

## RVU-itis: Is There A Cure?

**L**et me be up front: “RVU-itis” is not a disease or a medical condition. Don’t try to search Google for “RVU-itis” as you will only be referred to “Uveitis” web sites. You won’t find an ICD-10 code for this. Rather, it is my invented term for the behavior manifested by physicians and other providers whose compensation is judged solely by the quantity of care rather than any other aspect of the care they provide.

Relative value units (RVU’s) are the most common metric used to gauge physician productivity. A recognized danger of using RVU’s as a metric connecting monetary rewards such as productivity bonuses to patient volume may encourage undesirable behaviors. This might include overbooking patients, focusing on more highly valued RVU procedures and working longer and longer hours. At the same time while metrics may go up, so does the risk for another more commonly recognized condition among physicians: burnout.

While the RVU system is embedded in modern medical practice, many of us may not be aware of its origins. Harvard economics professor Bill Hsiao, PhD, created the RVU concept in the 1980’s based on physician surveys of clinical services. The Omnibus Budget Reconciliation Act of 1989 was passed by Congress to reign in rapidly rising medical costs giving life to the RVU concept. This resulted in major changes to the Medicare that included creating specific fee schedules. The goal of the fee schedule was to establish payment rates reflective of the value of the service using the RVU system. The RVU includes three components: 1) the value of physicians’ work (time and intensity—including the cognitive effort and judgment, technical skill, psychological stress), 2) the practice expenses, and 3) the cost of professional liability insurance. Prior to these changes, physicians were paid based on the “usual, customary and reasonable” model that resulted in extreme payment variability across geographic regions and specialties.

The Relative Value Scale Update Committee (RUC) was created by the American Medical Association (AMA) in 1991 to make recommendations about the relative value of physician work for Medicare and Medicaid. The RUC is a group of multi-specialty physicians that provides insight into what it takes to perform physician activities. The group’s recommendations are based on the Current Procedural Terminology (CPT) codes associated with each activity. Medicare began using the RUC’s recommendations for RVUs in 1992 to determine how they reimbursed hospitals and physicians and it is now used by commercial carriers as well.

There are clear benefits with the RVU system. This allows organizations to monitor and compare physician performance. The RVU system encourages increased patient or procedure volumes to optimize constrained health care resources. In most systems, physicians are reimbursed based solely on the RVU calculation and not the actual payments to their employer or hospital system.

Goodhart’s Law states that all metrics of scientific evaluation will eventually be abused and therefore once a metric is chosen as an indicator of function, it ceases to be a reliable indicator of that function.<sup>1</sup>

Consistent with Goodhart’s Law, one published surgical study showed that RVUs may not accurately measure the complexity of a surgeon’s work. Some commonly used surgical RVU values correlated poorly with length of stay, operative time, and mortality, commonly used surgical outcome measures. This study concluded that “given the increasing emphasis on measuring and tracking surgeon productivity, more objective measures of surgeon work and productivity should be developed.”<sup>2</sup>

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A recent quote from our nephrology colleagues also sums up the challenges with the RVU system that is now 30 years old: “The end result of over-reliance on flawed benchmarking data is that clinicians are not appropriately evaluated for their efforts, feel disrespected, suffer burnout, and ultimately feel like they are chasing numbers rather than focused on high-value, cost-conscious care. The issue is not the RVU system but how RVU benchmarking has been translated into inflexible productivity targets”.<sup>3</sup> A *JAMA* editorial has also weighed in stating: “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 healthcare system.”<sup>4</sup>

Changes are taking place in health care payment models. In contrast to a “fee-for service” RVU based model, the “pay-for-performance” (also called value-based care) approach stresses quality over quantity of care. This allows healthcare payers to financially encourage clinical practices that they believe promote better patient health outcomes and is used in some settings. Criticisms of the pay-for-performance system suggest that it may reduce access for socioeconomically disadvantaged groups; physicians who treat a larger share of low-income patients tend to perform worse on pay-for-performance measures and can be disincentivized from treating these patients.<sup>5</sup>

I learned long ago as a new academic Department chair, the ideal compensation model for physicians does not exist. Over dependence on achieving a specified RVU target to avoid a salary reduction or achieve a bonus is problematic particularly in academic medicine. Not only does the metric undervalue patient satisfaction and outcome, in the medical school environment spending time teaching while in the clinical care setting may negatively impact RVU productivity.

Perhaps I can best describe “RVU-itis” as the manifestation of a conflict leading to frustration between obtaining RVU work credits and taking a little longer to care for the needs of a patient. In the academic world, the conflict may be between giving a medical school lecture or reducing clinic hours to attend a meeting. All of these scenarios can create the anxiety of generating less RVU for the day.

In its most basic form, “RVU-itis” is the intrinsic need for most physicians to maintain or increase RVU targets potentially at the expense of other aspects of their chosen professional mission. I wish I had a cure for “RVU-itis”. Sir William Osler, the father of modern medicine, is credited with saying, “Listen to the patient. He is telling you the diagnosis.” We have the diagnosis of an RVU system often at odds with good patient care, patient satisfaction and spending extra time educating our patients and students. What is needed is a uniformly accepted cure.

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## References

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