Relative Value Units and the Measurement of Physician Performance

In response to a need for a standardized language to describe medical services, the Current Procedural Terminology (CPT) coding system was created in 1966. This system persists today and is used by most payers to communicate standardized information about medical services. In 1981, the Relative Value Scale Update Committee (RUC) was created by the American Medical Association to make recommendations about the relative value of physician work for Medicare and Medicaid beneficiaries based on CPT codes. In 1992, Medicare began reimbursing hospitals and physicians based on the values established for services by the RUC, which are now used by both commercial and government payers.

Relative value units (RVUs) were designed to provide relative economic values for medical care based on the cost of providing services categorized as physician work, practice expense, and professional liability. Physician work accounts for approximately half of the relative value of a service and is based on the time it takes to perform the service, the technical skill and physical effort, the required mental effort and judgment, and the stress caused by the potential risk to the patient. The existence of financial incentives for physicians to provide more care, and more highly reimbursed care in particular, is the subject of much consternation. Evidence suggests that when performance is measured by RVUs, the number of RVUs generated tends to increase. Dissatisfaction with this linkage has led some organizations to transition away from RVU-based, fee-for-service reimbursement methods and toward alternative payment models that limit the incentive for more care and create a focus on providing better care at lower costs. Early data suggest that value-based payment systems may indeed reduce costs while maintaining or improving outcomes. For example, following implementation of the 2016 Centers for Medicare & Medicaid Services comprehensive care bundled payment program for joint replacements, Haas and colleagues observed reduced spending without significant changes in hospital length of stay, readmissions, complications, 30- or 90-day mortality, or volume of episodes relative to control hospitals not participating in the program.

In addition to the above rationale not to use RVUs as the primary measure of physician performance, there are equally compelling moral and professional arguments. In simplest terms, a clinician’s primary responsibility is to the patient. Clinicians also have important, if secondary, responsibilities to payers and the health care system in which they work. Assessing physician performance by RVUs monetizes the patient-physician relationship and incentivizes more, and not necessarily better, care. This focus can lead to higher costs for both payers and the health care system. Further, the way that RVUs are calculated tends to deemphasize primary care, population health, and public health and tends to favor procedural specialties.

Assessing performance based largely on RVUs also subtly disincentivizes clinicians from focusing on those behaviors that are essential to deliver better outcomes and lower costs. For example, a cardiac surgeon who cares for a complex heart failure population and spends hours coordinating with a cardiologist to create a definitive plan produces fewer RVUs and as a result may receive a smaller bonus than a cardiac surgeon who is not so collaborative and simply operates.

Other examples are numerous. The physician who volunteers, without extra compensation, for additional night shifts, when the ability to generate RVUs is lower than during the day; the clinician who regularly spends extra time exploring a patient’s personal values in deciding what procedure should be done. Each of these activities benefits patients, colleagues, or both and also...
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Discounted fee-for-service contracts currently make up for losses to specialty, and private practice settings, perhaps because of the way that production appears to be equally prevalent in academic, multispecialty practices. Extending this observation, it is clear that incentive systems primarily based on RVUs to the exclusion of quality or value metrics are focused on trying to improve outcomes for their patients, cost has not historically been a focus of physicians' care or responsibility. Evidence suggests that when provided with the right information and a system that prioritizes a focus on value, physicians can reduce costs. Other experiments with redesigned performance assessment systems that focus on more than just RVUs are under way. For example, Spectrum Health, a multispecialty medical group, developed a system-wide compensation and performance model focused on guiding principles.

In sum, a change is overdue. The current model for measuring physician performance creates both an unattractive working environment for physicians and the potential of harm to patients from overtreatment. Physician performance measurement should be decoupled from RVU production, which, in fact, was never designed to assess professional behavior. With this approach, the medical profession could reorient from a focus on billing toward the patient-centered values that drive most people to enter medical school. This important adjustment has the potential to improve patient satisfaction and sustain physicians' commitment to the highest professional ideals over the entirety of their careers.

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REFERENCES