



# RVU FAQ

## Understanding RVU Compensation in Physician Employment Agreements



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## Overview

As the nation’s leading physician search and consulting firm, Merritt Hawkins receives numerous requests from physicians and from hospital and medical group managers about Relative Value Units (RVUs).

Following are frequently asked questions about RVUs with answers that explain concepts important to physicians evaluating their contracts and to employers considering the performance metrics by which they evaluate and compensate physicians.

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## 1. Why is it important to understand how RVUs function?

It's very important to understand how RVUs function for several reasons. First, the "Total RVU" system (also known as the Resource-Based Relative Value Scale, or RBRVS method) is used by the Center for Medicare and Medicaid Services (CMS) to reimburse physicians and healthcare facilities for their services. Second, the percentage of practicing physicians who have their income tied to RVU productivity has increased dramatically over the last several years.

In its 2014 Review of Physician Recruiting Incentives, Merritt Hawkins reported that of the 2,322 physician search assignments it conducted during the previous twelve months which offered a financial package consisting of a base salary and production bonus, 59% of these searches included RVU productivity as a component of their overall compensation methodology. The Medical Group Management Association also has reported a significant increase in the use of RVUs as a compensation metric among medical groups.

## 2. What is an RVU?

The acronym RVU stands for "Relative Value Unit." The general term "RVU" is used when referring to either a Total RVU, or a Physician Work RVU, depending upon context.

A Total RVU consists of 3 components including the Physician Work RVU, a Practice Expense RVU and a Malpractice Expense RVU. These three combined factors are multiplied by a Geographic Practice Cost Index when determining the Total RVU of each particular CPT (Current Procedural Terminology) code.

A Physician Work RVU reflects the relative level of time, mental effort, technical skill, judgment, stress and an amortization of the physician's education. The initial basis for determining the physician work value was the primary contribution made by the Hsiao study in 1988 while developing the RBRVS method. Today the RUC (Relative Value Scale

Update Committee) examines each new code to determine a relative value by comparing the physician work of the new code to the physician work involved in existing codes. The RUC also makes recommendations for revising values of existing codes. The RBRVS does not include adjustments for outcomes, quality of service, severity, or demand.

Work RVUs therefore are a method for calculating the volume of work or effort expended by a physician in treating patients. A well patient visit, for example, would be assigned a lower RVU than an invasive surgical procedure. Given this relative scale, a physician seeing two or three complex or high acuity patients per day could accumulate more RVUs than a physician seeing ten or more low acuity patients per day. "Work," rather than number of patients or billings, is the behavior being measured and rewarded.

### 3. What important terms and abbreviations are commonly used when discussing RVUs?

Here are several abbreviations or acronyms for organizations involved with defining RVU systems and components. Each is provided with some with relevant commentary:

**CMS** – the Centers for Medicare & Medicaid Services has an RVU “Look Up” feature on their Physician Fee Schedule website where someone can convert any HCPCS code (including the CPT codes) to an RVU.

**PFS** – is the CMS Physician Fee Schedule. Part of the Physician Fee Schedule is the PFS Relative Value Files. Clicking the link for the PFS Relative Value Files takes you to the CMS website where you can download the full .zip folder. These files contain large spreadsheets with all the HCPCS codes (including the CPT codes) and RVU information as well as modifiers and GPCI. These get updated almost every quarter, or upon new public releases and revisions. The PFS is based on the RBRVS system. When CMS provides cash reimbursements to facilities and physicians for services rendered, they pay an amount equal to their CMS current Conversion Factor (CF) multiplied by the number of Total RVUs.

**RBRVS** – is the Resource-Based Relative Value Scale. RBRVS is a schema used by CMS to determine how much money medical providers should be reimbursed. RBRVS assigns a relative value to medical products, services and procedures performed by a physician or other medical providers based on the facility and location where treatment occurred. It assigns a Total RVU for each type of encounter.

**MP RVU** – is a Malpractice Expense RVU. The MP RVU (sometimes referred to as PLI RVU which stands for Professional Liability Insurance RVU) is the portion of a Total RVU assigning a relative value to the cost of professional liability insurance associated with a particular type of encounter.

**Total RVU** – a Total RVU is comprised of 3 components added together which include: the Physician Work RVU, the Practice Expense RVU and the Malpractice Expense RVU. The three components are also adjusted by a Geographic Practice Cost Index per location. This determines the Total RVU for each particular CPT code. When CMS provides cash reimbursements to facilities and physicians for services rendered, they pay an amount equal to their CMS current Conversion Factor (CF) multiplied by the number of Total RVUs. This methodology is outlined in the CMS Physician Fee Schedule (PFS). Here is a link to the PFS.

