . The MPPR is limited in scope because it does not apply to a broad range of services, nor does it capture efficiencies occurring in the physician work component.*¹

Although the report points out that there is potential opportunity for reduced payments to physicians due to an overlap of physician work, such as postoperative care, it is not correct for employers to equate or combine Medicare's current MPPR formula, a 50% reduction, with the physician work overlap.

3. How does the formula credit physicians for unlisted procedure services? Who determines and sets the work RVU for these services?

This is a particularly important point for innovative surgeons and specialists who are the first in their market to perform new procedures or use new devices that don't yet have a CPT code. For example, when plastic surgeons began using the DIEP flap, the procedure had zero RVUs—it was still a Category III code. The hospital would get paid \$120,000, and the surgeon would get zero RVUs. Deciding how physicians will get paid for procedures like this is very important—or you risk the health system getting paid a lot, and you get little to nothing.

Your contract should state that the hospital follows CPT guidelines, not payer reimbursement guidelines.

Establish work RVUs for all commonly performed unlisted procedures you perform, before you sign the contract. Typically, private practice physicians who perform unlisted services negotiate a fair work RVU with their partners by taking the work RVU for a similar CPT code that has a defined RVU and modifying it based on whether the new procedure is more or less work. So for example, the work RVU for a carpal tunnel release is 4.97. If an unlisted procedure such as an endoscopic cubital tunnel release is about 20% more difficult than a carpal tunnel release, increase 4.97 by 20%, and use that as the work RVU when a cubital tunnel release is performed.

4. What are the rules and guidelines for when the physician bills for "nonbillable" services?

Commonly, the hospital's contract will state that any nonbillable services—identified through billing edits or “reimbursement guidelines for the primary payer for date of service”—will not be included in the physician's work RVU totals. This is to protect the hospital from egregious or simply inaccurate coding and billing. That's fair.

But what about nonbillable service edits from payers that have developed their own reimbursement guidelines—and those guidelines don't follow CPT rules? For example, code 69990 is commonly reported to describe “*microsurgery techniques requiring the use of the operating microscope*.” CPT defines scenarios where 69990 is not reportable. But Medicare's CCI edit definitions go beyond these scenarios and disallow separate payment for 69990 in additional code combinations.

Your contract should state that the hospital follows CPT guidelines, not payer reimbursement guidelines. If claims are correctly coded according to CPT standards, all services should be credited to your work RVU total—regardless of whether the payer has reimbursed them.

5. Do physicians receive credit for services they supervise but don't perform directly?

This is an essential question for physicians who use non-physician providers. One hospital agreement we reviewed for a surgical client stated: “*Compensation shall be based upon those CPT codes that include a work RVU and which are **personally performed** by the Physician and are determined compensable by the hospital board.*” We advised the group to ask how it would compensate physicians for supervising visits and procedures in the office when warranted—you should do the same.

Engage advocates and advisors who are as strong a negotiating partner as the hospital.

In the case of a physician assistant or nurse practitioner, the physician is responsible for providing direction and answering questions, whether the service is billed direct under the nonphysician provider's name or incident-to the physician. Compensation formulas that credit the physician only for personally performed services would not be fairly recognizing the time required for such direction.

Similarly, in otolaryngology, physicians are accustomed to supervising audiology within their offices, and historical compensation levels reflect audiology-generated revenues. Make sure your agreement accommodates work RVUs for supervision such as this.

6. When payers require that procedure bilateral claims be submitted using single-line reporting, will the work RVU credit formula be adjusted to give two units of credit?

Table 1. Payer Claims Submission Requirements Vary for Bilateral Procedures

Two-Line Reporting		Single-Line Reporting	
CPT Code	Units	CPT Code	Units
20610	1	20610-50	1
20610-50	1		
Total units	2		1

Attention surgeons: Payer claims submission guidelines vary with respect to bilateral services. (See Table 1.) Although in both cases, two distinct clinical services are performed, some plans require two-line reporting with two units of service, and others require single-line reporting with one unit of service.

Hospital groups commonly use CPT frequency reports to compute an employed physician's total work RVUs. Single-line reporting gives physicians less credit for the same service because the CPT frequency report counts “units” submitted on claim forms. Fewer units reported equals fewer CPT codes on the hospital's report.

Your goal is to be credited based on two-line reporting so you are compensated on the work RVUs for two units. What if some of your payers require single-line reporting? Submit the claims in their required format, but the hospital should adjust the units for those claims at month end, so you are credited and compensated on the work RVU for both procedures.

7. Can I review the contracted rates for codes in my specialty?

It is not uncommon to find hospitals negotiating significant reimbursement for some service lines at the expense of other surgical specialties. Further, we often find physician fee schedules are not given the attention that the facility side receives. The surgeon works harder, but is credited with fewer dollars per RVU because of hospital negotiation strategies.

Meet with hospital administration to understand its philosophy on physician compensation, with specific attention to these three things:

- Contracted fee schedules and equity among surgical specialties;
- Carve-outs for facility fees and the impact on total case reimbursement; and
- Review of current charges and allocation of payments and RVUs per procedure.

You might even offer to assist the health system's contracting department with payer renegotiations for your services in your specialty. Most hospitals will find this very helpful, since often they don't have someone on staff that understands specialty nuances that impact reimbursement.

8. Is my compensation agreement at risk if collections per RVU go down, compared with what they were when I was in private practice?

In private practice, physicians have control over billing staff or billing service performance. After becoming a hospital employee, this control disappears.

Your agreement should specify that compensation will not be affected by decreases in collections per RVU—a common metric used to measure the “efficiency” of collections—that result from situations outside of your control, from, for example, suboptimal performance or management of the central billing office, or a change in payer mix that results from you being asked to see patients in a different area of town.

Calculate your practice’s baseline collections per RVU prior to hospital employment. Purchase the MGMA’s *Annual Physician Compensation Survey* (available at www.mgma.com) to find out what’s realistic for your specialty and geography. Having these data available can be handy for future meetings, should physician collections per RVU be called into question.

Finally, engage advocates and advisors who are as strong a negotiating partner as the hospital. A good healthcare attorney—not a general attorney or the person who negotiated your office space lease—who understands reimbursement rules can be an invaluable resource in helping you discuss these eight questions with hospital administration. ■■

REFERENCE

1. *Fees Could Better Reflect Efficiencies Achieved When Services Are Provided Together*. GAO-09-647. Jul 31, 2009; www.gao.gov/assets/300/293552.pdf.