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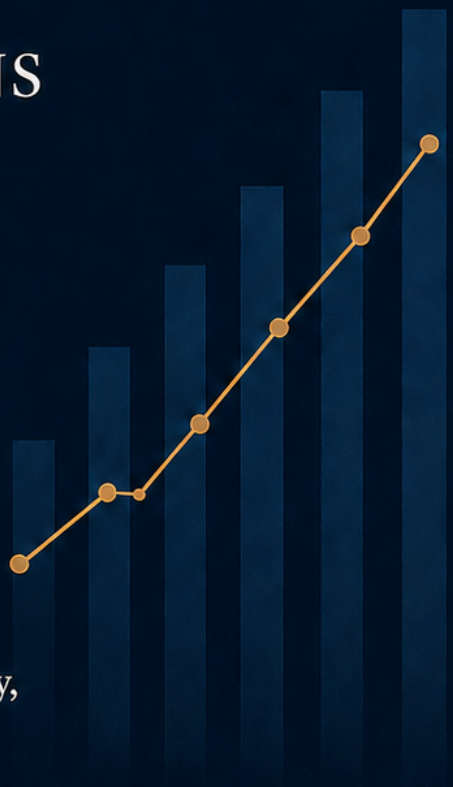
The Truth About RVUs



A Practical Guide to RVUs, Productivity,
and Compensation
for Residents, Fellows,
and Early-Career Providers

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Master the Business of Medicine, One RVU at a Time

Welcome

We spend years learning about medicine. From basic sciences to our clinical rotations.

We learn how to take a history, perform a physical examination, interpret laboratory results, present a patient, assist in procedures, and make increasingly complex medical decisions.

We learn how to interact with our patients, show empathy and compassion, and offer support.

But there is something many medical professionals are rarely taught: how the healthcare system measures and values their work. How do physicians, nurse practitioners, and physician assistants get paid?

That is where Relative Value Units, better known as RVUs, come in.

Unfortunately, in many places, talking about money and the business side of medicine is still seen as taboo by many of our medical peers. But in my opinion, speaking about RVUs, compensation, and the business side of medicine is not incompatible with our higher mission. Healthcare providers are called to care. But we must also understand the finances of the current healthcare system in the United States. Learning about RVUs and how our income is calculated is an opportunity to take control of our own financial future.

RVUs influence provider compensation, productivity expectations, bonuses, staffing decisions, contract negotiations, and the financial performance of medical practices and departments, regardless of how you get paid. Even providers who receive a fixed salary may eventually discover that their employer is measuring their work, their bonuses and their productivity through RVUs behind the scenes.

The purpose of this playbook is not to turn you into a professional coder, biller, or healthcare economist. My goal is to make this complicated subject accessible to doctors, nurse practitioners, and physician assistants entering the job market, as well as future providers. I certainly wish that, when I finished residency, someone had taught me what I am about to share with you now. In retrospect, my financial and professional decisions would have been very different. I can assure you of that.

Because understanding RVUs is not simply about billing. It is about understanding your work, your contract, your income, and your career.

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About Medicine, Dollars & Decisions

Medicine, Dollars & Decisions (MD&D) is a free educational platform for physicians and advanced practice providers, covering productivity, RVUs, medical finances, and leadership.

Our mission is to help clinicians build the financial literacy and confidence to take ownership of their careers.

Life and Business in Medicine

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PART ONE

What Is an RVU?

What Is an RVU?

RVU stands for Relative Value Unit.

Think of RVUs as chips in a casino. A chip does not have an inherent cash value until the house assigns one to it. It is the same basic concept with RVUs. In healthcare, each billable service is represented by a code, and each code is assigned an RVU value.

RVUs are standardized, nonmonetary units used to compare the relative value of medical services provided to patients.

Every billable patient medical encounter or procedure is associated with a code. These include office visits, hospital consultations, diagnostic procedures, surgeries, and many other professional services. Most provider services are reported using Evaluation and Management (E/M) codes and Current Procedural Terminology (CPT) codes.

E/M codes cover encounters such as office visits, emergency department visits, hospital care, and virtual encounters.

CPT codes describe surgeries and procedures performed in an office, in the operating room, or in other settings.

