AJNR

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AJNR Am J Neuroradiol published online 18 July 2013
http://www.ajnr.org/content/early/2013/07/18/ajnr.A3674.citation

Published July 18, 2013 as 10.3174/ajnr.A3674

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ABBREVIATIONS: RVU = Relative Value Unit; CF = Conversion Factor; GPCI = Geographic Practice Cost Index; CMS = Centers for Medicare and Medicaid Services; MP = malpractice; RBRVS = Resource-Based Relative Value Scale; CPT = Current Procedural Terminology; SGR = Sustainable Growth Rate

To understand the Medicare compensation system for physician services, it is necessary to understand how the relative values of medical services are translated into fee schedule payment amounts. Basically, the relative value of a procedure multiplied by the number of dollars per Relative Value Unit (RVU) is the fee paid by Medicare for the procedure (RVU_W = physician work, RVU_{PE} = practice expense, RVU_{MP} = malpractice). The Conversion Factor (CF) is the number of dollars assigned to an RVU. It is calculated by use of a complex formula (Fig 1) that takes into account the overall state of the economy of the United States, the number of Medicare beneficiaries, the amount of money spent in prior years, and changes in the regulations governing covered services. Medicare fees are set according to a relative value scale rather than a free market, payments are made by third parties rather than consumers, and the labor market for physicians is illiquid, so the pricing mechanisms that regulate markets in other parts of the economy are not effective in rationalizing prices. The factors that influence the CF calculation are similar to those that are used in calculating global health care budgets; therefore the principles are durable, even if the precise formula might be altered in the future.

Annually, the CF is based on the previous year's CF and adjusted for the Medical Economic Index, the Update Adjustment Factor, Legislative Change, and Budget Neutrality. The Medical Economic Index is a calculation of the inflation rate for medical services, which is generally higher than inflation in consumer prices overall. The Update Adjustment Factor encompasses the Sustainable Growth Rate (SGR) that takes into account growth or decline in the Gross Domestic Product, changes in the number of beneficiaries, and certain regulatory adjustments that may affect the demand for and costs of providing Medicare services. This is the mechanism through which the relative proportion of Part B Medicare spending is maintained at an acceptable level with respect to overall government spending and the size of the economy as a whole. The process of setting the CF each year balances increases in demand for medical services and the finite productive capacity of the economy. The calculation is then subject to Budget Neutrality, requiring any increase in the relative expenditures in one area of the Medicare program to be offset by cuts in other areas. The calculation must result in a budget for Medicare that is within $20 million of the target.[1]

What Is the CF?

The monetary CF is 1 of 3 key elements that determine physician payment under the Medicare Physician Fee Schedule, along with the Resource-Based Relative Value Scale and Geographic Practice Cost Indices (GPCIs) ($GPCI_W$ = physician work, $GPCI_{PE}$ = practice expense).

With the Resource-Based Relative Value Scale (RBRVS), an RVU is assigned for each Current Procedural Terminology (CPT) code on the basis of resource costs associated with 1) physician work, 2) practice expense, and 3) professional liability insurance. As determined by Congress at the inception of the RBRVS, all of the CPT codes on the Medicare Fee Schedule are subject to review on an annual basis.[1]

Each Current Procedural Terminology code RVU is adjusted on the basis of the GPCI associated with each geographic area, adjusting for different medical costs and wage differentials. GPCIs are reviewed every 3 years.

The CF, a national dollar multiplier, is used to "convert" the geographically adjusted RVU to determine the Medicare-allowed payment amount for a particular physician service.

The CF is used separately to price facility and nonfacility payment amounts. Facility pricing typically covers services provided to inpatients or in a hospital outpatient clinic setting or other off-site hospital facilities. Nonfacility pricing covers services gen-

Received April 10, 2013; accepted after revision April 30.

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http://dx.doi.org/10.3174/ajnr.A3674

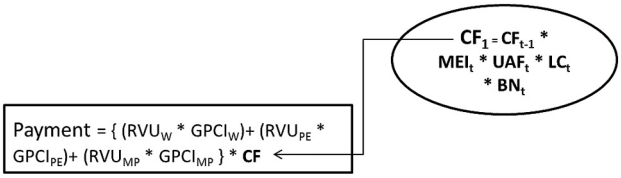

FIG 1. Role of the conversion factor in the Medicare fee schedule.

erally provided in a physician office or other freestanding setting such as an Independent Diagnostic Testing Facility.[2]

How Is the CF Calculated? Why Is the Calculation So Complex?

