

What's Your Value? RVUs and How to Market to Potential Employers

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Your Premier Practice Management Seminar



Topics Covered Today

- ◆ Understanding the “Work RVU”
- ◆ How wRVU is used to rate YOUR productivity
- ◆ How to calculate wRVU values based on Medicare
- ◆ wRVU incentive structures
- ◆ MGMA based wRVU values
- ◆ Private Practice vs. Hospital Based Compensation
- ◆ Case examples
- ◆ Highlights for Negotiation Purposes

History of RVU

Relative Value Unit

- ◆ Relative Value Unit:
 - ◆ **wRVU** ~ 50-53% of total RVU
 - ◆ **peRVU** ~ (practice expense) ~ 45% of total RVU
 - ◆ **mpRVU** (mal practice) ~ 5% of total RVU
- ◆ Payment for service based on RVU (combining resources and cost attributed to physician service)
- ◆ Based on 1988 CMS study with introduction of Resource Based Relative Value Scale (RBRVS) and tied to CPT structure
- ◆ **Expenses of the physician practice, professional liability insurance, overall physician work / professional component**
- ◆ Medicare determines \$\$\$ amount by a **conversion factor** (regardless of specialty)
- ◆ Adjusted for geographic differences
 - ◆ Geographic practice index

RVU values can change

- ◆ Based on a committee / editorial panel comprised of ~ 29 members and the Relative Value Scale Update Committee (RUC) make recommendations to CMS
- ◆ Committee primarily involved in the (w) work component of the RVU vs. the (PEAC) practice expense component of the RVU
- ◆ CMS introduced the Budget Neutrality Work Adjuster (BNWA) which lowers work RVU for any proposed increase in overall RVU reimbursement
 - ◆ **Meaning** less compensation for each wRVU to avoid overpayment for the same “amount of work”

Work RVUs (“Your Productivity”)

- ◆ Based on Common Procedural Terminology (CPT) as well as E/M codes
- ◆ Designed to rate physician productivity
- ◆ (W) = work or “physician effort”
- ◆ **Components:**
 - ◆ Facility / Geography
 - ◆ Global
 - ◆ Provider
 - ◆ Complexity

Growth of wRVU Compensation

- ◆ 2007 MGMA reported 16% of group practices used a **wRVU compensation formula**
- ◆ 2010 MGMA report noted **wRVU based compensation** rising to **35%**
- ◆ 2011 Merrit Hawkins Review of Physician Recruiting Incentives
 - ◆ 52% of searches feature salary plus production bonus based on wRVU
 - ◆ www.merritthawkins.com
- ◆ **wRVU model** exceeding net collections for productivity measurement
 - ◆ *Dobosenski et al. Group Practice Journal 2105*

The wRVU

Uses in Practice Management

- ◆ Consideration of cost of services per unit
- ◆ Operating margin determined: average collected revenue per RVU
- ◆ Evaluation of **productivity** and identification of **trends**



Key Limitations of RVUs

- ◆ Not meant to provide adjustments for risks associated with case complexity or prognosis
- ◆ Not a measure of “collections” / “real money” coming into a practice
- ◆ Does not take into account billing / office issues
- ◆ Does not consider **QUALITY OF CARE** and no determination of practitioner **EFFICIENCY**
- ◆ **Low producers have been shown to have the highest wRVU**
 - ◆ *Hyden et al al. How to measure physician compensation per RVU. MGMA 2013.*



Influence of Medicare

<https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx>

- ◆ Federal government determination of what the provider should get credit for
 - ◆ Based on the calendar year
 - ◆ **Lower RVUs are reimbursed lower**
- ◆ The Medicare Fee Schedule is based off of the wRVU and conversion factors
- ◆ Medicare does not differentiate DPM/DO/MD provider when comparing RVUs or wRVUs
- ◆ Modifiers can impact wRVU compensation

- Medicare
- Medicaid/CHIP
- Medicare-Medicaid Coordination
- Private Insurance
- Innovation Center
- Regulations & Guidance
- Research, Statistics, Data & Systems
- Outreach & Education

- OVERVIEW
- PHYSICIAN FEE SCHEDULE SEARCH**
- DOCUMENTATION FILES

Physician Fee Schedule Search

Search Criteria

Begin your search below by selecting search criteria. Additional search criteria will appear depending on which selections you choose. Once your selections are complete, you will be asked to submit your criteria. All search criteria options displayed on this page are required.

