How the AMA/Specialty Society RVS Update Committee (RUC) / Current Procedural Terminology (CPT) Functions and What That Means to The Practicing Physician

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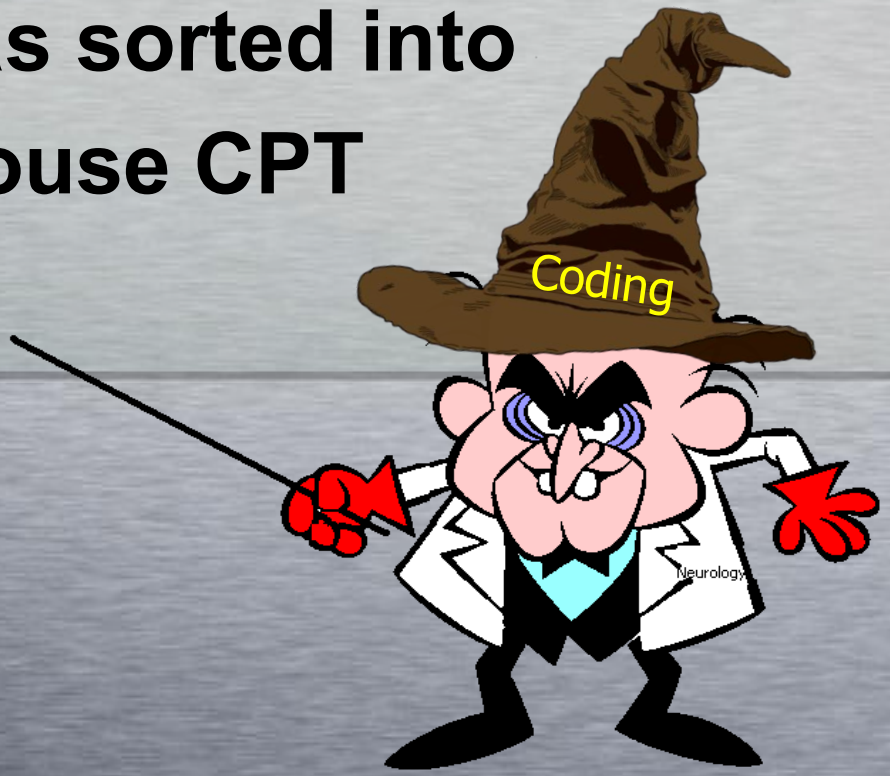
Knowledge that will change your world

Disclosures

Dr. Bailey has no disclosures.

He was sorted into

House CPT



Objectives

- Increase awareness and understanding of CPT codes and RUC valuation of them
- Recognize the importance of the functioning of these two committees

Disclosures

Dr. Bailey has no relevant financial conflicts of interest or disclosures.

Every effort has been made in the creation and presentation of this material to include cultural diversity and the elimination of implicit bias.

Dr Simon Bar Sinister

- Evil mad scientist and arch-nemesis of our hero, Underdog in 60's era Saturday morning cartoon.
- Now esteemed Neurologist, scholar, and patron saint of UAB Neurology

CPT and RUC

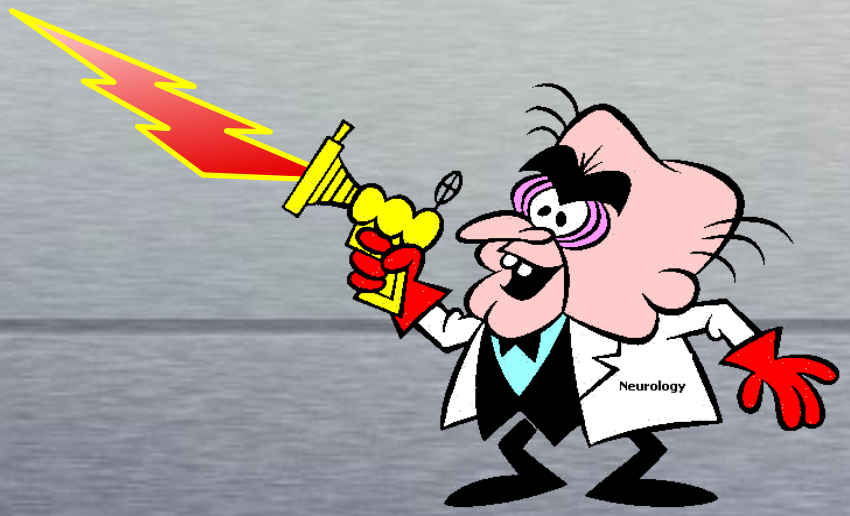
At the most basic level:

