PRACTICE MANAGEMENT IMPROVEMENT STRATEGIES

Work RVU compensation formulas and surgery modifiers: To discount RVUs or not

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In hospital employment settings, as well as large groups, work relative value unit-based compensation agreements and formulas are often standard. Understanding how work relative value units are credited is an essential element of creating or negotiating relative value unit-based compensation. Our firm has found there is no single method applied within physician organizations that use relative value unit-based compensation. This article explains why some work relative value unit reductions make sense and others should be carefully addressed with administrators.

Since 1992, many physician organizations have used work relative value units (RVUs) as a methodology for physician productivity and as an element of their physician compensation formulas. Work RVUs are published annually as part of the Resource-Based Relative Value Scale (RBRVS) developed by the CMS.

Almost all CPT codes are assigned a relative value. While physician productivity is typically measured in terms of the work element of a CPT code's total RVU, the total RVU also includes physician expense and malpractice expense. Total RVUs also vary based on the facility or non-facility site of service.

A key negotiation point when using work RVUs as a measure of productivity is determining whether the organization will give full work RVU credit for all CPT codes billed or it will apply reductions due to modifier usage.

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As its rules are applied consistently across the country, we have referenced the CMS reimbursement formulas for modifier usage as a comparison point within this article; other payer policies may vary.

Reduce work RVUs for modifiers 80, 82, 62?

Our firm says, "Yes," for the following reasons. Modifier 80 is defined in CPT as assistant surgeon and modifier 82 is used in a teaching setting for an assistant surgeon (when a qualified resident surgeon is not available). When reimbursed, claims

with modifiers 80 or 82 are allowed by CMS at 16% of the allowable amount paid to the primary surgeon. As the intensity of service is significantly reduced for an assistant vs. a primary surgeon, most physicians accept that a parallel work RVU credit reduction is reasonable.

The same approach is often applied to claims with modifier 62 (two surgeons/co-surgeons). Each surgeon in a co-surgery case is reimbursed at 62.5% of the standard allowable for the CPT code rather than the full 100% that would be allowed if a single physician performed the entire service. As the physicians do not each perform all components of the CPT code description, it is generally accepted that a parallel work RVU credit reduction is reasonable when calculating physician productivity for these services. A physician compensation plan that includes these reductions is fair in that it reasonably reflects a physician's work effort.

Reduce work RVUs for modifiers 50, 51, 59?

Our firm says, "Not so fast." The idea of reducing work RVUs when modifiers 50, 51 and 59 are used requires careful consideration.

Modifiers 50, 51 and 59 are defined in CPT as bilateral procedures, multiple procedures and distinct procedural services, respectively.

For bilateral procedures, CMS allows reimbursement at 100% for the first side of the bilateral procedure and at 50% for the second side. For multiple and distinct procedures designated with modifiers 51 and 59, CMS reduces the allowable amount for the second through the fifth service to 50% of the standard. This allowable reduction is applied to reflect service overlap in the practice expense portion of the service. The methodology is called the Multiple Procedure Payment Reduction (MPPR).

For example, in a claim with two fracture CPT codes, the allowable for the lesser-valued code will be reimbursed at 50% of the standard allowable.

When calculating productivity, some organizations take the approach of applying a 50% credit reduction to any CPT code that is appended with modifiers 50, 51 or 59. The rationale for doing so is the organization receives less than 100% reimbursement for the modified codes under the MPPR. Under this approach, the organization correlates a reimbursement reduction with productivity reduction.

In another variation, some employers apply a 50% work RVU reduction to services with modifiers 50 and 51, but do not apply a work RVU reduction to procedures with modifier 59. Given that all three modifiers have the same reimbursement impact, this

approach seems inconsistent.

When considering this issue, it is important to remember what is included in the relative value credit for a service. Each surgical CPT code is valued to include a combination of preoperative, intraoperative and postoperative work and costs. For example, the RVU distribution for musculoskeletal services is at or close to 10% preoperative, 69% intraoperative and 21% postoperative. In a case that includes more than one procedure, the intraoperative elements of each service are unique, but there is service overlap for the preoperative and postoperative components because preoperative and postoperative care is conducted per surgical case, not per surgical CPT code.

In July 2009, the U.S. Government Accountability Office (GAO) published a report about service overlap and its impact on MPPR formula applied by CMS. It stated, “Under an MPPR, the full fee is paid for the highest-priced service and a reduced fee is paid for each subsequent service to reflect efficiencies in overlapping portions of the practice expense component-clinical labor, supplies, and equipment.” Although the report went on to describe that reimbursement reductions could be achieved by applying the MPPR policy to the physician work component of certain imaging services, a key take-away from the report is a footnote which states, “Although the reduction is applied to the entire fee for each subsequent service, according to the rules we reviewed, the MPPR reflects duplication in practice expenses, not physician work.”

Our take-away from that is although the GAO report recognizes there is some overlap of physician work in multiple-procedure cases, it has not been formally valued and is not reflected in the Medicare reimbursement methodology. As a result, we find that using the MPPR policy to justify reducing physician work RVU credit in a compensation formula is flawed.

Reduce work RVUs for modifiers 78, 52, 22?

Our firm says, “Doing so will take some work to manage.” The same holds true for unlisted procedures. Modifiers 78, 52 and 22 are defined in CPT as Unplanned Return to the OR for Related Procedure During the Postoperative Period, Reduced Service, and Unusual Service, respectively.

For each of these modifiers, the level of work increases or reduction varies by case, which renders it difficult to administer a standard RVU adjustment. Our firm has not found that physician organizations have a standard approach to recognizing these. For

a large organization, it could be an administrative burden to adjust the work RVU credit for every affected surgical case.

Data formatting matters

Another reason modifier reductions can be tricky is payer directives vary. For example, the Medicare Administrative Contractors do not recommend providers use modifier 51 in their claim submission; adjustments are applied automatically. This guidance is not the standard for non-Medicare payers. If a group applies modifier 51 reductions to a physician's work RVUs, the weighted RVU amounts for a case sent to Medicare would be higher than the same case sent to a non-Medicare payer, resulting in inconsistent credit for the same case.

Recently, National Correct Coding Initiative edits and guidelines developed by CMS have restricted billing/payment for services that are otherwise separately payable under CPT rules. Orthopedic examples include use of the operating microscope in spine surgery, shoulder joint cases that involve multiple procedures and secondary closed non-reduced fractures treated with the same cast or splint. A key question is whether work RVU credits are being used to quantify physician productivity or to quantify only reimbursable services. If the former is the case, the group will need to differentiate how services are reported for overall tracking from how these are submitted for payer reimbursement.

What is next?

It should be noted there is a degree of preoperative and postoperative service overlap within surgical procedures. The lack of formal recognition of this factor by CMS, other payers and benchmarking entities makes it a challenge to quantify in a physician productivity/compensation formula and differentiate it from practice expense overlap.

It is suggested the following be done:

- review your compensation agreement to assess if and how RVU reductions are applied, and what justification has been established for the reductions;
- share the GAO report with hospital or practice leaders, and discuss the concept of RVU tracking for productivity vs. reimbursement; and
- negotiate where it makes sense; accept reductions that are consistent with reduced work.

Any productivity tracking methodology that uses modifier adjustments will require detailed data analysis and ongoing maintenance to ensure accuracy and reliability. The goal should be to give reasonable credit for work that is performed, in a manner

that is organizationally consistent.

References:

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For more information:

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Disclosure: Wiskerchen reports she is a consultant with KarenZupko & Associates Inc., which develops and delivers CPT Coding and Practice Management workshops presented by the AAOS in conjunction with KarenZupko & Associates Inc.