Please select a year (see 'Notes for Selected Year' box for details):

Type of Information:

- Pricing Information
- Payment Policy Indicators
- Relative Value Units
- Geographic Practice Cost Index
- All

Select Healthcare Common Procedure Coding System (HCPCS) Criteria:

- Single HCPCS Code
- List of HCPCS Codes
- Range of HCPCS Codes

Select Medicare Administrative Contractor (MAC) Option:

- National Payment Amount
- Specific MAC
- Specific Locality
- All MACs

NOTES FOR SELECTED YEAR

2016: The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the Medicare sustainable growth rate (SGR) update formula for payments under the Medicare Physician Fee Schedule. For 2016, the Physician Fee Schedule update factor is 0.5% and the conversion factor is 35.8043.

PFS UPDATE STATUS

Data last updated: 04/04/2016

Year:

Type of Info.:

HCPCS Criteria:

MAC Option:

HCPCS:

Modifier:

[Update Results](#)

Single HCPCS Code

Code	Description
11044	Deb bone 20 sq cm/<

[Print Results](#)

[Download Results !\[\]\(cbe2492b119e39e02a1dab2af4a4b296_img.jpg\)](#)

[Email Results](#)

For your convenience, search results can be printed, downloaded or emailed.

1

View Items Per Page: [Go](#)

MODIFIER	PROC STAT	PCTC	NOT USED FOR MEDICARE	WORK RVU	NA FLAG FOR TRANS NON-FAC PE RVU	TRANSITIONED NON-FAC PE RVU	NA FLG FOR FULLY IMP NON-FAC PE RVU	FULLY IMPLEMENTED NON-FAC PE RVU	NA FLAG FOR TRANS FACILITY PE RVU	TRANSITIONED FACILITY PE RVU
	A	0		4.10		4.20		4.20		1.90