- CPT writes, edits, and maintains the language of the codes
- RUC advises a wRVU and direct practice inputs for that code to CMS – based on a standardized survey process
- CMS assigns work value – most of the time following RUC recommendations

Direct practice expense inputs are those costs directly assumed by a physician in the course of providing the service. These include the costs of medical supplies, staff time, and equipment. Direct expense inputs are collated and then converted into relative value units.

CPT

- CPT codes were developed by the AMA in 1966.
- They are updated annually through a process that is led by the CPT Editorial Panel.
- CPT Panel members do NOT represent their various societies' special interest at the table.
- The CPT Editorial Panel meets three times a year.



CPT Editorial Panel

- The panel is composed of 17 members.
  - 11 are physicians nominated by the national medical specialty societies and approved by the AMA Board of Trustees. One of the 11 is reserved for expertise in performance measurement. They serve 4 year terms and may be reappointed once.
- One physician is nominated from each of the following:
  - Blue Cross and Blue Shield Association
  - America's Health Insurance Plans
  - American Hospital Association
  - CMS
- The remaining 2 seats on the CPT Editorial Panel are reserved for members of the CPT Health Care Professionals Advisory Committee.
- Five members of the editorial panel serve as the panel's executive committee.
  - Editorial panel chairman, co-chairman and 3 panel members-at-large, as elected by the entire panel.
  - One of the 3 members-at-large of the executive committee must be a third-party payer representative.

CPT Advisory Committee

- The CPT Advisory Committee serves as a resource to the CPT Editorial Panel Members
- **Pain** is represented specifically by:
  - American Society of Interventional Pain Physicians
  - International Pain and Spine Intervention Society
  - American Society of Regional Anesthesia and Pain Medicine
  - American Academy of Pain Medicine
  - Others

Each has at least one Advisor and Assistant Advisor to the CPT panel who provide input concerning upcoming code change applications (CCA).

CPT

- Medical societies, physicians, hospitals, payers, or others may submit applications for changes to CPT. (Code Change Application – CCA)
- AMA staff reviews the applications or commentary.
- The CPT staff posts the CCA and supporting document to the collaboration website for Advisor comments
- The proposal is added to the CPT Editorial Panel Meeting agenda.
- At the meeting, the proposal is considered and voted up or down.
- If approved by the CPT Editorial Panel, the code is sent to RUC for valuation

CPT Code Types

- **Category I**
  - Procedures that are consistent with contemporary medical practice and are widely performed. These have the most stringent criteria
- **Category II**
  - Supplementary tracking codes that can be used for performance measures
  - Their use is optional and infrequent
- **Category III**
  - Temporary codes for emerging technology, services and procedures
  - Category III codes can become Cat I if requirements are met
  - The requirements for Cat III codes is much less stringent than for Cat I

RUC

- 1985 Initiation of Harvard National RBRVS Study
- Medicare Implemented RBRVS on January 1, 1992
- In 1991 the AMA created the RUC to represent the entire medical profession to interact with HCFA and the RBRVS payment system
- RUC is composed of 34 individual members
- RBRVS is maintained by CMS, which relies on input from multiple sources including the RUC
- July 1992 RUC submits first recommendations to HCFA for 253 new and revised codes

RUC Composition

- **AMA**
- **AOA**
- **Chairperson of Practice Expense Review Committee**
- **Health Care Professionals Advisory Committee (HCPAC)**
- **Chairperson of RUC**
- **CPT Editorial Panel**

- Anesthesiology
- Cardiology
- Dermatology
- Emergency Medicine
- Family Medicine
- Clinical Oncology
- General Surgery
- Geriatrics
- Infectious Disease*
- Internal Medicine
- Neurology
- Neurosurgery
- Obstetrics/Gynecology
- Ophthalmology
- Orthopedic Surgery
- Otolaryngology
- Pathology
- Primary Care*
- Pediatric Surgery
- Pediatrics
- PM&R*
- Plastic Surgery
- Psychiatry
- Radiology
- Thoracic Surgery*
- Urology

