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## PRODUCTIVITY AND STAFFING GUIDANCE FOR IMAGING PHYSICIANS

**1. PURPOSE:** This Veteran Health Administration (VHA) Directive defines the policy for tracking imaging physician productivity.

### 2. BACKGROUND

a. In January 2003, the Deputy Under Secretary for Health charged a VHA Advisory Group on Physician Productivity with developing productivity models for physicians in VHA. This Advisory Group was asked to:

(1) Evaluate the relative productivity of full-time and part-time Department of Veterans Affairs (VA) physicians in comparison with external benchmarks;

(2) Improve the management of providers and better understand how resources become services in outpatient care;

(3) Demonstrate how veteran perceptions and needs are related to physician and other support staffing;

(4) Develop incentives to improve the delivery of care by clinical providers; and

(5) Develop a prototype infrastructure for conducting physician productivity and staffing studies in other specialties.

b. To meet these goals, this Advisory Group developed a Relative Value Unit (RVU)-based model for measuring productivity of specialty providers and providing staffing guidance for specialty services. For purposes of physician productivity measurement, only the physician work component of the RVU value is utilized, and is referred to as wRVU. This is consistent with external benchmark data.

c. In 2005, the RVU-based analysis of productivity was extended to imaging physicians. A study was made of imaging productivity within VHA during the period October 1, 2004, to February 28, 2005. Although many imaging physicians work in more than one sub-specialty, it was not possible to calculate productivity for general radiology, nuclear medicine, and interventional radiology separately. Combining the sub-specialties into a single practice produced the most reliable productivity results. The study elements are described as follows:

(1) **Workload.** Each medical center extracted their Current Procedural Terminology (CPT) workload from local Veterans Health Information Systems and Technology Architecture (Vista) systems using standardized parameters, and provided that information to the Advisory Group.

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(2) **Employee Physicians.** The number of full-time equivalent (FTE) radiologists was computed from the Personnel and Accounting Integrated Data (PAID) file. Only the clinical portion of FTE employee, referred to as “FTE(c),” was considered. *NOTE: The fraction of time the employee devoted to administration, teaching, and research, as specified in the current Support System (DSS) labor mapping Directive, was excluded from the FTE(c) calculation.*

(3) **Contract Physicians.** Contracted imaging physicians were reimbursed in a number of ways, which complicated the calculation of their FTE(c). For example, a contractor may be reimbursed by the study rather than by the hour. In order to convert all contracted professional services to an FTE employee, the total cost of contracts was divided by the median salary of a radiologist as specified in the Medical Group Management Association (MGMA) 2004 Physician Compensation and Production Survey Report, and with geographic salary adjustment by Medicare locality reimbursement factors. Costs for on-site Fee physicians were obtained from Fee files. Contract costs for other contractors were obtained from the Enhanced Sharing and Scarce Medical Specialist Database. As a result of this conversion, contractor productivity was calculated on a per-cost rather than the per-hour basis used for employees. An expensive contractor who read the same number of studies as an inexpensive contractor was considered to be less productive. Another assumption of the study was that 100 percent of a contracted physician’s VA compensation was for clinical duties.

(4) **Validation of FTE(c).** A table of calculated FTE(c) was distributed to facilities, which were asked to verify the number of imaging physicians. In some cases, this resulted in corrections to the database. For example, Fee Basis files or Enhanced Sharing and Scarce Medical Specialist databases were occasionally incomplete. Contract costs might include services other than staffing, or staff might be contracted for duties other than clinical care.

(5) **Productivity Modifiers.** In order to learn what factors (modifiers) may influence productivity, a survey was taken of each radiology and nuclear medicine practice. The survey collected data on such factors as the number of support staff, residents, equipment, hours of service, and means of report transcription. In addition, the Veterans Equitable Resource Allocation (VERA) complexity of patients, size of the facility, and degree of academic mission were considered. Each of the potential modifiers was tested to see it had a significant association with productivity.

d. The results of the productivity study are posted at the VHA Physician Productivity web portal at: <http://main.vssc.med.va.gov/sites/physicianproductivity/default.aspx>. Salient findings of the study are:

(1) The observed productivity (wRVU per FTE(c)) for combined radiology and nuclear medicine practices was 5453 (mean) and 4904 (median).