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Some Terms You Should Know

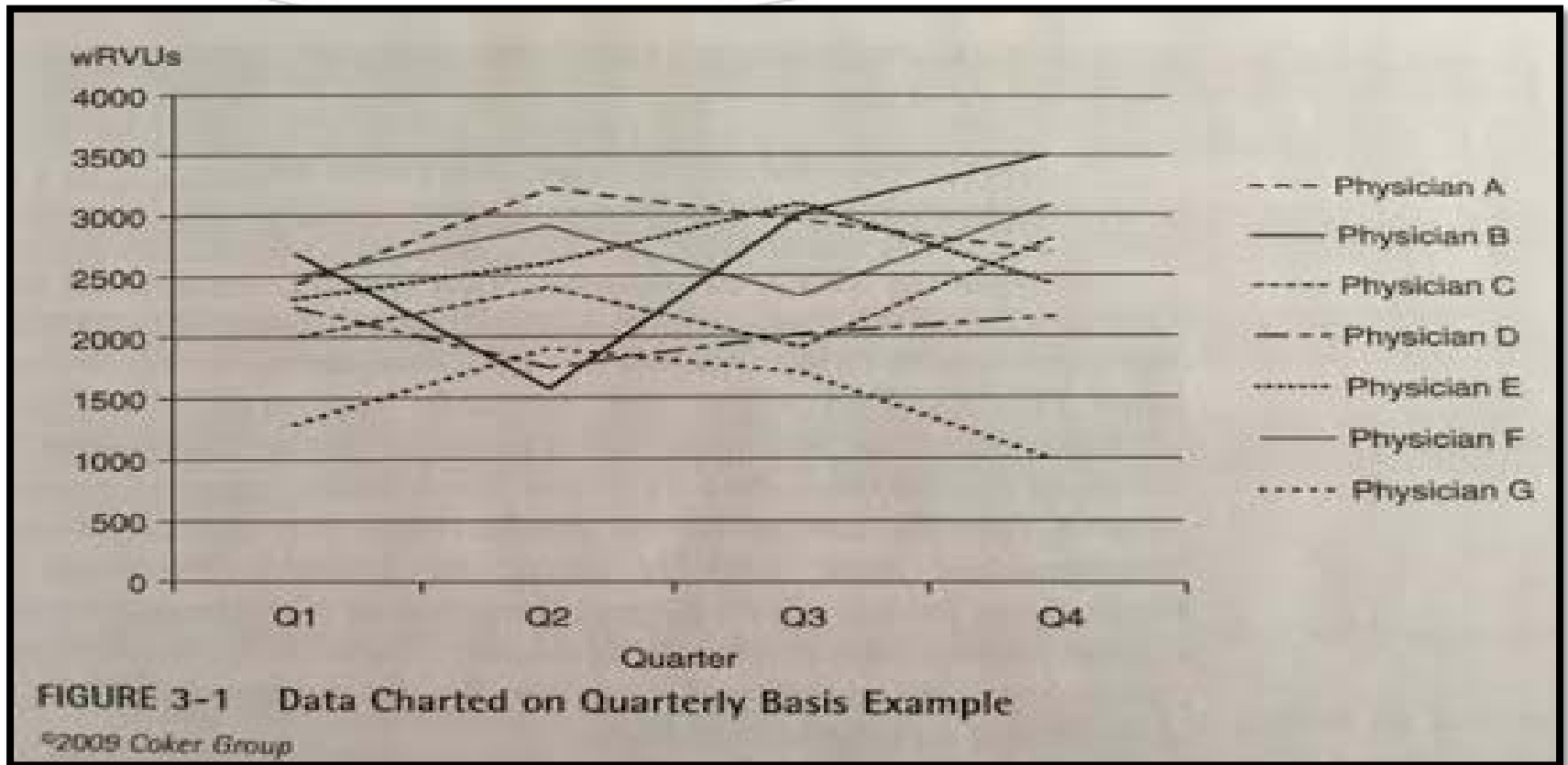
- ◆ **Gross charges:** full fee schedule of the practice (% of Medicare established by the practice)
- ◆ **Net charges:** all charges are adjusted; typically amount collected
- ◆ **Gross collections:** prior to refunds for overpayment or errors
- ◆ **Net receipts:** calculated after refunds or adjustments

Practice Incentive Compensation

- ◆ Varies from institution to institution
- ◆ **Two Scenarios:**
 - ◆ wRVU “goal” established at time of hiring
 - ◆ wRVU “goal” is NOT established at time of hiring
- ◆ wRVU may be used as a measure of physician clinical activity and “**complexity**” of work performed
- ◆ **Profit / Loss (P&L Reports)**
- ◆ Typically, at month’s end, E/M and CPT submitted to outside company and “**scrubbed**” for conversion to wRVU then compared to charges submitted