**** Rotating seat***

Health Care Professionals Advisory Committee (HCPAC) Composition

- Audiologists
- Chiropractors
- Dieticians
- Nurses
- Occupational Therapists
- Optometrists
- Physical Therapists
- Physician Assistants
- Podiatrists
- Psychologists
- Social Workers
- Speech Pathologists

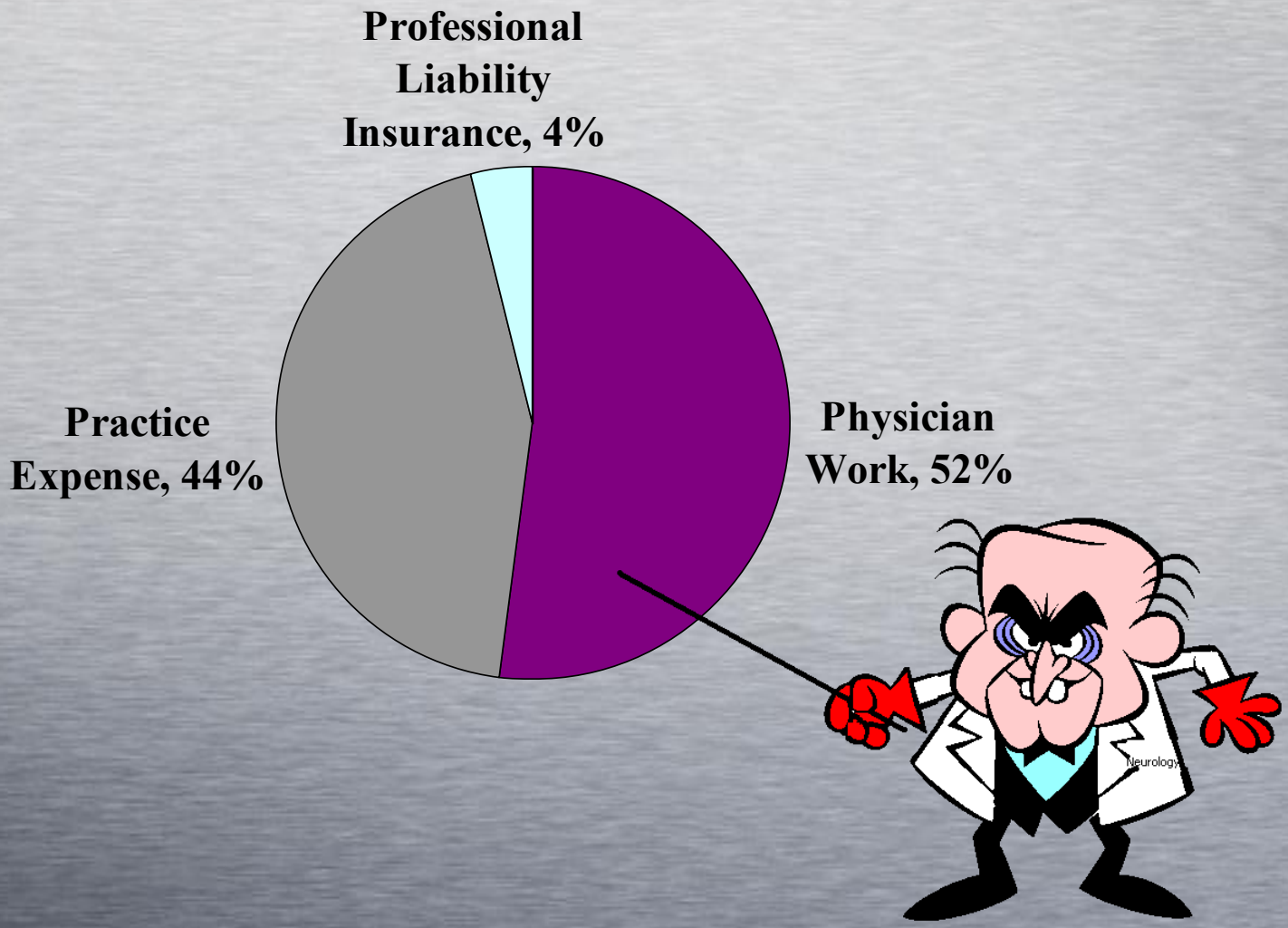
Medicare RBRVS

The resources for providing each service (RVU) is divided into three components

- Physician Work
- Practice Expense
- Professional Liability Insurance

Components of the RBRVS

Percent of Total Relative Value



Physician Work – 52%

Divided into 3 distinct categories:

- Pre-service period
- Intra-service period
- Post-service period

Physician Work determined by:

- The **time** it takes to perform the service
- The **intensity** of performing the procedure
  - The technical skill and physical effort
  - The required mental effort and judgment
  - Stress due to the potential risk to the patient

Practice Expense – 44%

PE RVUs are divided into direct and indirect physician practice resources involved in furnishing each service:

Direct expense categories include:

- Clinical labor
- Medical supplies
- Medical equipment

Indirect expenses include:

- Administrative labor
- Office expense
- All other expenses

The RUC submits recommendations to CMS on Direct practice expense inputs for new and revised codes

Indirect inputs are determined by CMS formula and are related to the total physician wRVU

Professional Liability – 4%

- In 2000, CMS implemented the resource-based professional liability insurance (PLI) relative value units
- The PLI is determined by CMS formula and is based on specialty risk adjustors and premium data

RBRVS
Resource-Based Relative Value Scale

Calculation of code value / payment level based on RBRVS:

Work RVU
\+ Practice Expense RVU
\+ Malpractice RVU
= TOTAL RVU

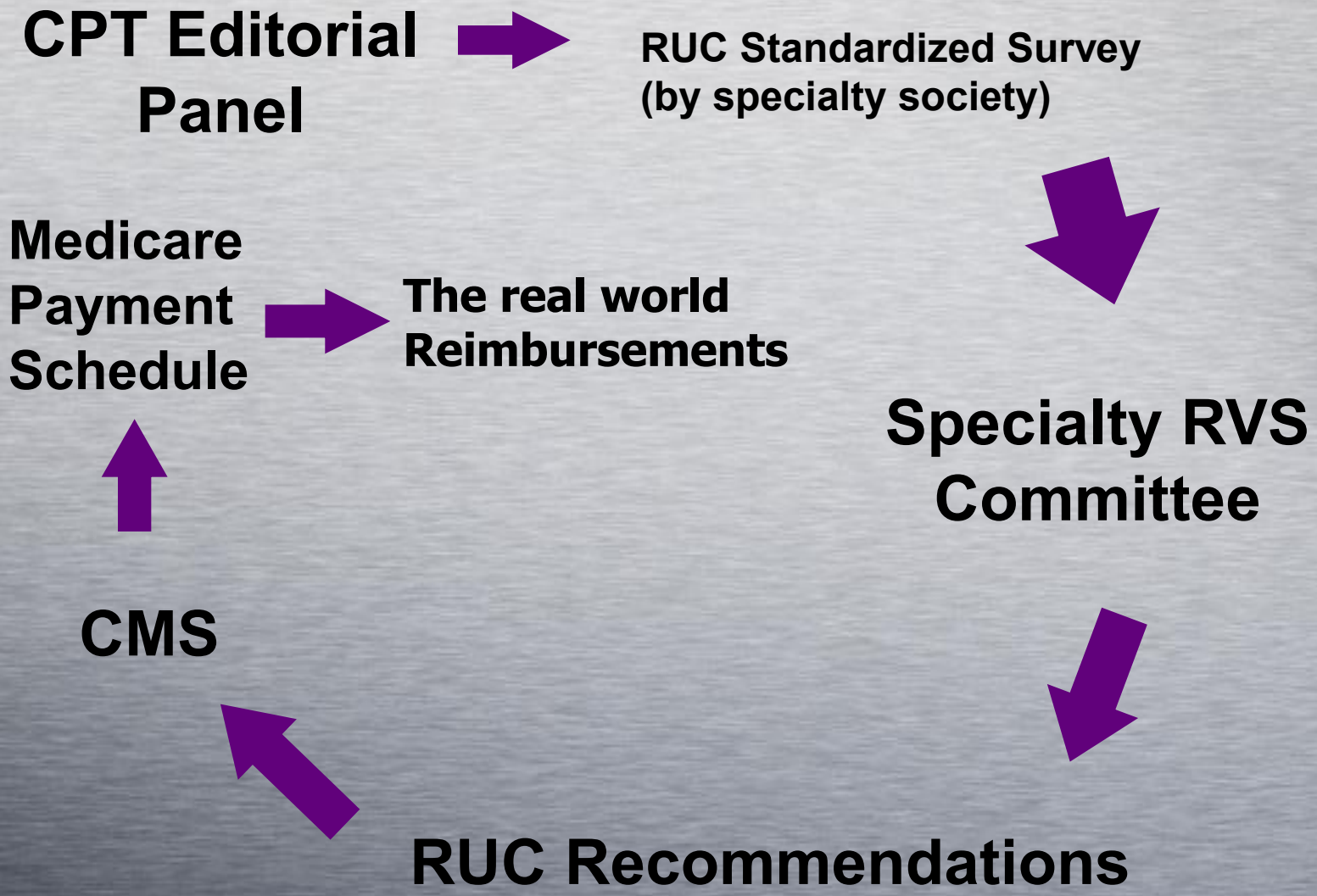
TOTAL RVU x $Conversion Factor = Payment

