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wRVU Compensation Formulas: Time to Review

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Many hospitals, physician groups, or other providers compensate employed or contracted practitioners based on the work relative value units ("wRVUs") they generate, *e.g.*, a physician may be paid $x per wRVU performed. Depending on the contract terms, those wRVU values may soon be affected by the 2021 Medicare Physician Fee Schedule. If you have not already done so, you should review your wRVU compensation formula for the following issues:

1. Changes to RVU Values. The 2021 Medicare Physician Fee Schedule will increase the CMS-assigned wRVUs for several codes, including common E/M codes. (*See* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched). If your wRVU compensation formula is based on the then-current CMS wRVU values or automatically incorporates the 2021 changes, you may soon owe your physicians more pay than you otherwise anticipated. You may want to adjust your contractual wRVU conversion factor to account for unanticipated and unwarranted increases in practitioner compensation. If your contract does not allow for unilateral adjustments, you may need to obtain the practitioner's agreement to the change or, alternatively, invoke contract termination provisions. Going forward, you may want to tie the wRVUs to the CMS values that existed at the time the contract was executed rather than the operative CMS values, thereby avoiding the need to monitor or update CMS changes to wRVUs.

2. Personally Performed Services. Ensure that you are only paying physicians based on wRVUs they personally perform, not wRVUs that are actually performed by others. The federal Stark law allows employers to pay employed physicians based on services they personally perform, but Stark generally prohibits paying employed physicians based on the volume or value of services performed by others, including those to whom the physician refers services.[1] (42 CFR § 411.357(c), (d) and (l)). Similarly, Stark and the federal Anti-Kickback Statute prohibit paying independent contractor physicians based on the volume or value of referrals or other business generated by the physician. (42 CFR §§ 411.357(d), (l), and 1001.952(d)). The compensation formula should define wRVUs to include only those services that are personally performed by the physician or relevant practitioner, not others.

3. wRVUs Performed, Billed or Collected. Consider whether the compensation formula is based on wRVUs performed, billed, or collected. If based solely on wRVUs that are performed, the employer may bear the risk that the services may not be billable. If based solely on wRVUs billed, the employer bears the risk that it may not collect on the wRVUs even

though it must pay the physician. Consider defining wRVUs to exclude those wRVUs that cannot be billed or collected, *e.g.*, because the practitioner performed the service as a "no charge"; the service was medically unnecessary; the service failed to comply with the standard of care; or the practitioner failed to complete required records. You should reserve the right to adjust the compensation or wRVUs if, *e.g.*, a claim is denied or repayment owed because of the acts or omissions of the practitioner.

4. wRVU Modifiers. Payers typically include modifiers to wRVUs for certain procedures, *e.g.*, multiple procedures, bilateral procedures, repeat procedures, surgical assists, etc. The compensation formula should allow the employer to adjust the wRVUs consistent with such modifiers or other payer adjustments.

5. Unlisted Procedures. CMS may not have assigned wRVU values to a particular service yet. The wRVU formula should address such situations by, *e.g.*, allowing the employer to use the wRVU values of a comparable procedure or requiring the parties to work together in good faith to determine an appropriate wRVU value.

6. Authority to Determine CPT Codes. wRVUs are based on CPT codes. Physicians may or may not be adept at identifying or inputting CPT codes in the records. The employer should retain the authority to adjust or modify the CPT codes consistent with appropriate professional standards.

7. Duplication. Ensure that the wRVU compensation coordinates with and does not duplication other compensation you may be paying. For example, if you are paying a base salary with a wRVU-based bonus, ensure the wRVU bonus does not kick in until after the practitioner performs sufficient services to cover the base compensation. Similarly, if you are paying a physician by the hour or per shift for certain services (*e.g.*, call coverage, hospitalist shifts, etc.), consider whether the physician should receive wRVU credit for services performed during such shifts; paying wRVU compensation in addition to an hourly rate may result in double payments for the same service and over-compensation.

8. Computation Period. For wRVU bonuses, consider the appropriate bonus period. For example, will you pay a wRVU-based bonus on a monthly, quarterly or annual basis? Paying on a monthly basis incentivizes productivity through more immediate rewards, but it can permit the practitioner to game the system by, *e.g.*, working hard in one month and receiving a sizeable bonus only to have subpar performance over subsequent months. You may have paid a significant bonus even though, if averaged over subsequent months, no bonus would be due. Paying a bonus on a quarterly or annual basis helps normalize the performance, but a delayed bonus may not be as effective in incentivizing performance. An alternative is to allow the practitioner to take a periodic draw or advance against the final bonus subject to a reconciliation at the end of the bonus period. If draws are allowed, consider capping the amount of the draw based on the practitioner's recent performance. Also, consider whether the practitioner must remain employed or contracted for the entire bonus period before the bonus is earned, thereby encouraging the practitioner to

remain employed to receive the bonus.

9. Value-Based or Quality Metrics. There is a growing trend to incorporate value-based and/or quality metrics into compensation formulas. Employers may want to adjust wRVU-based formulas to coordinate with such metrics, including items such as timely completion of records, patient satisfaction scores, quality outcomes, etc. This will become increasingly important with the shift to value-based care.

10. Cap the Compensation. Stark and the Anti-Kickback Statute generally require that compensation represent fair market value. (42 CFR §§ 411.357(c), (d), (l), and 1001.952(d)). Employers may want to cap the total wRVU-based formula so that the total compensation does not exceed fair market value. It is fairly common to cap the compensation at a certain percentage of a reputable practitioner compensation survey such as the MGMA survey. Alternatively, the employer may reserve the right to periodically review the practitioner's performance and compensation to ensure that the overall compensation remains within fair market value.

Reviewing and, as necessary, updating your wRVU compensation formula can help ensure the practitioner's compensation aligns with their productivity while avoiding misunderstandings or disputes.

[1]Stark contains a limited exception for physicians in a "group practice" (as defined by Stark): such physicians may be paid based on services they personally perform as well as "incident to" services. (42 CFR 411.352(i)(1)). For more information about group compensation formulas, see our client alert at https://www.hollandhart.com/group-compensation-arrangements-stark-requirements.