**PE RVU** – is a Practice Expense RVU. The PE RVU (or simply PE) is determined by the Practice Expense Review Committee. It consists of expenses related to supplies and non-physician labor used in providing the service, and the pro rata cost of the equipment used. Whether the patient encounter occurred in a “Facility” or “Non-Facility” is considered, and the PE RVU is often different depending on the type of facility. For many CPT codes this results in a variance when looking at a “Non-Facility Total RVU” vs. a “Facility Total RVU.” The Physician Work RVU is the same regardless of facility type.

**Work RVU** – refers to a Physician Work RVU. It is also used by non-physician healthcare providers. You may occasionally see Work RVU written as “wRVU” or simply as “RVU” depending on the context. A Physician Work RVU reflects the relative level of time, mental effort, technical skill, judgment, stress and an amortization of the physician’s education. See also “What is an RVU?” in this FAQ. It is common for physician employment agreements to have a productivity incentive feature based on Work RVUs as a fee-for-service compensation methodology.

**GPCI** – is a Geographic Practice Cost Index used in adjusting Work RVU, PE RVU and MP RVU when calculating a Total RVU. It is intended to account for differences in the cost of doing business and providing healthcare services by location.

**AMA** – is the American Medical Association. The AMA owns the CPT code set and operates the RUC which makes recommendations to CMS for revision of the RBRVS and subsequently RVU values.

**CPT** – is the Current Procedural Terminology code. The AMA owns and maintains the CPT code set which is used by the RBRVS method and the CMS Physician Fee Schedule while maintaining the HCPCS code set and attributing RVU values for each.

**RUC** – is the Relative Value Scale Update Committee. It is also sometimes referred to as the RVS Update Committee. The RUC

examines each new code to determine a relative value by comparing the physician work of the new code to the physician work involved in existing codes. The RUC also makes recommendations for revising values of existing codes. The AMA formed the RUC to act as an expert panel in developing relative value recommendations to CMS. As of 2014 the RUC composition has 21 of its 31 members appointed by major national medical specialty societies. Four seats rotate on a two-year basis, with two reserved for an internal medicine subspecialty, one for a primary care representative and one for any other specialty. The RUC Chair, the Co-Chair of the RUC Health Care Professionals Advisory Committee Review Board, and representatives of the AMA, American Osteopathic Association, the Chair of the Practice Expense Review Committee and CPT Editorial Panel hold the remaining six seats.

#### 4. What is the difference between Total RVUs and a physician's compensation plan based on Work RVU?

It's important to have a clear understanding of the difference between the CMS Resource-Based Relative Value Scale (RBRVS) method, and the specific formula being used in the compensation section of the physician's employment contract which determines how he or she will be paid. These formulas are not identical.

The RBRVS method is predicated on a "Total RVU" system. CMS reimburses for services based on Total RVUs (which includes the combined Physician Work RVU, the Practice Expense RVU and a Malpractice Expense RVU all adjusted by a Geographic Practice Cost Index), then this Total RVU is multiplied by the current CMS Conversion Factor (CF) in calculating the reimbursement for a service.

However, physicians are most frequently compensated by their employer per the "Physician Work RVUs" they generate. Fewer physicians have an incentive bonus based on Total RVUs. In either case, all of the RVUs generated by the physician are typically tracked and credited toward the doctor's overall productivity, since they will in most cases also see patients from payers other than CMS (i.e. private insured patients, self-pay patients and those without insurance). It is less prevalent for an employed physician to have an incentive bonus based on Total RVUs. However, since there are typically differences in the actual cash reimbursement (from both CMS and private insurance payers) dependent on the type of facility where a patient encounter or procedure

occurred, there are private groups entering service arrangements with health systems for compensation per Total RVU.

Since Work RVU models are the most prevalent form of physician compensation in the United States today, we'll focus on examining these metrics and systems in greater detail in this FAQ.

The CMS published Physician Fee Schedule - Relative Value Files will show the corresponding Work RVU for each CPT code and these figures can be used in calculating physician Work RVU productivity for determining bonus compensation in accordance with the model outlined in a particular healthcare providers employment agreement.

## 5. How are Compensation per Physician Work RVU Benchmarks Derived and Utilized?

Physician compensation per wRVU is a metric that is often misunderstood. When constructing a productivity bonus based on compensation per wRVU, it is crucial to understand how these data points are derived in various national annual financial surveys. The figure reported is simply a representation of a physician's total compensation for the year divided by the number of wRVU that physician generated.

However, it is very common for both health systems and physicians to reference these data points when negotiating a fair market value compensation per wRVU rate to be included in the productivity bonus section of the physician employment agreement, and also when negotiating base salary or work volume expected by the employer of the physician.