(2) The teaching mission enhanced imaging physician productivity. While the number of junior level residents did not affect productivity to a significant degree, the addition of a fifth-year resident or fellow increased physician productivity by 238 wRVU per FTE(c).

(3) Support staff ratios were important in understanding imaging physician productivity. An additional registered nurse increased physician productivity by 365 wRVU per FTE(c).

(4) Support staff functions were associated with imaging physician productivity. Additional support staff, whose responsibility usually was to coordinate patient care, was associated with an increase in physician productivity of roughly 1304 wRVU per FTE(c). Additional support staff, whose responsibility always was to coordinate patient care, was associated with an increase in physician productivity of roughly 1630 wRVU per FTE(c). The likely interpretation of these statistics is that nurses and other support staff improve physician productivity by reducing interruptions while physicians are reading studies.

(5) Patient complexity was associated with imaging physician productivity. A higher proportion of VERA complex patients (patients in VERA10 groups 7 – 10) tended to lower imaging physician productivity. An increase of 1 percentage point in the proportion of VERA complex patients who underwent imaging exams implied a productivity loss of 332 wRVU per FTE(c) in the practice.

(6) Percentage of on-site Fee physicians was associated with imaging physician productivity. A higher proportion of on-site Fee physicians tended to increase imaging physician productivity. An increase of 1 percentage point in the proportion of on-site Fee FTE as a proportion of FTE (c) implied a productivity increase of 31 wRVU per FTE(c) in the practice.

e. Public Law 107-135 Section 124, requires the Department of Veterans Affairs (VA) to “establish a nationwide policy on the staffing of Department medical facilities in order to ensure that such facilities have adequate staff for the provision to veterans of appropriate, high-quality care and services.”

f. **Definitions**

(1) **Imaging Physician.** An Imaging Physician is a Radiologist or Nuclear Medicine Physician.

(2) **Current Procedural Terminology (CPT).** The American Medical Association has defined a numerical code for each service or procedure performed by a physician; this is the CPT. In VHA, these codes are assigned to an imaging procedure by the technologist at the time the study is performed, and in accordance with the nature and scope of the imaging study.

(3) **Relative Value Unit (RVU).** RVU is a measure of the difficulty and expense of a professional service. The number of RVUs associated with each CPT code is determined by the Centers for Medicare and Medicaid Services (CMS) as published in the CMS Medicare Fee Schedule. RVUs are primarily designed for reimbursement purposes, but have been widely employed to measure workload as well. **NOTE:** *The RVU used in this Directive and by CMS differ from those defined by DSS.* The total RVU consists of three components: physician work, practice expense and malpractice expense. **NOTE:** *RVU tables are available on the Veterans Integrated Service Network (VISN) Support Service Center (VSSC) web site at: <http://klfmenu.med.va.gov/medicare/rvu.asp>.*

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(4) **Direct Patient Care Time.** Direct patient care time is defined as the time to prepare, provide for, and follow-up on the clinical care needs of patients. Direct patient care time, or “clinical” time, is time not occupied by administrative duties, teaching, or research. **NOTE:** *A detailed definition of these duties, and how to account for them in DSS, is provided in Attachment A.*

(5) **Physician (MD) FTE(c).** MD FTE(c) is the portion of a FTE employee physician which is devoted to clinical, direct patient care as assigned in DSS labor mapping.

(6) **Support Staff.** For the purpose of this Directive, support staff includes nurses, technologists, clerks, transcriptionists, Automated Data Processing Application Coordinators (ADPACS), radiation safety officers, nuclear pharmacists, and service managers assigned to the imaging service.

(7) **Imaging Practice.** An imaging practice is defined as the imaging physicians in a medical center and its clinics who are appointed to an imaging service or service line and are privileged to perform imaging procedures. **NOTE:** *In some hospitals, radiologists and nuclear medicine physicians may be in separate services, but are considered, for the purposes of this Directive, to be in the same practice.*

(8) **External Benchmarks.** External benchmarks are gathered from organizations such as MGMA. MGMA is an association of medical group practices, both academic and non-academic, that surveys membership on an annual basis. External benchmarks are a primary source of information on physician productivity, support staff, and availability of capital assets at private sector and academic medical practices.