Each of these codes is assigned a relative value (RVU). These thousands of patient encounters are categorized based on their complexity. In simple terms:

- A more demanding service should generally receive a higher RVU value than a less demanding service.
- An uncomplicated follow-up visit may carry fewer RVUs than a complex new patient evaluation.
- A minor office procedure may generate fewer RVUs than a major operation.

The system considers factors such as time, technical skill, mental effort, and complexity when making this distinction.

But it is very important to underline that the system is not saying that one patient is more valuable than another. It is just attempting to measure the relative resources involved in delivering different services.

It is a measurement used by the healthcare payment system to value a particular service.

Bruno's Tip

An RVU is not a measure of your worth as a provider.

The Three Components of an RVU

The total RVU assigned to a medical service is generally built from three components.

1. Provider Work RVUs

This component reflects your work in each billable interaction with your patients, whether surgical or nonsurgical.

It considers factors such as:

- Time
- Technical skill
- Mental effort
- Clinical judgment
- Training
- Stress
- Complexity
- Risk to the patient

This portion is commonly called the work RVU, or wRVU. When employers discuss provider productivity, they are often referring specifically to work RVUs. Work RVUs are the measure used for your compensation.

2. Practice Expense RVU

Providing medical care requires more than a provider's work. We are not self-sufficient. We all need the appropriate support to do our job. This portion of the RVUs covers what you need to take care of your patients.

- Clinical and administrative staff
- Examination rooms
- Medical equipment
- Supplies
- Electronic health record systems
- Rent
- Utilities
- Scheduling and billing support

And many other resources that help the provider take care of the patient, and, yes, help the provider look good.

If you work for a hospital, medical group, private office, or urgent care center, the organization generally receives the payment from practice expense RVUs. If you are one of the few remaining solo

providers hanging your own shingle, then you are the one responsible for, and receiving payment toward, those costs.

In summary, the practice expense component is intended to account for the overhead associated with delivering health services.

3. Malpractice RVU

Different medical services carry different levels of professional liability risk. Different specialties carry different litigation risks.

The malpractice RVU attempts to account for the cost of liability insurance associated with providing a particular service. The payment associated with malpractice RVUs helps cover professional liability costs. The entity paying for your malpractice insurance, whether it is your institution or you, gets this portion.

The three components together form the total RVU for each service, encounter, procedure or surgery.

In summary, work RVUs are commonly used to measure provider productivity. Practice-expense and malpractice RVUs are part of the total payment calculation and generally help cover costs incurred by the practice or organization.

PART TWO

From Medical Service to Payment

From Medical Service to Payment

Understanding RVUs becomes easier when you separate the process into several steps.

Step 1: A Medical Service Is Performed

A provider evaluates a patient, performs a procedure, provides a consultation, or completes another billable professional service.

Step 2: The Service Gets a Code

The encounter or procedure is documented and associated with the appropriate billing code. For procedures or surgeries this is a CPT code. For non-surgical encounters we use E/M codes.

Step 3: Each Code Has an RVU Value

Each code has an assigned RVU value based on the resources and work associated with caring for the patient. The codes and their Medicare payment values appear in the Medicare Physician Fee Schedule, or MPFS.

Step 4: RVUs Get Adjustments

Your location in the country matters, and sometimes a lot. For Medicare payment, the components of an RVU are adjusted based on the geographic area where the service is provided.

In other words, Medicare applies geographic adjustments to account for differences in the cost of providing care across the country. A scalpel, an office, and a staff member do not cost the same in Tupelo, Mississippi, as they do in Honolulu, Hawaii.

Geography is only one part of the payment calculation. Payment may also differ depending on whether a service is performed in a facility, such as a hospital or ambulatory surgery center, or in a nonfacility setting, such as a provider office.

Step 5: The Adjusted RVU Value Is Converted Into Dollars

The geographically adjusted total RVU is then multiplied by something called Medicare’s conversion factor, to calculate the allowed payment for the professional service you provided.

Private insurers may use Medicare’s framework as a reference, but they negotiate their own fee schedules and payment rules.

A Simplified Example

Imagine that a provider sees a patient for a routine annual evaluation and generates 2 work RVUs.

Suppose the provider's employment agreement pays $45 per work RVU.

The productivity value of that service would be:

2 wRVUs × $45 = $90

Now, for the purpose of this simplified example, imagine that the payment is adjusted based on where the provider works. If the provider works in Alaska and the hypothetical geographic adjustment factor is 1.5, the calculation would be:

$90 × 1.5 = $135

The adjusted value of that routine annual evaluation would therefore be $135.