The compensation per wRVU figures per medical specialty quoted in annual reports are not the same as the rate of compensation per wRVU being listed in the productivity incentive bonus section of the physician's employment contract. A physician's total annual compensation will often include, their base salary, signing bonus, stipends, production bonus and quality incentives combined. The rate per wRVU in the production bonus is only a piece of this equation.

The only instance in which these two figures are synonymous is when the physician's entire compensation is determined by their wRVU productivity generated over the course of a year multiplied by that predetermined set rate. These models certainly exist but they are the exception, not the norm.

When a physician is assessing a financial package which offers a wRVU bonus, they would need to calculate their anticipated total annual income (including their base salary, signing bonus, stipends, quality incentives and their likely cash bonus for wRVU productivity according to the guidelines and rates stipulated in the employment agreement), and then divide that projected total compensation by the number or wRVU they anticipate generating over the course of the year to get a figure which would be comparable to the data points published in the annual surveys.

That's not exactly a precise science. Further, national benchmarking surveys are based on prior year's data and physician contracts tend to have terms of at least a year or two. So, benchmarking compensation per Work RVU tends to be a process of having the "tail wag the dog."

## 6. What are some common RVU productivity bonus systems used in physician employment contracts?

Here are several examples. Please note, these are not recommendations, but rather some simple standard methods outlined below for illustrative purposes. By referencing data from the AMGA, MGMA or other national surveys, a practice or physician employer can obtain an idea of standard Work RVU to compensation ratios by medical specialty and also review data on Work RVU productivity for the specialty while determining benchmarks for the set threshold(s).

*In an effort to provide consistency across the examples, let's assume they're referring to a somewhat typical traditional (inpatient and outpatient) primary care practice intended to be aligned with national market benchmarks of roughly \$225,000 of total income, an expectation of around 5,000 Work RVUs generated and a compensation to Work RVU ratio of \$45.00.*

**ANNUAL THRESHOLD** – this methodology sets an established threshold which must be reached prior to any bonus being paid. A reasonable salary is offered in an amount needed to recruit and retain a physician based on the attractiveness of the practice and desirability of the location.

- One structure would be to pay a salary of \$200,000. Then provide an annual bonus for Work RVUs generated by the physician which exceed the established threshold. In this example the bonus might be \$45 per Work RVU once a threshold of 4,444 is reached.
- An alternate financial package using this model which would also maintain alignment with the stated example above could be an \$180,000 base salary, and a \$50 bonus per Work RVU exceeding a threshold of 4,100.
- Please note, both scenarios will yield a physician income of approximately \$225,000 as well as a compensation per Work RVU ratio of \$45 if the physician produces exactly 5,000 Work RVUs.

**QUARTERLY THRESHOLD** – The aforementioned ANNUAL THRESHOLD method can be used to establish a quarterly bonus on a pro-rated basis as well. In the model above which offered a \$200,000 base salary, a quarterly bonus of \$45 per Work RVU could be paid for each Work RVU exceeding 1,111. To obtain that figure, the annual threshold of 4,444 was just divided by 4 to get a quarterly threshold.

- A quarterly threshold bonus often also has an annualized reconciliation feature. Since it's impractical and imprudent to retract previously paid income from quarterly bonuses at the end of the year, some institutions will state that the production metric for each previous quarter must be met during the course of the year before the subsequent quarterly bonus is paid. For instance, if the physician generated 1,000 Work RVUs during the first 3 months no bonus would be paid, and the threshold over the next 3 months would be increased to 1,222 to maintain alignment with the annual target of 4,444.

**CONSISTENT RATE WITH SALARY AND THRESHOLD** – here's example language for compensating a physician at a set rate per Work RVU which uses the physicians salary y as a determining factor in establishing what level of productivity must be reached before bonuses are paid.

*For all services rendered by Physician on behalf of Employer, pursuant to the terms of this Agreement, the Employer shall pay Physician a Base Salary of \$225,000 annually, payable according to the existing payroll policies of Employer. Employer will provide additional remuneration (the "Production Bonus") to Physician for attaining certain productivity metrics described herein. The Production Bonus will be based on Physician Work Relative Value Units (hereafter referred to as "Work RVUs")*

as outlined by the Centers for Medicare & Medicaid Services using the Resource Based Relative Value Scale method. The Production Bonus will be paid at a rate of \$45.00 per Work RVU (hereinafter referred to as the "Rate"). The Production Bonus will be a dollar amount equal to the total number of Work RVUs generated by Physician during the year, multiplied by the Rate being paid per Work RVU, minus the Physician's Base Salary. The Production Bonus cannot be a negative number and Physician's Base Salary will not be reduced if the Production Bonus is not attained. Physician's Work RVUs will be calculated on a monthly basis by converting Physician's CPT codes for each patient encounter to a Work RVU figure, using the current year Physician Fee Schedule. A report illustrating the tracking of this productivity will be shared by Employer with Physician no less frequently than every 90 days. Payment of Production Bonus shall be made to Physician no later than 30 days following each anniversary date during the term of this Agreement. Production Bonus may begin being paid prior to the anniversary date, after Physician has generated a number of Work RVU equal to the quotient of the Base Salary divided by the Rate. The Production Bonus may be prorated when applicable.