The CF is updated annually according to a complex formula set by statute. Every year, by use of the formula, the Centers for Medicare and Medicaid Services (CMS) must publish an estimated SGR and estimated CF applicable to Medicare payments for physician services for the following year, as well as the data underlying these estimates. CMS cannot change its overall budget by more than $20 million. The use of this SGR target is intended to control growth of aggregate Medicare spending. The targets are not expenditure limits, but an update to the Physician Fee Schedule to reflect a comparison of actual to target expenditures. If RVU adjustment causes a differential greater than that $20 million or exceeds the target, CMS uses the Budget Neutrality factor to bring overall payments down to an acceptable level.

Under statute, the update for each year is determined by comparing cumulative actual expenditures with cumulative target expenditures since April 1, 1996, through the end of the year before the year in question. As an example, the update for 2013 compares the cumulative actual with cumulative target expenditures from April 1, 1996, through December 31, 2012. The calculation is as follows for 2013:

2013 Non-Facility Pricing Amount = [(Work RVU * Work GPCI) + (Transitioned Non-Facility PE RVU * PE GPCI) + (malpractice expense [MP] RVU * MP GPCI)] * CF 2013 Facility Pricing Amount = [(Work RVU * Work GPCI) + (Transitioned Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * CF.

The CF for calendar year 2013 is $34.0230.

If the Formula Were Followed, What Would the CF Be for Next Year?

Under current law, the CF for 2014 would be similar to 2013, reduced by approximately 26.5% to $25.0069 (compared with the current $34.0230). This reduction would be effective January 1, 2014, unless Congress passes a legislative fix. The latest estimates of the cost of the so called "doc fix" are between $150 and $300 billion, depending on assumptions regarding economic performance, policy changes, and physician behavior.

What Happens Next?

Annually, the Sustainable Growth Rate–mandated cuts in the CF have been overridden by Congress, usually through last-minute negotiations that cover numerous contentious issues. Many interested in health policy recognize the need for a reform of this process to improve clarity and remove uncertainty from the annual determination of the CF. Because of the large and growing discrepancy between the statutory CF and the established CF, the budgetary need for a more permanent solution is also considered important, going forward. Recently, the magnitude of the adjustment required in the CF to maintain Budget Neutrality has been revised downward. It is likely that this is a temporary consequence of the disparate timing of effects on the various components of the Sustainable Growth Rate formula related to recent economic conditions. As the economy returns to more normal levels of growth, we can expect these short-term trends to revert to their prior patterns and continue to increase.

Some of the proposals on the table include cuts in the overall level of Medicare fees weighted heavily toward cuts in specialist services such as imaging and relatively sparing primary care. Others reduce costs by changing the calculation of Medicare premiums and/or means testing them. Another approach is to adjust the relationship between the CF and the rate of inflation and the rate of economic growth. Other proposals seek a more fundamental overhaul of the program, through premium support models similar to those already being used in Medicare Part D. Others seek to preserve the status quo. Regardless of the fate of the current CF formula and the precise relationships among the components, the ingredients of the CF are combined in recipes for global health care budgets under discussion in health care policy circles.[3]

Disclosures: David Seidenwurm—*RELATED: Consulting Fee or Honorarium:* CMI, ACR, Medical Legal, Medical Management, Comments: CMI is a consortium of radiology practices in California; meeting honoraria are paid to Dr Seidenwurm's practice. Dr Seidenwurm performs medical legal consulting and medical management consulting. Dr Seidenwurm participates in the ACR MRI accreditation program; *Support for Travel to Meetings for the Study or Other Purposes:* NQF, ASNR, RAS, CMI, PCPI, ACR, Comments: Dr Seidenwurm receives travel reimbursement for participation in numerous activities related principally to performance measurement and quality improvement in medicine and radiology; *Other:* Hill Physicians Medical Group,* Comments: Utilization review for HMO, ACO and other activities; *UNRELATED: Board Membership:* CMI*; *Consultancy:* Medical Legal, Medical Management; *Employment:* RAS; *Expert Testimony:* Medical Legal; *Payment for Development of Educational Presentations:* Kluver, Comments: Textbook chapter; *Stock/Stock Options:* Aaken Labs,* Comments: Electrophysiology and imaging fusion. Judith H. Burleson—*OTHER RELATIONSHIPS:* Employed by the American College of Radiology.

REFERENCES

1. Woody I. **The fundamentals of the US Medicare physician reimbursement process.** *J Am Coll Radiol* 2005;2:139–50
2. American Medical Association. *2012 RBRVS: The Physicians' Guide.* Chicago: American Medical Association; 2012
3. **Health policy brief: Medicare payments to physicians.** *Health Affairs.* Updated February 13, 2013