(9) **Veterans Equitable Resource Allocation (VERA) Patient Complexity.** The percentage of patients enrolled at a facility who meets the VERA methodology definition for complex care.

**3. POLICY:** It is VHA policy that each facility Director assess imaging physician productivity on a quarterly basis using standardized methods (see Att. A).

### 4. ACTION

a. **National Directors of Radiology and Nuclear Medicine.** The National Directors of Radiology and Nuclear Medicine are responsible for proposing productivity standards for imaging physicians based on: productivity data, available quality and access indicators, and the approval of the Under Secretary for Health.

b. **The Office of Productivity, Efficiency and Staffing (OPES).** OPES is responsible for conducting an annual study of imaging physician productivity.

c. **Vetrans Integrated Service Network (VISN) Director.** The VISN Director is responsible for reviewing the annual imaging productivity report in seeking to optimize imaging productivity at their facilities.

d. **Facility Director.** The facility Director is responsible for:

(1) Ensuring that each Chief of Staff and all imaging service chiefs engage in assessment activities including the quarterly review of imaging physician productivity.

(2) Certifying physician labor mapping assignments according to current VHA policy.

(3) Reviewing the imaging productivity reports.

(4) Reviewing and implementing plans to improve physician productivity as appropriate.

e. **Facility Chief of Staff (COS).** The facility COS is responsible for coordinating the activities of Imaging Service Chiefs in assessing and measuring productivity and staffing on a quarterly basis, including performing needs assessments for the hiring of contract physicians in imaging services(see VA Directive 1663).

f. **Imaging Service Chief.** The Imaging Service Chief is responsible for:

(1) Performing the quarterly monitoring activities for measuring physician activities, workload, and contracting

(2) Coordinating with the COS in reporting to the facility Director annually that the quarterly monitoring activities have been accomplished.

(3) Developing plans for improving physician productivity, timeliness of care, and patient access, as needed.

## 5. REFERENCES

a. VA Directive 1663.

b. Lu Y, Arenson RL, "The academic radiologist's clinical productivity: an update," Academic Radiology, 2005, Vol. 12: 1211-1223.

c. Medical Group Management Association (MGMA) Physician Compensation and Production Survey: 2004 Report Based on 2003 Data, 2004, MGMA, Englewood, CO.

d. Medical Group Management Association (MGMA) Academic Practice Compensation and Production Survey: 2005 Report Based on 2004 Data, 2005, MGMA, Englewood, CO.

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**6. FOLLOW-UP RESPONSIBILITY:** The Office of Patient Care Services, Directors of Radiology and Nuclear Medicine (115) are responsible for the contents of this Directive. Questions may be directed to (202) 461-7361.

**7. RESCISSIONS:** None. This VHA Directive expires February 28, 2013.

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ATTACHMENT A

IMAGING PHYSICIAN PRODUCTIVITY MONITORING

1. STAFFING AND PRODUCTIVITY GUIDELINES

a. **Imaging Physician Productivity**

(1) Imaging practices need to maintain yearly productivity of at least 5000 observed Relative Value Unit (RVU) per clinical portion of Full-time Equivalent (FTE) employee (FTE(c)) averaged over all physicians in the Radiology and Nuclear Medicine services, calculated using the methodology defined in this attachment. For purposes of physician productivity measurement, only the physician work component of the RVU value is utilized, and is referred to as wRVU. This is consistent with external benchmark data.

(2) Productivity above the 5000 level is considered best practice, taking care not to compromise quality and patient access standards. *NOTE: Consideration should be given to the influence of productivity modifiers (as outlined in subpar. 2d of the Directive) when assessing practices.*

(3) There is no national minimum productivity standard for individual imaging physicians; however, service chiefs need to track the productivity of each physician to ensure it meets local expectations. There is no maximum productivity standard for individual imaging physicians, so long as healthcare quality and access is not compromised. Indicators of excessive workload might be loss of diagnostic accuracy or lack of availability of the physician for consultations and technologist supervision.

b. **Imaging Physician Staffing.** The ideal imaging service staffing model considers the productivity of the practice, access and quality standards, types of procedures performed, and the needs of the population served. Imaging physician staffing is defined as adequate when the imaging physicians' productivity falls within an acceptable range, performance standards are being met, and the needs of the population are served.

c. **Support Staffing**

(1) Sufficient support staff should be assigned so that:

(a) Veterans receive timely service, and

(b) Imaging physicians are not drawn away from the performance of procedures and the interpretation of images in order to carry out duties that should be performed by support staff.