- This method is not really significantly different than the ANNUAL THRESHOLD model except that rather than trying to figure out how to balance figures for salary, threshold and a Work RVU bonus rate from national survey benchmarks, instead only a rate of compensation per Work RVU is chosen. The threshold number isn't necessarily stated in the compensation model, but it is clearly understood that the physician's salary divided by the compensation per Work RVU rate is the de-facto threshold. In the example above the compensation plan begins paying bonuses at a production level 5,000 Work RVUs (i.e. \$225,000 divided by \$45).
- One of the benefits of this type of model is that as an organization is recruiting new providers, they can adjust the salary

per physician by what is necessary to hire and retain that particular practitioner, but also express that they're paying the same compensation per Work RVU for the particular medical specialty as the bonus rate for all their employed physicians in the service line.

- It's important to note that if a physician with a \$225,000 salary produces 4,000 Work RVUs (instead of the targeted 5,000 Work RVUs), they have in fact been paid \$56.25 per Work RVU. Further, if a physician with a \$200,000 base salary does not meet their productivity guideline and only produces 3,000 Work RVU over the course of the year, they have in fact been paid \$66.67 per Work RVU. These would be the metrics that they report to national surveys as compensation per Work RVU.
- Commentary: A trend of increasing base salaries and decreasing Work RVU productivity within a medical specialty may impact productivity bonus targets and physician compensation rates for that specialty in subsequent years by inadvertently making it seem like doctors of that medical specialty should be paid higher rates per Work RVU generated. This occurs because of the way benchmarking is done by some institutions when crafting contracts and it can be problematic.

**FLAT RATE** – This method simply pays a flat rate per Work RVU. As an example, when an already employed physician is seeking to renegotiate or renew their contract, and they already have an established practice, this method is sometimes used for an easy transition into a monthly or quarterly compensation model without a base salary. Some institutions will eliminate the base salary after 2 years (once the initial term of the contract has been completed and the physician has consistent patient volume). At that point there may be mutual agreement to begin a pure Work RVU productivity model with the set rate. A physician's regular payroll checks for

the subsequent quarter can be based on the physicians prior 3 months Work RVU production multiplied by the agreed rate. This process is repeated every quarter to determine pay for the following three months.

**TIERED WORK RVU MODEL** – See Chart 1.1 below with several tiers of increasing compensation per Work RVU as an example to illustrate how a tiered model might function for a traditional primary care practice.

Chart 1.1

2014 MGMA: FamilyMedicine (no OB)	25th%ile	Median	Average	75th%ile	90th%ile
<b>Total Compensation</b>	\$175,139	\$211,452	\$230,884	\$268,915	\$345,540
<b>Physician Work RVUs</b>	3,695	4,763	4,965	5,887	7,342
<b>Compensation to Work RVU Ratio</b>	\$38.43	\$45.34	\$51.87	\$55.25	\$71.03

Chart 1.2

Family Medicine: Tiered Physician Work RVU Compensation Model Example)	wRVU Tier Threshold	wRVU Tier Cap	Potential Bonus wRVU in Tier	Compensation Rate per Bonus wRVU in Tier	Potential Bonus	Maximum
<b>Base Tier</b>	0	3,699	0	N/A	N/A	\$180,000
<b>Tier 1</b>	3,700	4,500	800	\$38.00	\$30,400	\$210,400
<b>Tier 2</b>	4,501	5,000	500	\$45.00	\$22,500	\$232,900
<b>Tier 3</b>	5,001	5,500	500	\$50.00	\$25,000	\$257,900
<b>Tier 4</b>	5,501	6,000	500	\$55.00	\$27,500	\$285,400
<b>Tier 5</b>	6,001	7,000	1,000	\$60.00	\$60,000	\$345,400

The tiered model illustrated in Chart 1.1 shows a base salary of \$150,000 with five tiers thereafter, each paying an increasing amount of compensation per Work RVU. The model purposefully caps out at a maximum of 7,500 wRVU and \$362,500 to avoid potential regulatory and compliance concerns of remuneration significantly exceeding norms for various primary care specialties. However, you'll note that the level of productivity and compensation are fairly well aligned with the original example in this section (i.e. \$225,000 of income at the 5,000 Work RVU productivity level).