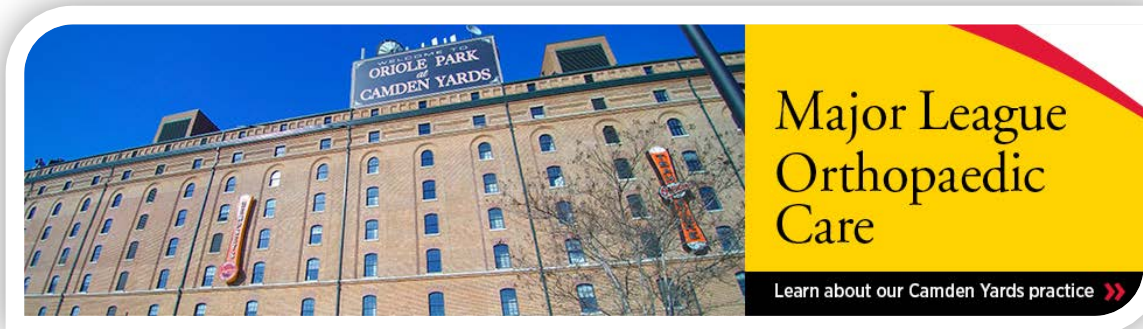


Quarterly Reporting



wRVU & Physician Compensation Private Practice

- ◆ **Bottom Line Allocation:** overhead subtracted from collections (creating a “pool of money”)
 - ◆ 10% to future growth of the practice
 - ◆ Remaining amount allocated to providers based on wRVU
 - ◆ 75% based on individual productivity and remaining 25% allocated equally
- ◆ **Revenue / Expense:** All collections distributed based on “set criteria”



Revenue / Expense Compensation Private Practice

Total practice revenue: \$6.3 million (divided by 7 practitioners = \$135,000)

Practice Expenses: \$2.5 million

Profit before **physician** expenses: \$3.8 million

TABLE 4-4 Sample Revenue/Expense Allocation

Physician	wRVUs	Revenue		Expenses		Total
		Equal	Production	Equal	Production	
Physician A	11,297 17.02%	\$135,000	\$911,421	(\$214,286)	(\$170,200)	\$661,935
Physician B	10,728 16.18%	\$135,000	\$866,439	(\$214,286)	(\$161,800)	\$629,353
Physician C	9,091 13.70%	\$135,000	\$733,635	(\$214,286)	(\$137,000)	\$517,349
Physician D	8,124 12.24%	\$135,000	\$655,452	(\$214,286)	(\$122,400)	\$453,766
Physician E	10,438 15.71%	\$135,000	\$841,271	(\$214,286)	(\$157,100)	\$604,885
Physician F	10,803 16.28%	\$135,000	\$871,794	(\$214,286)	(\$162,800)	\$629,708
Physician G	5,860 8.97%	\$135,000	\$474,989	(\$214,286)	(\$88,700)	\$307,003
	66,362 100.00%	\$945,000	\$5,356,000	(\$1,500,000)	(\$1,000,000)	\$3,800,000
		15%	85%	60%	40%	

2009 Coder Group

REVENUE

Productivity:

\$6.3 million x 85% x wRVU

EXPENSE

Productivity:

2.5 million x 60% x wRVU

Revenue - Expense =

COMPENSATION

15% Revenue allotted equally / 85% wRVU ; Expenses allotted 60% equal / 40% wRVU

Physicians A and F have the highest wRVU in the group and will receive higher compensation

wRVU & Physician Compensation Hospital - Based Practice

- ◆ **Profit is less achievable**
- ◆ Worse payer mix
- ◆ **Basic wRVU Model:** wRVU multiplied by conversion factor = cash compensation
- ◆ Hospital use of industry benchmarks
- ◆ wRVU thresholds are established
- ◆ Guaranteed compensation (base pay) is set artificially low to allow for incentives



The Reality



WELCOME TO BALTIMORE



A WELL BALANCED SOCIETY

Tiered wRVU Model of Physician Compensation Hospital - Based

- ◆ Once fixed cost is covered, additional income is available which can be shared with physician
- ◆ **More productivity** allows for a higher conversion factor (**an area for negotiation**)
- ◆ Varies from institution to institution (2-5+ tiers are possible)



Basic Model vs. Tier Model Hospital - Based Practice

TABLE 4-5 Basic wRVU Model with Guaranteed Compensation

	Scenario One	Scenario Two
Base Compensation	\$125,000	\$125,000
wRVU Threshold	4,000	4,000
Conversion Factor	\$31.25	\$31.25
wRVUs Produced	4,500	3,500
wRVU Compensation	\$15,625	\$0
Total Compensation	\$140,625	\$125,000

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TABLE 4-6 Tiered wRVU Model

Tier	Low End of Range	High End of Range
One	-	3,750
Two	3,750	4,500
Three	4,500	5,500
Four	5,500	6,500
Five	6,500	

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TABLE 4-7 Example of Tiered wRVU Model