(2) Activities that are appropriate for an imaging physician include:

(a) Screening of orders to ensure they are appropriate;

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- (b) Setting protocols;
  - (c) Obtaining informed consent;
  - (d) Supervising technologists;
  - (e) Performing procedures;
  - (f) Interpreting and reporting studies; and
  - (g) Conferring with other caregivers.
- (3) Activities that are not appropriate for imaging physicians include:
- (a) Scheduling of patients;
  - (b) Routine intake screening of patients;
  - (c) Monitoring of vital signs; and
  - (d) Filing film jackets.

***NOTE:** Service Chiefs and facility leadership need to assess their support staff levels relative to Veterans Health Administration (VHA) averages.*

**2. LABOR MAPPING.** The imaging service chief, in consultation with the Chief of Staff, assigns the fraction of time devoted to clinical care, administration, teaching, and research for each employee physician in the practice, and is responsible for updating these values in the Decision Support System (DSS) in a timely manner as duties change. Labor assignments as entered in DSS are the basis for computing Physician (MD) FTE(c).

a. **Clinical Time.** Clinical time is the time left when justifiable administrative, teaching, and research hours have been subtracted. Reviewing requisitions and medical records, researching diseases of active patients, setting protocols, interviewing patients, monitoring technologists and patients, interpreting images, writing and approving reports and notes, and consulting or reviewing studies with the treating team on an ad hoc basis are examples of clinical duties. Time spent preparing for and attending scheduled multidisciplinary conferences is clinical. Time spent attending medical courses for Continuing Medical Education (CME) credit is clinical. Time spent reading out current studies with residents is clinical. ***NOTE:** It is strongly recommended that clinical duties be recorded daily, for example on a duty roster, so that calculation of FTE(c) can be verified.*

b. **Teaching Time.** Teaching time is time spent showing teaching files to residents, as is time spent preparing and delivering lectures.

c. **Research Time.** Research time is time spent conducting approved research protocols, attending research committee meetings, and preparing and presenting scientific abstracts and publications.

d. **Mapping of Authorized Absence.** Authorized absence to give lectures, research presentations, or for administrative Department of Veterans Affairs (VA) business is to be reflected as teaching, research, or administrative time as appropriate.

e. **Physician Labor Mapping Scenarios.** The following examples illustrate how to map the time of imaging physicians with a range of different responsibilities:

(1) **Direct Patient Care**

(a) Dr. Scott is a full-time VA staff chest radiologist whose clinical responsibilities consist entirely of supervising technologists, interpreting imaging studies, and consulting with clinicians. He is not responsible for managing any programs and does not serve on any medical center or Veterans Integrated Service Network (VISN) committees. He reads imaging studies with a resident each day, but does not give lectures or show teaching file studies. He is not involved in any educational courses or research. **In the preceding scenario, all 80 of Dr. Scott's Personnel Accounting Integrated Data (PAID) hours need to be mapped to Direct Patient Care Account Level Budgeter Cost Centers (ALBCCs).**

(b) Dr. Alvarez is a half-time VA staff radiologist who spends 50 percent of his time attending on the body imaging service, and 50 percent of his time attending on the nuclear medicine service. He is not involved in any educational programs or research. **In the preceding scenario, all 40 of Dr. Alvarez's PAID hours need to be mapped to Direct Patient Care ALBCCs.**

(2) **Administration.** Dr. Hollingsworth is the Chief of Radiology at a large VA medical center. She spends one-half of her time handling administrative responsibilities as Chief of Service. Her administrative duties include attending VISN Imaging Committee meetings. She spends the other half of her time as a gastrointestinal radiologist. She is not involved in any educational programs or research. **In the preceding scenario, 40 of Dr. Hollingsworth's PAID hours need to be mapped to ALBCCs in Administration and 40 of those hours need to be mapped to Direct Patient Care ALBCCs.**