- In this example if the physician produced 5,700 wRVU they will have been paid \$247,500 for completing Tier 2, plus an additional \$10,000 for 200 bonus wRVU at \$50 each in Tier 3. Their overall income from this model would be \$257,500.

- **Commentary:** To understand how compensation to Work RVU ratios are reported in national surveys, please note this physician would actually report a compensation per Work RVU ratio of \$45.18 at the end of the year (\$257,500 divided by 5,700 is \$45.18).
- **Commentary:** To further clarify, if this physician was also paid a \$15,000 signing bonus, plus a \$5,000 qualitative incentive over the course of the year, their actual compensation per Work RVU ratio would be  $\$48.68 = (\$257,500 + \$15,000 + \$5,000) \text{ divided by } 5,700$ .

## 7. Why is bonus compensation per work RVU in my physician employment contract significantly different than what other physicians practicing the same medical specialty are reporting as their compensation per work RVU in national benchmarking surveys?

These figures are often used as benchmarks for designing productivity compensation plans in physician's employment agreements. Sometimes this causes confusion for those negotiating a contract because the rate

listed on a physician's contract may differ substantially from a typical compensation per work RVU listed in the surveys. Please see, "How are Compensation per Physician Work RVU Benchmarks Derived and Utilized?"

## 8. Where can I find various benchmarking data for RVU productivity and compensation per RVU for my respective medical specialty?

There are several resources where this information is readily available online for purchase, such as national surveys. Benchmarking data may be obtained by engaging a consulting company for services, or via working with a physician recruiting company while discussing financial packages and assessing available opportunities within your medical specialty.

**AMGA** the American Medical Group Association publishes an annual Medical Group Compensation and Financial Survey representing medical groups, health systems, and other organized systems of care. They produce their survey which covers compensation and production metrics as well as management and staff in collaboration with the consulting firm Sullivan Cotter.

**AAMC** the Association of American Medical Colleges publishes an annual Report on Medical School Faculty Salaries which indicates fixed/contractual (e.g. base salary) and total compensation per faculty rank, but does not indicate respective levels of RVU productivity as the job responsibilities of academic faculty often vary greatly in their percentage of clinical duties.

**MGMA** the Medical Group Management Association publishes the most frequently referenced Physician Compensation & Production

Survey. The survey is a good cross section of private practice, large group and health system employed physicians. It reports a very wide variety of metrics including: Compensation, Collections, Encounters, Total RVUs, Work RVUs, Compensation to RVU Ratios, Collections to RVU Ratios, Encounters to RVU Ratios, etc. The MGMA also has an Academic Practice Compensation and Production Survey for Faculty which illustrates compensation and RVU productivity (as well as other metrics) by reporting faculty member's percentage as a Clinical FTE.

**UHC** the University HealthSystem Consortium is an alliance of the nation's leading nonprofit academic medical centers and their affiliated hospitals. Many academic medical centers will benchmark some faculty member's salary to AAMC figures per rank, and use UHC information, or some of the other aforementioned surveys in establishing RVU production guidelines and compensation metrics.

**Medical Specialty Societies** – some medical societies have their own surveys which may contain RVU data.

**Compensation Consulting Companies** – such national firms as Sullivan Cotter and Associates, and Navigant Healthcare.

**Physician Recruiting Firms** – such as Merritt Hawkins or other knowledgeable and reputable retained firms will usually have access to some of the relevant surveys and experienced recruiters will be able to offer perspective on financial packages currently being offered to physicians of a particular medical specialty.

Large physician recruiting companies also maintain placement lists per specialty and community which can be exceptionally valuable in determining fair market value of base salaries and signing bonuses (i.e. guaranteed financial packages). Feel free to peruse available opportunities at [www.merrithawkins.com](http://www.merrithawkins.com).

## 9. Where can I find information about how to convert particular CPT codes to their respective Total RVU or Work RVU values for calculating RVU productivity?

There are several resources where this information is readily available.

CMS has as an RVU “Look Up” feature on their Physician Fee Schedule website where someone can convert any HCPCS code (including the CPT codes) to an RVU. Here’s the direct link.

The AMA site also has a CPT to RVU conversion search feature. Here’s the direct link.

Someone can download the full .zip folder from the CMS website with the updated Physician Fee Schedule, Relative Value Files here. These files contains large spreadsheets with all the HCPCS codes (including the

CPT codes) and RVU information as well as modifiers and GPCI. This page gets updated almost every quarter, or upon new public releases and revisions.