Now imagine that the provider generates 8,000 work RVUs during the year.

At $45 per work RVU and using the same hypothetical geographic adjustment factor of 1.5:

8,000 wRVUs × $45 × 1.5 = $540,000

That is a lot of annual routine evaluations. Your final compensation may also depend on:

- Base salary
- Productivity thresholds
- Quality incentives
- Administrative stipends
- Call coverage
- Benefits
- Employer policies
- Contract terms

This example simply demonstrates how work RVUs can be converted into provider compensation.

But RVUs are more than just a variable used in a formula.

PART THREE

Who Decides What a Medical Service Is Worth?

Who Decides What a Medical Service Is Worth?

One of the most important questions in medicine is rarely addressed during medical training:

The Centers for Medicare & Medicaid Services publishes the Medicare Physician Fee Schedule (MPFS) and establishes the official payment rules used by Medicare.

However, providers and specialty societies also participate in the process of evaluating medical services and recommending relative values.

A provider committee reviews medical services and considers factors such as:

- Time required
- Clinical complexity
- Mental effort
- Technical skill
- Training
- Patient risk
- Intensity of the service

Recommendations are submitted to the federal government, which ultimately determines the values used in the Medicare payment system.

This means that RVUs are not created by a simple mathematical formula alone. They are influenced by surveys, estimates, provider recommendations, regulatory decisions, economic constraints, and healthcare policy.

The process is structured, but it is not perfect. It also evolves over time.

PART FOUR

Why Were RVUs Created?

Why Were RVUs Created?

Before the modern RVU system, provider payment was often based heavily on historical charges.

Or on factors such as the experience of the provider, the institution where they worked, or even where they completed their medical education.

Different providers could charge different amounts for similar services. Payment lacked a national consistent framework for comparing the resources required to perform different kinds of medical work.

The RVU system was created to bring more structure to provider payment.

The goals were:

- Creating a standardized method to assign a value to medical services
- Comparing different services using a common framework
- Reducing reliance on historical provider charges
- Accounting for provider work, practice expenses, and malpractice costs
- Improving consistency in Medicare payment

The idea was logical: to create a common unit that could be used to compare the relative resources involved in medical care. But this system, designed primarily for reimbursement, eventually became much more than that. RVUs are now frequently used to evaluate provider productivity, bonuses, and compensation. That evolution had major consequences for medical professionals.

RVUs have evolved into much more than a reimbursement tool. They have become a tool used to assess provider work in many different ways.

PART FIVE

RVUs and Provider Compensation

RVUs and Provider Compensation

Many providers assume that RVUs matter only when a provider has a productivity-based contract. That is not true. RVUs can affect compensation under several different models.

Fixed Salary

A provider may receive the same salary regardless of short-term production.

However, the employer may still monitor RVUs to decide whether the provider is meeting expectations.

RVU performance may influence:

- Contract renewal
- Future salary increases
- Bonus eligibility
- Staffing decisions
- Schedule changes
- Leadership opportunities
- Perceptions of performance

Salary Plus Productivity

The provider receives a guaranteed base salary and may earn additional compensation after exceeding a defined production threshold.

For example, a contract might establish:

- A base salary
- An annual wRVU target
- A conversion rate for RVUs generated above the target

This model is common, but the details matter enormously.

Pure Productivity

Some providers are compensated only according to the number of work RVUs they generate. Under this arrangement, income is very closely connected to production. This can offer significant upside, with significant potential for a high income. But it also places more financial risk on the provider.

Academic Compensation and Leadership Positions

Academic providers may receive compensation for a combination of:

- Clinical care
- Teaching
- Research
- Administration
- Program development

Even in academic medicine, RVUs may still be used to measure the clinical portion of a provider's work. For example, if your team does not reach certain RVU benchmarks, your income may be affected.

Private Practice

Private-practice compensation may be based more directly on collections, revenue, expenses, ownership, and profit distribution. Nevertheless, RVUs may still be used to assess productivity, compare providers, or allocate practice resources.

Bruno's Tip

Regardless of your compensation model, RVUs may affect your income.

PART SIX

The Difference Between RVUs and Collections

The Difference Between RVUs and Collections

RVUs and collections are related terms, but they are not the same thing.

