

# Resource-Based Relative Value Scale (RBRVS) 101

Payment under the Resource-Based Relative Value Scale is based on the computation of relative value units (RVUs). The number of relative value units is multiplied by a conversion factor to generate a dollar amount for each of the 8000 or so codes in the scale.

The total of RVU's for a code is the sum of 3 components: work RVU's, Practice Expense RVU's, and malpractice expense RVU's.

Work RVU's account for work personally performed by the physician (or qualified healthcare professional, QHP, a person who is permitted to bill Medicare directly, e.g., NP's, PA's). Physician work includes direct interaction of the physician with the patient AND supervision of staff who interact directly with the patient.

Practice expense RVU reflects the cost of staff salaries, equipment (e.g., EKG machine, ultrasound), supplies. This is called direct practice expense. There is also indirect practice expense, including rent, utilities, computers, billings, etc.; these are costs that are difficult to attribute to a particular interaction with a patient.

Malpractice expense RVU's reflect the cost of malpractice expense, very low for geriatricians.

These three factors are summed and multiplied by a conversion factor to get a dollar amount, which is the payment to the physician. The conversion factor used in actual practice will vary depending on setting, as discussed below.

The simplest scenario is the private practice. The physician does the work, bears the practice expense cost, and the malpractice cost, and is paid as above using the (ridiculously inadequate) Medicare conversion factor.

Now consider the situation of an academic-affiliated or hospital clinic. The institution can "register" with Medicare as a physician office, in which the payment is as above. But in many cases the institution will label this as a "hospital outpatient department" in which case the payment system is different. I suspect this latter arrangement will be very common among practices participating in Patient Priorities Care.

The physician work is the same whether this is an office practice or a HOPD. The wRVU does not vary by this distinction.

But in the HOPD, typically the staff, the space, the equipment are expenses borne by the hospital, not the physician. The hospital is paid separately under the HOPD system for those costs. The PE RVU paid to the physician is reduced, but to a non-zero amount, since there are still some PE costs borne by the physician, e.g., license, DEA, stethoscope, etc., etc.

I think the wRVU is the best info to share, avoiding the complexity of the different settings. In the HOPD setting, a market determines geriatrician income, which typically is much higher than the RVU times Medicare conversion factor calculation. Still, the RVU times Medicare conversion factor determines the amount the institution receives for the physician's work. Institutions often use wRVU to determine productivity expectations and back-engineer a conversion factor to achieve a market-based figure. This also comes into play where productivity figures directly into compensation.

The CCM code is a good example of these concepts. Here the code is defined by the work of the staff, but the wRVU is for the work of the physician, who is supervising the work of the staff. The work provided directly by the staff is practice expense, the payment for which is determined by the setting as above.

Thus, RVU's figure into the financial situation of the geriatrician's practice regardless of whether she is paid a salary, by production, or by other means.