These items are a little more useful from the perspective of coding and billing as opposed to financial benchmarking or negotiating contracts, but they do contain the seminal data upon which RVU physician compensation plans are structured. It’s probably important to avoid becoming over analytical and potentially “missing the forest to see the trees” when it comes to RVUs. Particularly in recruitment scenarios, don’t let analysis paralysis prevent the hiring of a good physician.

## 10. Should I look at state specific or regional RVU productivity benchmarks and compensation ratios when negotiating a contract or is it better to reference national figures?

Institutions often have a tendency to attempt regional or state benchmarking with prior year physician compensation survey data for a medical specialty; however, competitive starting income is more closely correlated with the desirability of a specific location and current demand on the national market for the respective medical specialty due to the supply and demand of commensurately trained physicians willing to relocate in a

given year. It is appropriate to use national compensation and productivity guidelines for smaller medical specialties, or when the sampling size in an annual survey has a limited number of respondents.

Concern should certainly be raised when health systems and physicians attempt to negotiate a compensation per wRVU bonus rate for inclusion in the employment agreement and

focus on whittling down reported survey benchmarks to a very small (less statistically significant) sample size of like style practices of the medical specialty within the state, and disregard other variables of the overall compensation equation which may have an even greater effect on the fair market value of the financial package, the physician's total income and their eventual real compensation per wRVU.

In many instances the sampling size is too small for a particular medical specialty for it to be prudent to focus on state or regional data. Often specialty specific benchmarks in annual surveys are derived from just a few practices and only dozens of physicians nationally. In these cases it's usually wiser to use national figures. Likewise, in smaller specialties it can be problematic when looking at benchmarks for only health system employed physicians vs. private practice. The same issue arises when trying to construct a compensation plan for a physician of a particular medical specialty by using only data relating to other physicians of the same specialty with a similar number of years of experience.

In physician recruiting, financial offers often tend to be more closely correlated to the attractiveness of the community, than to the experience level of the physician being relocated to the area.

There certainly are noticeable differences in physician compensation across regions. It's fairly standard to review data points and find that the Midwest pays the most and that the Eastern region pays the least. However, regional numbers are often skewed by the portion of physicians practicing in that region who were offered very competitive or lucrative financial packages to work in remote areas. It's certainly more common to find very remote rural Midwest physician employers offering substantive financial packages needed for recruitment than it is in rural areas of the Mid-Atlantic or New England which are proximal to major metropolitan areas. That being said, if reimbursements in a particular location would not financially support a competitive financial package, perhaps the appropriate question to ask is, "do we need another physician of this particular medical specialty practicing in this location?"

## 11. Does Merritt Hawkins provide contract negotiation services for physicians, medical practices or institutions

We do in the context of the duties we perform for clients who have retained us to conduct a physician search. It is one of our primary functions as a consultative physician recruitment and staffing company to assist clients in creating competitive recruiting incentive packages and contracts. After we are retained by an employer seeking to recruit a new physician, we conduct an onsite opportunity profile meeting with all key decision makers and offer a consultative analysis of their proposed financial package before representing the available position. We also provide template contracts and review employment agreements being used for these recruitment projects during the process of taking the opportunity to the marketplace. We

discuss details of the financial package with physicians while presenting the opportunity for their consideration, and for the purpose of vetting the prospect's viability as a candidate before arranging an interview.

We are involved in negotiations between the employer and physician after the candidate has interviewed, when requested, and we provide third party assistance ironing out remaining details of the final working agreement as necessary.

When candidates call us and speak with one of our recruiters to begin a search process, and perhaps interview with one of the opportunities

we represent, our consultants typically provide financial benchmarking data to physicians and offer perspective on the various types of compensation methodology and fair market value rates for the respective medical specialty.

We do not, however, provide any professional tax or legal advice during this process, or offer paid contract negotiation services for physicians or employers outside the scope of recruiting for the opportunities we are retained to represent.

## 12. How can an employer pay a physician compensation per Work RVU in ranges from \$40 to \$80 when CMS only reimburses around \$35 per Total RVU?

It is true that the current conversion factor for reimbursement per Total RVU from CMS is just under \$36 for 2014. However, a Work RVU is just part of a Total RVU. So, one Work RVU may correspond to several Total RVUs. This varies greatly per encounter, and particularly due to the Practice Expense RVU by facility type. Nonetheless, for every Work RVU a physician generates the employer might be billing 2 Total RVU, or many times that amount.

Also, the physician likely has a patient base with a payer mix of insurances other than

Medicare as well, so their collections per Total RVU is not going to just be the current CMS conversion rate.

Almost all of the national surveys which report on Compensation per Work RVU Ratios or various medical specialties also report data on Collections per Work RVU Ratios and Collections per Total RVU Ratios for the various medical specialties as well. Looking at those tables helps to gain a much better understanding of the topic.