(3) **Education.** Dr. Chin is full-time academic radiologist working at a VA medical center affiliated with a medical school. He is the Residency Director for the radiology residency program. He spends 1 hour per day giving a lecture and showing teaching files to residents and medical students. In addition, he spends approximately 3 hours per week in various administrative tasks arising from this position, such as developing curriculum, planning schedules, and attending meetings at the medical school. He spends the remaining 80 percent of his time interpreting imaging studies. He is not involved in research. **In the preceding scenario, 20 percent of Dr. Chin's PAID hours (16 hours) need to be mapped to ALBCCs in Education and 80 percent of those hours (64 hours) need to be mapped to Direct Patient Care ALBCCs.**

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(4) **Research.** Dr. Singh is a full-time VA staff nuclear medicine physician who recently received a full-time Career Development Award in health services research. He continues to attend on the nuclear medicine service two 1/2 days a week. The other 4 days per week he spends involved in his research activities. He is not involved in any educational activities. **In the preceding scenario, 80 percent of Dr. Singh's PAID hours (64 hours) need to be mapped to ALBCCs in Research and 20 percent of those hours (16 hours) need to be mapped to Direct Patient Care ALBCCs.**

**3. APPROPRIATE CPT CODING.** Imaging physicians are not to expand the scope of a requested study, thereby increasing wRVU, without medical justification specific to that patient. Radiologists must follow the precepts of the Centers for Medicare and Medicaid Services (CMS) Correct Coding Initiative.

**4. APPROPRIATE UTILIZATION.** The need to increase workload must not be used as a justification for radiologists to recruit studies or approve studies that are unsafe, not indicated, or otherwise would not be performed.

### 5. MONITORS OF PHYSICIAN PRODUCTIVITY

a. Each year VHA conducts a study of imaging physician productivity. The service chief participates in this study by providing such data as support staff levels and contractor costs. The results of this study are posted on the VHA Physician Productivity Portal <http://main.vssc.med.va.gov/sites/physicianproductivity/pages/Radiology.aspx>.

(1) If the productivity level of the practice is found to be below 5000 wRVU per FTE(c), the service chief must devise an action plan to increase productivity to acceptable levels.

(2) Elements of such a plan could include implementing teleradiology or VISN-wide Picture Archiving and Communication Systems (PACS) to bring more work to underutilized personnel, re-evaluating the need for or cost of physician contracts, or hiring nurses or other support personnel so that physicians have more time to concentrate on interpretation, depending on the reason for low performance.

(3) Reduction of personnel as a tool to increase productivity needs to be weighed against the need to staff sub-specialty services, maintain diagnostic accuracy, provide adequate patient access, supervise technologists, staff clinical conferences and provide consultations, and meet national performance measures for timeliness of care.

b. The service chief needs to use the physician productivity monitor to help ensure equitable assignments, as appropriate, to each individual radiologist. **NOTE:** *The productivity monitor does not account for the frequency or difficulty of on-call responsibilities, attendance at clinical conferences, or the presence or lack of productivity modifiers such as number of support staff (see subpar. 2c(5) of the Directive).* The service chief may use these additional factors in an informal way when comparing physician productivities and setting duty assignments. In

addition, the service chief may use indicators of physician productivity when assigning duties, such as teaching and research, as relevant to the mission of the service.

c. Although the productivity performance standard applies to the practice as a whole, service chiefs need to track productivity for each imaging physician who has clinical privileges at the medical center. The radiologist productivity record is to be produced and reviewed at least quarterly. **NOTE:** *In order to assist service chiefs in the calculation of MD wRVU, an instruction guide and reporting template has been developed and is available on the VHA Physician Productivity Web Portal at:*

<http://main.vssc.med.va.gov/sites/physicianproductivity/pages/Radiology.aspx>. VHA has written a software patch to the management reports section of the Veterans Health Information and Technology Architecture (VistA) Radiology Package; the “Physician wRVU Report by Imaging Type” must be run for all physicians and for all modalities over the desired time period.

d. Instructions for calculating physician productivity are as follows:

(1) **Multi-facility work.** If a radiologist reads studies for another medical center, but is not assigned a fraction of their appointment to that center, then the workload that the radiologist performs at the second center needs to be included at their primary location. Service chiefs must exchange wRVU reports as needed to obtain a complete accounting. **NOTE:** *Care should be taken to not count workload at more than one medical center.*

