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What Every Physiatrist Should Know About CPT and RUC

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Determining the appropriate valuation of physician services is a significant task. Getting the proper value for Current Procedural Terminology (CPT) codes is important, because the resource-based relative value scale (RBRVS) has become the most common payment system in the United States. However, the valuation process remains something of a mystery to many physiatrists.

The basics of CPT

CPT is a list of terms and codes that provides standardized language for reporting medical, surgical, and diagnostic services. Additionally, CPT has provided physicians, coders, patients, insurers, and accreditation providers with a uniform language to enhance communication. The system gained acceptance in 1983, when the Health Care Financing Administration (now Centers for Medicare and Medicaid Services, CMS) merged CPT with its own Common Procedure Coding System, and mandated that all Medicare billing utilize CPT. The Health Insurance Portability and Accounting Act of 1996 (HIPAA) brought about further acceptance, specifying CPT as the standard procedural coding set for physician services.

A 17-member editorial panel governs the CPT system, developed and maintained by the American Medical Association (AMA). This group, composed primarily of physicians, makes final decisions on the content of CPT. Additional input comes from CMS, the Blue Cross Blue Shield Association, the American Hospital Association, and the private insurance industry.

CPT Editorial Panel seats are appointed by the AMA Board of Trustees for 4 years. Each Panel member can serve no more than 2 terms. There is also the CPT Advisory Committee, a group of physicians representing the national medical specialty societies, who advise the CPT Editorial Panel on matters concerning coding and nomenclature. Members of the CPT Advisory Committee serve three-year terms and are eligible for reappointment with no limit to the number of terms that an Advisor can serve. The AAPM&R CPT Advisor is Jeffery S. Brault, DO, of Rochester, MN and the CPT Alternate Advisor is Annie D. Purcell, DO, of Redding, CA. The CPT Editorial Panel meets three times each year.

What is the CPT process?

Medical specialty societies, individual physicians, hospitals, third-party payers and other interested parties may submit applications for coding changes to CPT for consideration by the CPT Editorial Panel. AMA CPT staff reviews all requests to revise CPT. If the CPT Editorial Panel has already addressed the question, staff informs the requestor of the Panel's coding recommendation. However, if the request presents a new issue or significant new information on an item that the Panel reviewed previously, the application is referred to members of the CPT Advisory Committee for evaluation and commentary. The AMA CPT application for a Category I or Category III code can be found on the AMA website at http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/applying-cpt-codes.page?.

The deadlines for submitting code change applications can be found on the AMA CPT website at www.ama-assn.org/resources/doc/cpt/cpt-ruc-calendar.pdf. The submission deadlines are based on a schedule that allows at least three months of preparation and processing time before the issue is ready for review by the CPT Editorial Panel. The Panel actions on an agenda item can result in one of four outcomes:

- Addition of a new code or revision of existing nomenclature, in which case the change would appear in a forthcoming volume of CPT.
- Referral to a workgroup for further study.
- Postponement to a future meeting (to allow submittal of additional information in a new application).
- Rejection of the request.

The Editorial Panel considers coding changes and additions. Once a service is appropriately coded, the Specialty Society Relative Value Scale Update Committee (RUC) acts as an expert panel, making recommendations to the CMS on the relative values of CPT codes.

What is RBRVS?

In 1992, the way physicians were paid was drastically changed. The federal government would no longer pay based on charges; instead, RBRVS was developed. Payment would be based on the resource costs needed to provide a service. Each service has a total relative value unit (RVU) based on three components:

- Physician work—the time, technical skills, physical effort, mental judgment, and potential risk of performing a service
- Practice expense (PE)—direct clinical staff time, disposable medical supplies, and equipment needed to perform the service and indirect practice costs
- Professional liability insurance (PLI)—the liability costs apportioned to each service

The final (total) payment is calculated by multiplying the three components of a service by a conversion factor; a monetary amount determined annually by CMS and separately by individual insurance companies. Additionally, payments are adjusted for geographical differences. To ensure organized medicine has input, the AMA created RUC.

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What is RUC?

RUC is a multi-specialty committee with twenty-one of the thirty-one members appointed by major national medical societies. Four seats rotate on a two-year basis, one seat reserved for a primary care representative, two are reserved for an internal medicine subspecialty and the remaining seat is open to any other specialty society not already a member of RUC, except internal medicine subspecialties or primary care representatives. The RUC Chair, the Co-Chair of the RUC Health Care Practitioners' Advisory Committee (HCPAC) Review Board, American Medical Association representatives, Osteopathic Association, and the Chairs of the Practice Expense Subcommittee and CPT Editorial Panel, hold six seats. RUC Members do not advocate on behalf of their society; in fact, they are impartial voting members of RUC. AAPM&R has RUC Advisors who attend the RUC meeting and present the society's recommendations, which the RUC evaluates. The AAPM&R RUC Advisor is David Lenrow, MD, of Philadelphia, PA and the Alternate RUC Advisor is Victor H. Chang, MD, of Houston, TX.

RUC meets three times a year for five days. RUC meetings are closely coordinated with both the CPT Editorial Panel schedule, and the annual updates to the Medicare Physician Fee Schedule. The RUC makes recommendations on each of the three components (physician work, PE, and PLI). However, the RVU determination made by the RUC is only a recommendation to CMS, which can be accepted, rejected, or modified.

What is the RUC survey process?

The RUC has a well-defined process for developing relative value recommendations:

Step 1: After the CPT Editorial Panel approves new or revised codes, the RUC staff develops a Level of Interest (LOI) form. The LOI summarizes the Editorial Panel's coding actions. Specialty societies indicate their level of interest value for the service in one or more of the following ways:

1. Survey members to obtain data on the physician work involved in a service;
2. Comment, in writing, on the recommendations developed by other societies;
3. Take no action.

Step 2: Society staff prepares and distributes survey instruments.
All surveys are prepared using RUC approved language and instructions. Physicians are asked to compare the work of the new or revised code to a reference service; a list of services as reference points that have been selected by the specialty RVS committee.

Step 3: The specialty society committee (for AAPM&R, the Reimbursement and Policy Review Committee) reviews the results, and prepares recommendations for the RUC. When two or more specialty societies are involved, the RUC encourages coordination of the survey process, and the development of an agreed upon recommendation. The final document consists of physician work, time, and practice expense recommendations.

Step 4: The specialty society Advisor(s) present and defend the recommendations at the RUC meeting.

Step 5: The RUC may accept, deny, or request modification of the recommendations. A two-thirds majority is required to approve any recommendations.

Step 6: RUC recommendations are forwarded to the CMS in May of each year. CMS makes the final determination of relative values. The final CMS values are published in late Fall in the Medicare Physician Fee Schedule.

The development of solid data requires involvement by the membership, and prompt completion of surveys when requested. The more surveys that are collected, and the more detailed the information provided the greater the credibility of the recommendations. Without time data from the surveys, there is no possible way to build an argument, and no possibility for change.

The Reimbursement and Policy Review Committee encourages AAPM&R members to share their concerns regarding issues related to CPT codes or reimbursement. For information, contact AAPM&R Manager of Health Finance and Reimbursement Jenny Jackson at (847) 737-6024 or jjackson@aapmr.org.org. ❖