## 13. Are RVU productivity and compensation expectations different for university based academic faculty even if their job description is defined as a 100% Clinical FTE?

Often the productivity expectation in academic settings is similar to private practice or health system employed positions, but the overall compensation per RVU tends to be much lower. There is some additional information about academic RVU benchmarking in this FAQ under "Where can I find various benchmarking data for RVU productivity and compensation per RVU for my respective medical specialty?"

Universities still have a tendency to try recruiting physicians into purely clinical satellite outreach positions while benchmarking their salary per faculty rank to the AAMC and offering a production model consistent with existing clinicians

and academicians within their respective department. These departments often have a difficult time retaining primarily clinical faculty. Departments and institutions that have a more competitive productivity incentive model for primarily clinical faculty have a greater ability to retain these physicians and grow their service line with outreach into peripheral markets.

It should be noted, however, that it is also common for university faculty physicians to have very good employee benefits, paid time off, an attractive clinical schedule, and an intellectually stimulating practice environment and that offsets some of the remuneration differences.

## 14. My medical specialty reports compensation per Work RVU which seems much higher than typical rates for primary care and other specialties. Why is that, and should I expect a productivity bonus system which pays a bonus rate in alignment with this data?

Probably not. There are some specialties that look like outliers when examining national surveys. Reports show certain specialties ultimately being paid an average compensation per Work RVU ratio in the range of \$80 to \$100. Actually, it is not really whole specialties that end up as outliers, it tends to be smaller “sub-specialties.” Some examples might include certain pediatric subspecialties, a few surgical subspecialties, some OBGYN fellowship trained subspecialties, hospice and palliative medicine, hematologists and oncologists, some hospitalists and intensivists, and occupational medicine physicians.

The reasons for this vary. Several of these specialties have a significant portion of their job responsibilities allocated to activities other than providing professional clinical services and RVU generation. Others require a fairly substantial

salary to recruit and are very necessary for a service line, regardless of whether there is a high volume of patients for them.

That being said, financial benchmarking for subspecialties that show reported high overall levels of compensation per Work RVU should probably focus on salary and job responsibilities more than compensation per Work RVU. It’s uncommon and probably imprudent to offer very high rates of compensation per Work RVU in the productivity bonus section of these physicians’ employment agreements, and further it would very likely incentivize the wrong behavior (e.g. increasing revenue vs. quality of care). Also, data for some of these subspecialties as reported in national surveys is often based on a fairly small sample size that may only represent a few practices across the country.

## 15. Our private practice is being acquired by the local health system, and we currently have significant revenue from established ancillary services. Should we consider a compensation based on Total RVU instead of Work RVUs?

You should probably consider both for comparison purposes and to gain a deeper understanding of how cash flow will look as you change from a private practice to a health system employed group.

Certain medical specialties, particularly those that are both surgical and clinical, may own a significant amount of equipment for diagnostics or procedures, staffed ancillary services, an ambulatory surgery center, etc. Being a private entity allocating revenue by ownership percentage and clinical productivity in a Stark

compliant manner, is vastly different than being a health system employed physician who is only being paid by their credited Physician Work RVU generation with no consideration of the other previous aspects of owned and operated extensions of clinical care. So yes, a Total RVU model may be a more appropriate transition.

However, it should be noted that when specialties report information in national surveys their total income from the practice is taken into account when reporting their Compensation per Work RVU Ratios, so depending on how the practice

is structured, some of those additional revenue streams may have already been factored into reported Compensation per Work RVU (if the income came from services provided through

the practice entity). Of course, revenue from ownership in separate corporate entities such as an ASC, or real estate LLC which owns the office building, would not be included.

## 16. What are the financial and political risks of using a physician compensation model based primarily on RVUs?

It is important to be aware of political risk and the key entities influencing RVU values. The AMA owns the copyrights for the CPT code and receives significant revenue annually from licensing fees for the association of RVU values with CPT codes. CMS also uses a concurrent code set called the HCPCS (which essentially contains the CPT codes with additional levels and modifiers). The CPT codes are periodically amended by the CPT Editorial Panel and their use is required by statute. The RBRVS system is based on the CPT code and the RBRVS system is mandated by CMS. This system is unlikely to be replaced any time soon. Nonetheless, the Relative Value Scale Update Committee (RUC) is mainly a privately run regulatory committee that must maintain budget neutrality when modifying Relative Values, and their meetings are not required to be open to the public.