Tier	High End of Range	Conversion Factor	Compensation
One	3,750	\$37.00	\$138,750
Two	750	\$40.00	\$30,000
Three	1,000	\$43.00	\$43,000
Four	1,000	\$46.00	\$46,000
Five	250	\$49.00	\$12,250
Total Compensation	6,750		\$270,000

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Pay Band wRVU Model of Physician Compensation Hospital - Based

- ◆ **Ideally:** Calculated quarterly previous 12 months compared to industry benchmark (MGMA)
 - ◆ Ie. Performing at 45th percentile for past 12 months, his/her compensation should be paid at this level for the next 3 months and if productivity increases to 55th percentile, compensation would increase accordingly.
- ◆ Model completely based on level of productivity
- ◆ Can also be compared to the median compensation pattern

BASE COMPENSATION IS USUALLY LOWER IN THIS MODEL

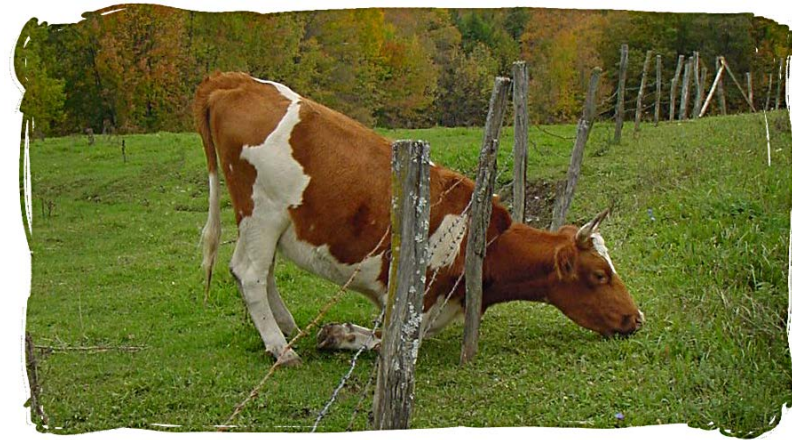
RVU: Hospital Based vs. Private Practice

◆ Private Office

- ◆ Physician compensation as a function of practice profitability
- ◆ More income = increase revenue or decrease expense
- ◆ **A problem:** services provided that generate sizable collections with low wRVU
 - ◆ Creates DIS-INCENTIVE for physician if productivity based on wRVU

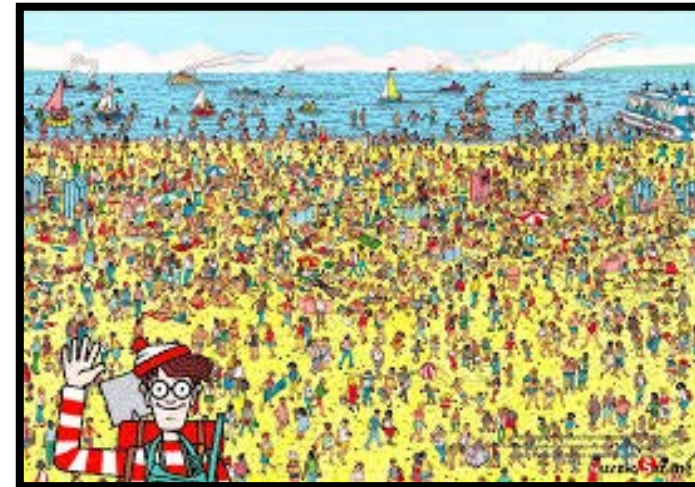
◆ Hospital-Based Practice

- ◆ More flexible (may deem losses acceptable)
- ◆ More latitude in combining wRVU & collections as a measure of productivity



How a Practice Should View You

- ◆ Internal comparisons to other physicians
- ◆ **External comparisons to industry benchmarks (MGMA)**
 - ◆ **Compare directly to a specific percentile**
 - ◆ **Calculate as a percentage of the median**
- ◆ Ratio analysis using compensation
 - ◆ $\text{Compensation} / \text{wRVU} = \text{conversion factor}$
 - ◆ \$25 - \$75
- ◆ Ratio analysis using collections
 - ◆ $\text{Collections} / \text{wRVU} = \text{identification of trends}$