RVUs Measure Relative Work and Resources

As I mentioned above, an RVU is a standardized value assigned to the services you provide to your patients.

Collections Represent Money Received

Collections are the actual payments received from insurers and patients after claims are submitted and processed. Each of these claims is composed of the codes and RVU values assigned to the services you provided to that specific patient.

Now, here is where the interaction between RVUs and collections directly affects providers. Two providers can generate similar RVUs but produce different collections. That means providers may receive different amounts due to:

- Insurance contracts
- Patient population (i.e. commercially insured versus Medicare)
- Payer mix
- Geographic location in the U.S.
- Denials
- Coding inaccuracy
- Lack of appropriate documentation
- Collection efficiency
- Procedure setting (i.e. hospital versus ambulatory surgical center)

This is one reason provider compensation can differ even when providers perform similar work. One employer may pay a provider based on work RVUs. Another may pay based on collections. A third may use a combination of salary, RVUs, quality metrics, and organizational performance.

Before signing a contract, you need to know which system applies.

PART SEVEN

Why the Same RVUs Can Produce Different Incomes

Why the Same RVUs Can Produce Different Incomes

Generating the same number of work RVUs does not guarantee the same income.

Consider two providers who each generate 7,000 wRVUs.

Provider A is paid $42 per wRVU.

Provider B is paid $52 per wRVU.

Their productivity compensation would be very different:

Provider A:

7,000 × $42 = $294,000

Provider B:

7,000 × $52 = $364,000

That is a difference of $70,000 for the same measured production. That is a significant difference.

Why is this happening? Why the difference in compensation?

Possible explanations include:

- Specialty (i.e. surgical versus cognitive specialties)
- Geographic market
- Employer finances
- Provider experience (i.e. a provider in peak production years versus a recent graduate)
- Recruitment difficulty (i.e. rural or urban areas)
- Negotiating leverage
- Local demand
- Compensation benchmarks
- Leadership responsibilities
- Call obligations
- Contract structure

This is one of the most important lessons in provider compensation:

Bruno's Tip

RVUs measure production, but the contract determines how that production becomes income.

PART EIGHT

Budget Neutrality

Budget Neutrality

Medicare provider payment operates within financial constraints.

When Medicare increases the RVU value of a particular service, it needs to make offsetting adjustments elsewhere, so that spending remains within a fixed limit. This is commonly described as budget neutrality.

Imagine a pizza. If one person gets a larger slice, the slices available to others may become smaller unless the entire pie grows. As a result, an increase in the RVUs assigned to one set of services does not automatically mean every provider will receive more money. This helps explain why providers may hear that a service has been assigned more value but still see limited improvement, or even a reduction, in actual payment.

Changes to RVUs and changes to the conversion factor can interact in complicated ways.

Bruno's Tip

Over time, the federal government has repeatedly stepped in to redistribute the slices of this RVU pizza.

PART NINE

The Job Market Still Matters

The Job Market Still Matters

Provider compensation is not determined by RVUs alone.

The labor market also matters. An employer trying to recruit a provider in a high-demand specialty or underserved geographic area may need to offer:

- A higher salary
- A more favorable RVU conversion rate
- A signing bonus
- Loan repayment
- Relocation assistance
- Additional time off
- Better call arrangements
- Partnership or ownership opportunities

An employer in a highly desirable location with many available candidates may feel less pressure to offer generous terms.

Compensation is therefore influenced by both:

1. The economic value of the provider’s work
2. The employer’s need to recruit and retain that provider

A compensation offer is not simply a statement about your clinical ability. It also reflects the employer’s market, finances, priorities, negotiating strategy, and staffing needs.

Understanding this can help you evaluate job offers more realistically.

PART TEN

What Residents Should Look for in a Contract

What Residents Should Look for in a Contract

You do not need to become a compensation expert before accepting your first job.

But you should be able to identify the questions that need answers.

Compensation Structure

ASK

- Is the compensation guaranteed, productivity-based, or both?
- How long does the guarantee last?
- When does productivity compensation begin?
- Is compensation based on work RVUs, total RVUs, collections, or another measure?

Productivity Target

ASK

- What is the annual RVU target?
- How was the target determined?
- Is it prorated during the first year?
- How does it compare with providers in the same specialty and region?
- What happens if the target is not reached?

