

Plastic Surgery Compensation Models and Patient Outcomes

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Compensation models for plastic surgeons vary between, and within, institutions. A fee-for-service approach is the most common model of healthcare compensation in the United States and compensates surgeons with certain dollar values for each service provided.¹ A salary-based approach guarantees a fixed salary regardless of clinical volume or activity. Recently, institutions have increasingly adopted a hybrid approach to compensation, using a model with a base salary plus productivity-related bonuses. Work relative value units (wRVUs),¹ linked to reimbursements, are applied in this approach. RVUs quantify effort and provide a measure of the technical skill required to deliver a specific service.¹ They are then converted into monetary values to be paid to providers. No compensation model is ideal, and each has attendant advantages and disadvantages (Table 1).

Data on patient outcomes tied to compensation models are extremely limited. Two studies have reported outcomes after a switch from a salary-based compensation model to one based on wRVUs. Conducted by the vascular² surgery and otolaryngology³ departments at Cooper University, no significant differences in readmissions, return to the operating room, mortality, or safety outcomes after the transition were reported.^{2,3} There was a significant increase in number of cases for otolaryngology procedures.³ Generalizations from these studies are limited due to short follow-up times² and restriction of analysis to only outpatient procedures.³

There is a dearth of similar investigations in plastic surgery. One potential reason is lack of wRVUs for some aesthetic and reconstructive procedures, complicating productivity quantification and necessitating use of tools such as net charges.¹ Value-based care (VBC) compensation models have become popular to address limitations of older models (Fig. 1). VBC closely ties compensation with patient outcomes, creating a self-reinforcing feedback loop.⁴ Care quality is assessed through surgical experience and technical skill (already elements of wRVUS), as well as

medical outcomes⁴ in combination with patient outcomes such as satisfaction and functional and psychological relief.⁴ It is challenging to quantify these factors in a field as diverse as plastic surgery, thus hampering the transition to VBC. One proposed accounting tool to help with this is Time-drive activity-based costing (Td-ABC). Td-ABC analyzes care as a production line, identifying inefficiencies to minimize unit cost per time.⁵ Td-ABC has been successfully applied to the workup of appendicitis.⁵ However, the caveat to the implementation of Td-ABC is that it functions best for repetitive services with predictable outcomes, which is not always true for plastic surgery cases.

VBC is nascent in plastic surgery likely because of the difficulties of value quantification, wide variety (and subsequent costs) of procedures, and the relatively recent emergence of VBC as a whole. Thus, there are little data on patient outcomes after implementation of VBC compensation models, limiting the scope of this viewpoint. To that end, well-designed studies investigating VBC compensation models in plastic surgery, following a similar model to the aforementioned studies in vascular surgery and otolaryngology before and after implementation of a VBC compensation model, are crucial to improving our understanding of the impact of compensation models on our patients.

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DISCLOSURE

The authors have no financial interest to declare in relation to the content of this article.

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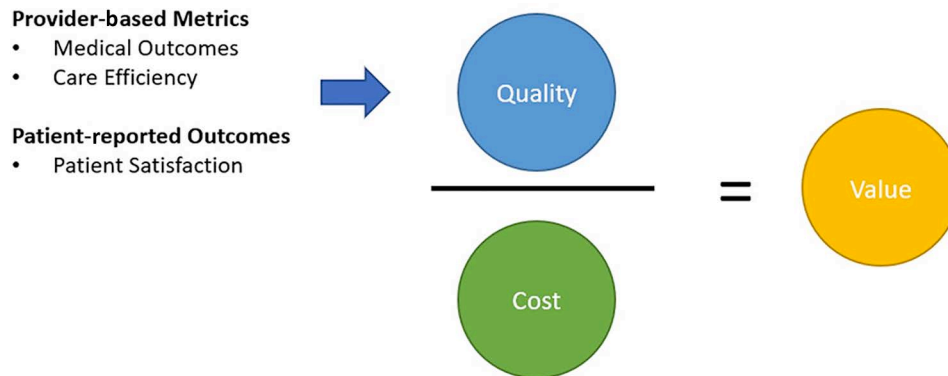
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Table 1. Characteristics of Common Physician Compensation Models in the United States

	Fee-for-service	Productivity-based Care	Salary Only	Value-based Care
Payment model	Fees for each service rendered by a physician	Base salary plus RVUs as a measure of productivity	Fixed salary regardless of clinical volume or activity	Payment tied to patient outcomes and costs
Pros	Encourage extensive workups and procedures	Balances productivity and costs	Discourages overutilization of resources	Reduced healthcare spending, higher patient satisfaction
Cons	Increases systemic and patient healthcare costs	RVUs do not perfectly capture surgical effort or patient outcomes	De-emphasize productivity	Requires reliable measures of patient outcomes and satisfaction



Value in value-based care is based on balancing quality and cost. Quality is determined by provider-based metrics such as care efficiency and medical outcomes, as well as patient-reported outcomes like overall patient satisfaction. Cost and quality must be balanced to maximize value.

Fig. 1. Components of VBC.