Compensation : Productivity Ratio

Compensation to Productivity Ratio

Component of Productivity Ratio	# of group responses	# of provider responses	50 th percentile	80 th percentile	Median	90 th percentile	Mean
Net collections	44	133	81.6%	83.7%	46.5%	37.8%	52.2%
Work RVUs	62	218	\$73.58	\$59.42	\$48.34	\$48.78	\$51.08

American Medical Group Association 2013 Medical Group Compensation and Productivity Survey - Primary Care
2013 Report Based on 2014 Data

•Conversion Factor

- Determination - National MEDIAN Compensation per specialty / # of work RVUs for that specialty
- This "Conversion Factor" acts as a "market rate" for doctors in that specialty
- Higher RVU cases impact compensation
 - A well patient visit has a lower RVU than an invasive surgical procedure
 - Surgeons doing more complex cases would accumulate more RVUs than a physician more low acuity patients per day

Review of MGMA Measures

- ◆ Medical Group Management Association (MGMA)
- ◆ Carries a wide number of respondents
- ◆ Breakdown geographically, demographically, and hospital size
- ◆ Used to establish **YOUR** percentile rank amongst the profession

WHERE DO
YOU FIT IN?



Anything besides MGMA?

<http://www.mgma.com/industry-data/mgma-surveys-reports>

- ◆ Sullivan, Cotter and Associates Physician Compensation and Productivity
 - ◆ <https://www.sullivancotter.com/healthcare-compensation-surveys/purchase-surveys/>
- ◆ American Medical Group Association Compensation and Financial Survey
 - ◆ https://www.amga.org/wcm/PI/SAT/OAF/ops_finance_16.aspx

DPM Compensation Reported American Medical Group Association 2015

Compensation and Productivity Survey - Podiatry (Based on 2014 Data)

DPM compensation Reported	# of Group Responses	# of Provider Responses	90th Percentile	80th Percentile	Median	20th Percentile	Mean	Std Deviation
Compensation	68	236	439,316	349,426	257,246	200,000	283,540	116,128
Total								
Group Size								
< than 50	6	7	-	-	-	-	-	-
50 - 150	22	43	464,953	363,690	276,775	221,183	302,824	111,701
151 - 300	13	34	417,618	328,447	241,194	199,992	285,600	131,102
> 300	27	152	412,543	348,948	252,969	196,102	275,767	113,855
Region								
East	12	50	392,878	330,000	226,257	157,362	247,956	109,394
West	17	62	498,766	411,664	304,079	245,901	336,459	121,895
South	11	21	360,460	311,199	227,500	170,000	266,029	143,266
North	23	103	374,311	322,756	258,014	200,000	272,530	99,509

DPM wRVUs Reported

American Medical Group Association 2015

Compensation and Productivity Survey - Podiatry (Based on 2014 Data)

DPM wRVU's Reported									
	# Grp Responses	# Provider Responses	90th percentile	80th percentile	Median	20th percentile	Mean	Std Deviation	
Total	62	218	8,505	7,197	5,578	4,429	5,959	2,080	
Group size									
< 50	4	5							
50-150	21	42	8,337	6,999	5,655	4,732	6,047	1,873	
151-300	11	31	7,508	7,214	6,119	4,633	6,191	2,476	
> 300	26	140	8,513	7,183	5,483	4,265	5,850	2,016	
Region									
East	12	48	9,132	7,544	6,071	4,068	6,499	2,259	
West	17	62	7,672	6,704	5,217	4,094	5,539	1,838	
South	10	20	8,952	7,297	6,244	4,555	6,518	2,527	
North	23	88	8,541	7,086	5,645	4,474	5,834	1,973	

“Physician Acuity”

- ◆ Part of the Physician Profile
- ◆ Trended by administration and compared to national peer statistics
- ◆ Measurement of physician consumption of resources for a specific procedure or service
- ◆ **Acuity** = Total # of wRVU billed / Total # of Encounters Billed
- ◆ Consider wRVUs generated per patient as a metric of productivity and complexity of procedures