Conversion Rate

ASK

- How much is paid per work RVU? (Probably the most important question.)
- Does the rate change after a threshold?
- Is the rate reviewed annually?
- Can the employer change it?
- Is there a cap on productivity compensation?
- Is there a floor on productivity compensation?

Measurement Period

ASK

- Are RVUs measured monthly, quarterly, or annually?
- Can excess production carry forward?
- Is there a reconciliation period in which my actual production is compared with the compensation I have already received?
- When are bonuses paid?
- What happens to unpaid productivity compensation if employment ends?

Access to Data

ASK

- Will I receive regular production reports?
- Can I review the codes and RVUs attributed to me?
- How are shared visits handled?
- How are procedures involving multiple providers allocated?
- Who corrects errors?

Nonclinical Responsibilities

Ask whether the compensation model accounts for:

- Teaching
- Administration
- Leadership
- Research
- Committee work
- Program development
- Call coverage
- Supervision of advanced practice clinicians

If those responsibilities are expected, they should be defined and appropriately recognized.

Time spent on nonclinical work can reduce clinical production.

Bruno's Tip

A decision made with information is worth more than a regret born of misinformation.

PART ELEVEN

Common RVU Mistakes

Common RVU Mistakes

Mistake 1: Ignoring RVUs Because the Job Is Salaried

A salary does not mean productivity is irrelevant.

Your employer may still be comparing your RVUs with a target, budget, or benchmark.

Mistake 2: Focusing Only on the Starting Salary

A high guaranteed salary may become less attractive if it is later replaced by an unrealistic productivity model.

Look beyond the first year.

Mistake 3: Accepting a Target Without Understanding the Rate

The production target and the conversion rate (the dollar amount assigned to each work RVU) must be evaluated together.

A reasonable target with a poor conversion rate may limit income.

A generous conversion rate is not valuable if the threshold is nearly impossible to reach.

Mistake 4: Assuming Every Employer Calculates RVUs the Same Way

Employers may differ in how they attribute procedures, shared visits, modifiers, advanced practice clinician work, and other services.

Ask for the methodology used to choose the conversion rate, salary and target in the offer.

Mistake 5: Failing to Review Production Reports

Errors happen.

Services may be missing, assigned incorrectly, or not credited to the appropriate provider.

Your production report deserves the same attention as your paycheck.

Mistake 6: Confusing Productivity With Quality

RVUs measure services and resources. They do not directly measure compassion, diagnostic wisdom, patient satisfaction, teamwork, leadership, or long-term outcomes.

A productive provider is not automatically a better provider.

A provider with low RVU production is not automatically less valuable.

Bruno's Tip

RVUs are a production measurement tool, not a definition of medical value.

PART TWELVE

A Resident’s RVU Checklist When Becoming an Attending

A Resident’s RVU Checklist When Becoming an Attending

Before beginning your first attending position, make sure you can answer the following questions.

My Compensation

- What is my guaranteed base salary?
- How long is it guaranteed?
- Is there a productivity bonus?
- What is the dollar amount paid per work RVU? (Perhaps, the most important question)
- When are bonuses calculated and paid?

My Target

- What is my annual wRVU expectation?
- Is the target adjusted during onboarding?
- Is it adjusted for vacation, parental leave, or administrative time?
- How was the target established?
- What happens if I exceed or miss it?

My Clinical Environment

- Will I inherit an established patient panel?
- How many clinic sessions will I have?
- Will I have operating room or procedure access?
- Is there adequate staffing?
- Who controls my schedule?
- How long does credentialing usually take?
- How long does it take new providers to reach expected production?

My Data

- How often will I receive RVU reports?
- Will reports show services by code and date?
- Who reviews coding accuracy?

- Is coding education available?
- What is the process for disputing missing or incorrect RVUs?

My Nonclinical Work

- Am I expected to teach?
- Will I have administrative responsibilities?
- Is call compensated separately?
- Is leadership time protected?
- Are these responsibilities included in the productivity target?

PART THIRTEEN

A Simple Monthly RVU Habit

A Simple Monthly RVU Habit

You do not need to obsess over your RVUs every day.

But you should develop a consistent habit of reviewing your work RVUs.