(2) **Employee FTE(c)**

(a) The FTE(c) for individual employees for each quarter is calculated as:

$$\text{Employee FTE(c)} = \frac{\text{clinical hours per pay period}}{80} \times \frac{(62.75 \times \text{FTE}) - \text{NDL days}}{(62.75 \times \text{FTE})}$$

(b) Where the symbol “x” denotes multiplication, clinical hours per pay period is the DSS clinical labor assignment per pay period, 80 is the number of hours per pay period for a full time employee, 62.75 is the number of week days per quarter, FTE is the fraction of appointment (example: a half-time employee would be 0.5), and non-discretionary leave days (NDL) are the total days of Family Care, Sick Leave, Military Leave, Adoption Leave, and Leave Without Pay. The number of leave days may be found in the Employee Leave History report of the VistA Time and Attendance menu. **NOTE:** *This formula only applies to a 1/4 of year period of time.*

(3) **Contractor and In-house Fee Physician FTE(c).** The FTE of contractors may be corrected for percent time not assigned to clinical duties, if the contract states that the contractor is paid to provide teaching, research, or administrative services, using official DSS definitions defined in current VHA policy. The fraction of time devoted to teaching, research and clinical duties must be specified by the contract. **NOTE:** *VA Directive 1663, outlines the procedures for contracting with physicians either on the basis of time or per procedure (paid by the study).*

(a) Contractor FTE(c) = (fraction of time clinical) x (FTE).

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(b) The FTE of contractors paid on the basis of time worked, such as per diem or locum tenens contractors, may be computed by dividing the number of hours on service for the quarter by 520, as:

$$\text{Per diem contractor FTE(c)} = (\text{fraction of time clinical}) \times \frac{\text{hours on service}}{520}$$

(c) The number of hours on service are usually the number of days on service times eight. The fraction of time clinical is usually one. *NOTE: This formula only applies to a 1/4 of year period of time.*

(4) **Monitoring Contractor Groups.** If the medical center contracts with a radiology group who staff a position from a pool of physicians in rotation, then the productivity of the contract can be monitored as a group. In that case, the wRVU is the sum of the wRVU for the contract, and the FTE(c) is the clinical part of the FTE for the contract.

(5) **Correction for Contractor Salary.** The FTE of contract physicians does not need to be adjusted by salary for the purposes of local productivity monitoring, but it will be so corrected in the national yearly report.

(6) **Exempt Physician.** The following physicians do not need to be tracked in the quarterly report:

- (a) Physicians who have no clinical assignment.
- (b) Physicians who work without compensation.
- (c) Contract physicians who are paid per procedure, rather than by the hour or FTE.
- (d) Contractors that cover on-call emergency duties only.

(e) A contract that is staffed for fewer than 5 days of service per quarter. When deciding whether contracted position(s) are staffed fewer than 5 days per quarter, one must add the days of attendance of all physicians in the contract.

(7) **Quarterly Productivity.** The quarterly productivity for an individual is defined as the quarterly wRVU divided by the FTE(c) for that individual. The quarterly average practice productivity is defined as the sum of the quarterly employee and contractor wRVU divided by the sum of the employee and contractor FTE(c). The yearly practice productivity is the sum of the four quarterly practice productivities. *NOTE: The quarterly practice productivity target is one-fourth the yearly practice productivity target or 1250.*

(8) **Scaled wRVU.** Physicians who read exclusively plain films or nuclear medicine studies accrue fewer wRVU for the same amount of time than do those who read exclusively Computed Tomography and Magnetic Resonance Imaging, or who perform interventional procedures. *NOTE: One option to correct for this time is to apply the scaling factors proposed by Lu and Arenson (see subpar. 5b of the Directive).* The correction is available in the VistA radiology

package RVU report. Use of these scaling factors is at the discretion of the service chief. If the scaling factors are used, they must be applied to all imaging physicians in the medical facility practice and not just to those who read plain films and nuclear medicine. The correction is only accurate if the correct Imaging Type has been assigned to each procedure in the VistA Radiology Package.

***NOTE:** Productivity may be used when recommending salaries to the compensation panel. Compensation panels need to consider other factors, such as on-call duties, special skills, teaching, research, and other non-RVU factors when recommending pay.*