Case #1: Wound Care Visit / Subsequent Encounter Debridement

- ◆ Time: **10 minutes**
- ◆ CPT 97597
- ◆ 0.51 wRVU / 1.59 RVU

- ◆ Other codes to consider
 - ◆ Incision of bone cortex (28005: 9.44 wRVU), Local tissue rearrangement (14040: 8.6 wRVU), Bone biopsy (20245: 8.98 wRVU), Partial resection of bone (28122: 6.76 wRVU)



Case #2: Bunion / Hammertoe

- ◆ Time: **90 Minutes**
- ◆ Lapidus
 - ◆ CPT: 28740
 - ◆ wRVU 9.29 / 13.88 RVU
- ◆ Weil osteotomy
 - ◆ CPT: 28308
 - ◆ wRVU 5.48 / 10.27 RVU
- ◆ MTPJ capsulotomy
 - ◆ CPT: 28270
 - ◆ 4.93 wRVU / 8.79 RVU
- ◆ PIPJ arthrodesis
 - ◆ CPT: 28285
 - ◆ wRVU 5.62 / 9.29 RVU



Case #3: Pediatric Flatfoot Reconstruction

- ◆ Time: 120 minutes
- ◆ Gastrocnemius recession
 - ◆ CPT: 27687
 - ◆ **wRVU 6.41** / 5.71 RVU
- ◆ Cotton osteotomy
 - ◆ CPT: 28304
 - ◆ **wRVU 9.41** / 13.17 RVU
- ◆ Evans osteotomy
 - ◆ CPT 28300
 - ◆ **wRVU 9.73** / 7.54 RVU
- ◆ Medial calcaneal displacement osteotomy
 - ◆ CPT 28300
 - ◆ **wRVU 9.73** / 7.54 RVU



Case #4: Arthrogyposis / Clubfoot with multiple osteotomies and Taylor Spatial Frame Application

Time: 4.5 hours + Office Encounters / Imaging / Adjustments

First MTPJ Fusion

28750 (8.57 wRVU / 13.73 RVU)

Tarsal Tunnel Release

28035 (5.23 wRVU / 9.35 RVU)

Medial calcaneal slide osteotomy

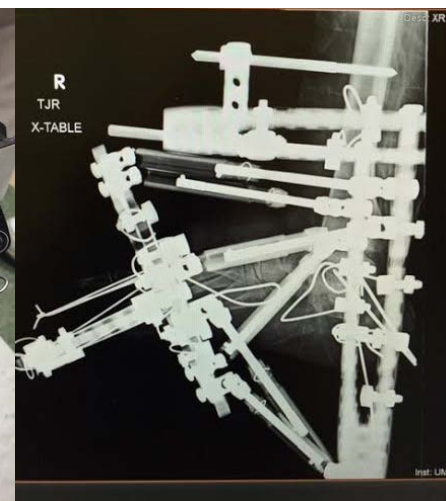
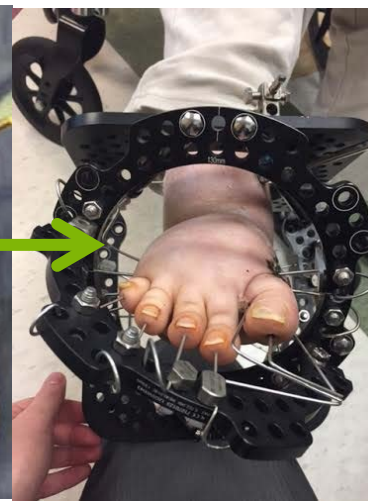
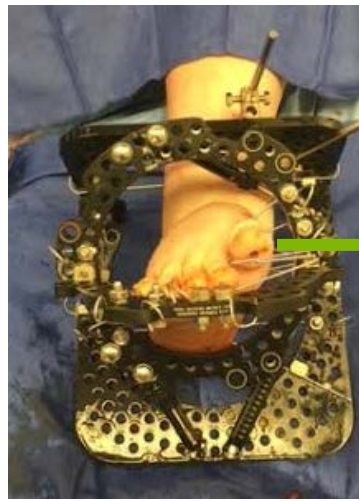
28300 (9.73 wRVU / 7.54 RVU)