All RVUs are modified based on geographic location

Budget Neutrality

- If more RVU's are assigned to one code, others must have their value reduced to maintain budget neutrality.
- Usually done via the conversion factor
- This is an absolute requirement (by statute)

RUC Valuation Cycle

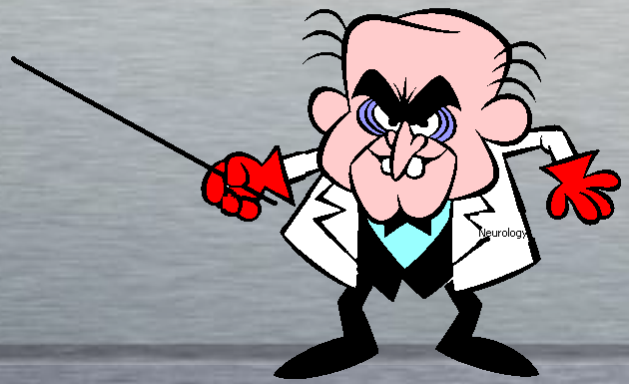


“We’re the Government and we’re here to help”

- For years physicians complained about the complexity of proper E&M coding. (bullet points and check boxes of what was done)
- CPT undertook the massive job of re-writing the E&M codes to answer this issue.
- In 2018 CMS issued a final rule that phased in this documentation simplification.
- Focus is now on Medical Complexity and/or Time as the main determinations of level of service (rather than the ‘bullet points’ previously used.

CPT Outcomes

- CPT Editorial Panel final recommendations are published in the big spiral bound CPT book we all get every year.
- CMS publishes the ‘Final Rule’ listing of codes that government insurances will cover
- This does not necessarily include all codes crafted by CPT and valued by RUC. (telemedicine codes are a good example)



Telemedicine Codes

- These are a subset of Evaluation and Management (E&M) codes.
- Not much used pre-COVID due to site of origin requirements
- Easing of requirements put in place and have been extended.
- In 2023, the CPT Editorial Panel established 17 new codes for telehealth services, but CMS chose not to adopt these codes, instead relying on billing office/outpatient E/M codes with a modifier (-95 for synchronous audio/visual, and -93 for synchronous audio-only).
- Some easing of restrictions may expire 1/30/2026. (unknown outcome at the time of preparation for this presentation.

RUC Outcomes

- RUC recommendations of work / wRVU are sent to CMS.
- CMS may or may not accept RUC recommendation and are free to modify it as they see fit. (About 91% accepted)
- CMS publishes these recommendations for public comment prior to going into effect

So what?

- This is how you get paid for what you do.
- How you code and what is required for use of that code can change
- E&M codes are a subset of CPT and for many of us represents the bulk of our billing.

Summary

- Coding is a complex process
- Few physicians have any idea of the staggering amount of work and detail that goes on in CPT / RUC behind the scenes

Wisdom of the Ancients

If something doesn't make sense to you, then there is something you don't know.

Save the Pangolins!

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