

Work Relative Value Units Generated by Pediatric Urologists

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Abstract

Introduction: As more physicians are employed by health care organizations and hospitals, salaries are often linked to productivity. To our knowledge there are no published data on RVUs (relative value units) generated by the average pediatric urologist. We sought to determine the typical work load of a pediatric urologist.

Methods: We reviewed de-identified billing logs submitted during 2007 and 2008 to the American Board of Urology by 230 applicants for a subspecialty certificate in pediatric urology. We analyzed wRVUs (work load RVUs), including wRVUs generated by nurse practitioners/physician assistants billing incident to the physician, for evaluation and management, ultrasound, urodynamic, biofeedback and operative codes. The relationship of wRVUs to self-reported information on practice demographics was examined.

Results: The median was 8,156 wRVUs per year with the majority (4,756) generated from operative procedures and the next largest amount (2,551) generated from evaluation and management codes for office visits. The 202 men generated more wRVUs than the 28 women (median 8,303 vs 6,705 wRVUs, $p < 0.02$). The 104 private practitioners generated more than the 108 academicians (median 9,359 vs 7,443 wRVUs, $p < 0.005$). There was also a difference by experience. The median for 75 physicians with less than 10 years in practice vs 60 with 10 to 20 years vs 95 with more than 20 years was 7,027 vs 8,972 vs 8,291 wRVUs ($p < 0.001$). The median was similar in 145 physicians in metropolitan areas and 77 in nonmetropolitan areas (8,279 vs 7,410 wRVUs, $p = 0.30$).

Conclusions: Pediatric urologists generated an average of 8,156 wRVUs per year. Most wRVUs are generated from operative procedures. Women and academic practitioners had lower median wRVUs. The most productive pediatric urologists were in practice between 10 and 20 years.

Key Words: urology, pediatrics, workload, professional practice, efficiency

Abbreviations and Acronyms

ABU = American Board of Urology

E&M = evaluation and management

NP = nurse practitioner

PA = physician assistant

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Judging how hard a physician works has been a subject of debate for many years. As a general rule this has often been determined by physician collections. In an attempt to quantify the physician work load Hsiao et al developed a resource based relative value scale system of RBRVUs (resource based RVUs) or RVUs.¹ In its initial implementation there were many debates about the relative work value of surgeons vs “cognitive doctors.”² Indeed E&M codes seemed to be favored over operative codes. Nonetheless the system has been widely accepted as a payment methodology (a given number of dollars per RVU) and as a method of comparing how hard a physician is working.^{3,4} In a private practice functioning under a fee-for-service model these methods might have been essentially the same. Thus, physician work is still often determined by collections.

In pediatric urology and many other specialties monitoring collections alone is somewhat limited by the fact that a significant percent of patients are insured by some form of Medicaid if they have insurance coverage at all. Medicaid generally pays far less than the typical rate per RVU paid by private carriers. Therefore, looking at collections alone will underestimate the work load of many specialists, including pediatric urologists. Further in the current environment a considerable part of physician revenue is determined by ancillary services. Physician collections include not only office and operative urology but also, for example, ultrasound and urodynamic procedures as well as in-office laboratory tests and pharmaceuticals. In many of these cases the reimbursement for these ancillaries may far exceed the reimbursement for the RVUs generated by the physician from office visits or procedures.

As more physicians become employed by large groups, hospitals or health care systems collections become less and less valuable in terms of judging how hard a physician is working. Instead RVUs are generally used to determine the pediatric urologist work load. To our knowledge there are no published norms to date for the typical pediatric urologist.

We sought to determine the median and range of wRVU productivity for a pediatric urologist. We hypothesized that an average pediatric urologist would generate approximately 8,000 wRVUs per year with most units from office based work. In addition we sought to determine whether there are differences in wRVU production by gender, practice type (academic vs private), location (large metropolitan vs smaller communities) and duration in practice.

Methods

Starting in 2007 ABU offered the possibility of a certificate of special competency in pediatric urology. As part of that

process all applicants were required to submit 12-month billing logs for all of their clinical activity. We reviewed ABU de-identified billing logs of the first 230 consecutive applicants, which were submitted in 2007 and 2008. Although some senior pediatric urologists did not apply for this certificate, the majority of practicing pediatric urologists did.

The RBRVU for each CPT code is determined using 3 factors, including physician work, practice expense and malpractice expense. The average relative weights are physician work 52%, practice expense 44% and malpractice expense 4%.^{5,6} To remove the geographic effects on practice and malpractice expenses we used work wRVUs only. We used 2013 RVU-CPT conversion factors but for some codes that had since been discontinued, we used the last available conversion factor. It should be noted that ABU billing log data include not only the pediatric urologist but also any NP or PA billing incident to that pediatric urologist. It was impossible to separate what the physician generated independently of the NP or the PA and it is well known that pediatric urologists use NPs and PAs extensively.⁷⁻⁹

We analyzed these logs by categories. We arbitrarily used the categories operative procedures, office and hospital based E&M codes, urodynamics, ultrasound and biofeedback. In addition we evaluated the wRVU productivity of urologists by applicant demographics. For this analysis we used gender (male vs female), type of practice (academic, private or other), time in practice (less than 10, 10 to 20 or greater than 20 years) and location (metropolitan area vs nonmetropolitan).

Data are presented as the median and IQR (25th to 75th percentile). wRVU data on individual physicians were not normally distributed (total wRVU Anderson-Darling test $p < 0.005$), showing an upward skew. Nonparametric tests were used to compare across 2 (Mann-Whitney test) or 3 (Kruskal-Wallis test) demographic categories. On multivariable analysis a logarithmic transformation was used, which normalized wRVU data (Anderson-Darling test $p = 0.84$). Log wRVU was used in a general linear model with hierarchical stepwise selection to incorporate multiple potentially predictive demographic factors and all possible 2-way interactions into the model. Analysis was performed with Minitab®, version 17.

Results

The median wRVUs for a pediatric urologist and any NP/PA working with them was 8,156/12 months (IQR 5,843–11,234) (table 1). Most of those wRVUs were generated in the operating room (4,657) while only 2,551 wRVUs had office E&M codes. Relatively few wRVUs were generated by urodynamics (128) and very few were generated by ultrasound or biofeedback.

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