Midfoot Gigli Osteotomy

28304 (9.41 wRVU / 13.17 RVU)

Application of Taylor Spatial Frame

20696 (17.56 wRVU / 13.75 RVU)



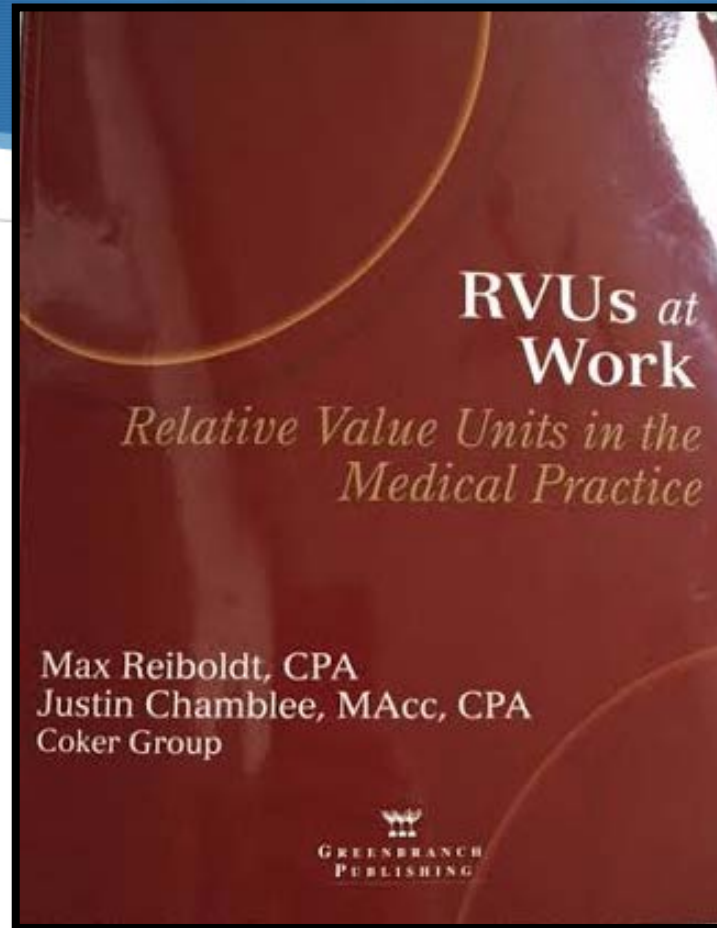
Summary: What the Administrators Think of...

- ◆ **wRVU:** physician work reflecting time, mental effort, judgment, technical skill, effort, and stress associated with patient care
- ◆ **Target RVU:** physician effort monthly correlated with work contract
- ◆ **New patient:** has not been seen in 3 years more new patients = practice is growing
- ◆ **Total Encounters:** treating the patient for a particular complaint (regardless of how long you spend with the patient)
- ◆ **Charges:** total gross charges billed to a 3rd party payer before adjustments
- ◆ **Accounts Receivable Balance:** gross amounts outstanding
 - ◆ New Balance at end of the month = balance of previous month - net payments - net adjustments for current month
- ◆ **Collection percentage:** % of gross charges being collected after all adjustments

Strategies for Negotiation

- ◆ For **residents / fellows**, determine wRVU per year of a successful practitioner who's practice you can emulate based on your training and goals
- ◆ For **current practitioners**, your worth is established by taking your productivity for the year and convert to wRVU and comparing to MGMA guidelines
- ◆ Inquire about **historic RVU data history** for other Foot / Ankle providers in the practice
- ◆ If limb salvage, wound care is part of your armamentarium, then use this to your advantage as a means of generating wRVUs during established **clinic visits** (in addition to **operating room productivity**)
- ◆ Make sure to ask about what incentive structure is used and market appropriately

Good Luck!



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