Once each month:

1. Review Your Production

Compare your actual monthly wRVUs with your expected pace. If your annual target is 6,000 wRVUs, the simple monthly average would be approximately 500 (6,000 ÷ 12). Actual production will fluctuate, but the estimate gives you a reference point.

2. Look for Missing Services

Review whether major procedures, consultations, and high-complexity encounters appear on your report. Review your production report for missing services and insurance denials, if that information is available.

3. Identify Operational Barriers

Low production is not always caused by lack of effort. Possible barriers include:

- Insufficient referrals
- Limited clinic space
- Poor scheduling
- Inadequate staffing
- Operating-room access
- Credentialing delays
- High cancellation rates
- Excessive administrative duties

And most importantly, life happens. Personal and family issues may affect your production. And that is fine. Life is not only about work.

4. Ask Questions Early

Do not wait until the end of the year to discover that your production is below target or that services are being credited incorrectly.

5. Keep Your Own Records

Maintain copies of production reports, compensation calculations, and written explanations of the formula used by your employer.

Information supports growth. Documentation protects it.

PART FOURTEEN

What RVUs Do Not Measure

What RVUs Do Not Measure

RVUs are influential, but they are incomplete.

They do not fully capture:

- The quality of a difficult conversation
- Time spent coordinating care
- Emotional support provided to a family
- Preventing an unnecessary procedure
- Mentoring a resident or medical student
- Building a clinical program
- Improving team culture
- Answering patient messages
- Managing complex social circumstances
- Leadership outside the examination room
- Long-term patient outcomes

This does not make RVUs useless. It means they should be understood for what they are:

A standardized economic measurement within our very large healthcare system.

They are not a complete measurement of professional capacity.

Bruno's Tip

RVUs are a tool, not a measure of the quality of your work.

PART FIFTEEN

The Bottom Line

The Bottom Line

RVUs influence much more than billing.

They can affect:

- Salary
- Bonuses
- Productivity targets
- Contract negotiations
- Recruitment
- Staffing
- Department finances
- Employer expectations
- Career decisions
- Provider burnout

You do not need to memorize every code or calculate every payment. But you need to understand the basic concepts of the healthcare system in the United States.

You spent years learning how to care for patients.

You should also understand the system that measures the work you perform.

Ten Questions to Ask Before Signing

1. Is my compensation based on salary, RVUs, collections, or a combination?
2. What is my annual work RVU target?
3. What is the conversion rate paid per work RVU?
4. How was the target determined?
5. What production do providers in this position usually achieve?
6. How often will I receive production reports?
7. How are bonuses calculated and when are they paid?
8. How are teaching, leadership, call, and administrative duties compensated?
9. What resources will I receive to help me reach the target?
10. Can the employer change the target or conversion rate without my agreement?

Key Terms

Current Procedural Terminology (CPT code): A code used to describe a surgery or procedure.

Evaluation and Management service (E/M code): A code for patient encounters involving evaluation, medical decision-making, and management. Nonsurgical encounters.

RVU: Stands for Relative Value Unit. It is used to compare the resources associated with different medical services.

Work RVU: The component intended to measure provider time, skill, effort, judgment, and intensity. What the provider gets for each patient encounter.

Practice expense RVU: The component associated with the overhead required to provide a medical service. In simple terms, this portion helps account for expenses such as staff, equipment, supplies, rent, and other operating costs. The organization or practice paying those expenses generally receives this portion of the reimbursement.

Malpractice RVU: The component associated with professional liability costs. It helps account for the cost of malpractice insurance related to providing a medical service. The organization or provider paying for the malpractice coverage generally receives this portion of the reimbursement.

Conversion factor: The dollar amount assigned by Medicare to one RVU to turn it into payment.

Conversion rate: The amount an employer agrees to pay a provider for each work RVU under an employment compensation formula.

Productivity threshold: The level of production a provider must reach before earning additional productivity compensation.

Collections: The money received from insurers and patients for medical services.

Payer mix: The proportion of patients covered by Medicare, Medicaid, commercial insurance, self-pay, and other payment sources.

Final Thought

The greatest risk is not failing to understand every technical detail of RVUs. The greatest risk is entering a career without realizing how much these numbers can influence their professional lives.

Learn the system. Ask questions. Review your data. Read your contract. And never confuse a numerical measure of medical production with the full value of the work you do.

Then build your practice, one RVU at a time.

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