Some criticisms of the system are that it attributes higher value to surgery and procedures as opposed to chronic disease management, preventive care, consultation and coordination of care. In an era experiencing movement from “volume to value” and movement from “quantity of care to quality of care,” using an RVU system has helped allow physicians to focus more on providing care with less thought given to revenue collection or a patient’s payer status, but using an RVU model still is “fee for service.”

Other critiques include that the RUC has an overrepresentation of specialists and needs more primary care physicians. Certainly some people have expressed concern over the fact that the AMA privately operates the RUC, which modifies

the RBRVS system mandated by CMS, and this may essentially be a form of “regulatory capture.”

Even if private insurance company, physician and health system reimbursement and payment models are not completely based on the RBRVS, they are certainly all greatly influenced and affected by it with a noticeable rippling effect through a multi-trillion dollar healthcare industry. To that effect, there have been news articles citing the lack of public transparency in RUC deliberations, but the greater issue is that the entire RBRVS system and subsequent RVU reimbursement and physician income productivity models may be so attenuated and convoluted that they essentially become incomprehensible.

It does not necessarily matter if the public is involved intimately in RUC meetings if people are not able to understand the discussions and if CMS is simply going to accept RUC recommendations anyway. The real risk existing to healthcare employers, employees and society in general becomes clear when we grasp that a demography of highly educated and intelligent individuals such as physicians and healthcare administrators rely on an entity like the RUC and RBRVS system because the complexity of products and services in the industry are so vast and dynamic that most busy professionals do not have time to provide oversight and just trust that the entity performing de-facto price setting is doing so appropriately in the best interest of the people.

So, paying physicians based on RVU productivity will always have a level of uncertainty, just like any other compensation model.

Further, financial benchmarking surveys (illustrating RVU and compensation information per specialty) are tools which report prior year data and they are commonly used for approximating fair market value in physician employment contracts for the subsequent 12-18 months following their release.

Practices and physicians participating and responding annually to these surveys by completing questionnaires usually receive a discounted price for the purchase of the upcoming report. Financial data provided by respondents is not always independently audited or verified.

## 17. Is it reasonable to have a physician employment agreement where the base salary goes away after a year or two and then have the physician paid only on their RVU productivity?

This is certainly becoming more prevalent. It often occurs when the initial term of an employment agreement expires (after a year or two), and is up for renewal. If the employer has a standard RVU productivity model in use for the specialty, or across multiple specialties, they may propose to simply look at the physician's prior production and continue paying them at a similar rate or renegotiated rate without a base salary.

Frankly, when a physician is significantly exceeding productivity guidelines, and covering their salary, that physician is in a position of control during a renewal negotiation and also typically isn't worried about the lack of a base salary but more concerned with how lucrative the RVU model might be moving forward.

When a physician is not meeting productivity guidelines and covering their base salary,

they may not be in a position of control during the renewal negotiation. There are many reasons why productivity guidelines might not be met. For example, there may be lack of patients in the service area, or lack of marketing for the practice, resources and staff for adequate patient flow might not be in place, the physician may choose to spend a great deal of time with each patient to ensure quality of care, it may be that the physician doesn't have a strong work ethic, or it might be that the established productivity guidelines are unrealistic. Whatever the reason, in these instances, it can be common for an employer to recommend a model with a lower base salary, or no salary, and compensation based only on RVUs moving forward. It is prudent to include discussions of quality metrics in these conversations as well.

## 18. What is a Proxy RVU?

A Proxy RVU is typically used by organizations that employ physicians with a Work RVU compensation and productivity model who also want to implement a method of paying their physicians for professional activities that do not have a corresponding CPT code and subsequent RVU value.

Some positions within the organization may have additional non-clinical job responsibilities

which require time and effort but would otherwise not be appropriately compensated if the physician were not credited a Proxy RVU for these activities. Examples might include administrative responsibilities, or directorship of facilities and equipment, or planning the schedule for the various physicians within the medical specialty's service line, or some curriculum development function, or business

negotiations, or perhaps staffing a satellite clinic which requires significant drive time back and forth from that location.

Accepting these necessary job functions would, in theory, decrease the physician's income by consuming time which would otherwise be allotted towards clinical productivity. If the only method of compensation for the department/organization is paying physicians based on their RVU productivity, the organization and physician may mutually define a specific Work RVU value for time associated with the aforementioned job functions and call it a Proxy

RVU. These Proxy RVUs would then be added to the physician's normal clinical Work RVU productivity and compensated under whichever rate or methodology is applied in the physician employment agreement.

Of course, these Proxy RVU aren't designed to be billed when invoicing payers, or reported in compensation per Work RVU metrics to national surveys, but they do allow for flexibility between employer and employee to design additional appropriate remuneration for non-clinical job responsibilities. Other institutions use stipends to accomplish the same goal.



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