American Urological Association, Inc.

PHYSICIAN REIMBURSEMENT: PATH TO PAYMENT

Members often call the American Urological Association (AUA) with questions about reimbursement: Is there a Current Procedural Terminology (CPT) code to report the surgical procedure performed and how did that code come about? Who determines the reimbursement payment? Why is my reimbursement going down/up? What is the importance of completing a RUC survey? Here, we review the basics and tell you everything you need to know about how physician payment is determined and how you can play a role.

What is a CPT code?

The basis for all physician reimbursement is the CPT code. CPT codes are the most widely accepted medical nomenclature used to report medical procedures and services under public and private health insurance programs. They are used in claims processing and in the payment of medical claims. CPT codes can be found in the CPT Manual, a copyrighted publication, maintained and published by the American Medical Association (AMA). The first edition of the manual was published in 1966 to encourage the use of standard terminology to document and report services and procedures provided by physicians. In 1983, CPT was adopted by the Centers for Medicare and Medicaid Services (CMS), and has subsequently been adopted nationwide for both government and commercial insurers.

What is the CPT code development process? What role does the AUA play?

There are defined steps, called the CPT process, for requesting a CPT code through the AMA. The first step is to submit a request for review to the AUA Coding and Reimbursement Committee (CRC) to evaluate coding proposals received from industry as well as individual urologists based on AMA criteria. The CRC provides a representative and well-rounded knowledge base of urological coding expertise, essential to a fair and thorough consideration of all proposals submitted.

What are the General Criteria for Category I and Category III Codes?

General Criteria for Category I and Category III Codes:

- The proposed descriptor is unique, well-defined, and describes a procedure or service which is clearly identified and distinguished from existing procedures and services already in CPT;
- The descriptor structure, guidelines and instructions are consistent with current Editorial Panel standards for maintenance of the code set;
- The proposed descriptor for the procedure or service is neither a fragmentation of an existing procedure or service nor currently reportable as a complete service by one or more existing codes (with the exclusion of unlisted codes). However, procedures and services frequently performed together may require new or revised codes;
- The structure and content of the proposed code descriptor accurately reflects the procedure or service as typically performed. If always or frequently performed with one or more other procedures or services, the descriptor structure and content will reflect the typical combination or complete procedure or service;
- The descriptor for the procedure or service is not proposed as a means to report extraordinary circumstances related to the performance of a procedure or service already described in the CPT code set; and
- The procedure or service satisfies the category-specific criteria set forth below.

Category I CPT Code Criteria: A proposal for a new or revised Category I code must satisfy all of the following criteria:

- All devices and drugs necessary for performance of the procedure of service have received FDA clearance or approval when such is required for performance of the procedure or service;
- The procedure or service is performed by many physicians or other qualified health care professionals across the United States;
- The procedure or service is performed with frequency consistent with the intended clinical use (i.e. a service for a common condition should have high volume);
- The procedure or service is consistent with current medical practice;
- The clinical efficacy of the procedure or service is documented in literature that meets the requirements set forth in the CPT code change application.

Category II CPT Code: In order to accommodate CMS's requirements for reporting of physician-level quality performance measurement on existing claim forms, the AMA worked with CMS to create a special new code, the Category II code, specifically for this purpose.

Category III CPT Codes – Emerging Technology - Criteria: The following criteria are used by the CPT/HCPAC Advisory

Committee and the CPT Editorial Panel for evaluating Category III code applications:

- The procedure or service is currently or recently performed in humans; AND

At least one of the following additional criteria has been met:

- The application is supported by at least one CPT or HCPAC Advisor representing practitioners who would use this procedure or service; OR
- The actual or potential clinical efficacy of the specific procedure or service is supported by peer reviewed literature which is available in English for examination by the CPT Editorial Panel; OR
- There is a) at least one Institutional Review Board approved protocol of a study of the procedure or service being performed, b) a description of a current and ongoing United States trial outlining the efficacy of the procedure or service, or c) other evidence of evolving clinical utilization.

What happens once the CRC reviews and approves a CPT request?

The CPT manual is updated annually through an editorial review process. The CPT Editorial Panel meets three times a year to review requests received from specialty societies, manufacturers and individuals. The Panel is supported in its deliberations by a larger body of CPT advisors, known as the CPT Advisory Committee. If the AUA's CRC approves a request either for a new or revised CPT code, AUA staff or industry then submits the Code Change Proposal (CCP) to the AMA where it is posted for comment and review by the CPT Advisory Committee. The request is then slated for the agenda of the next AMA CPT Editorial Panel meeting, where the CCP is approved or rejected.

What is the RUC ?

The Relative Value Scale Update Committee (RUC) is a joint AMA/Specialty Society decision-making body which reviews all survey recommendations of physician work values (52 percent of the total relative work value (RVU) for a service/procedure), practice expense or PE (44 percent of total RVU for a service/procedure) and Profressional Liability Insurance or PLI (4 percent of total RVU for a service/procedure). Through a rigorous review and voting process, the RUC determines a RVU for a procedure based on comparisons of other valued CPT codes and submits their recommendations to the Centers for Medicare and Medicaid Services (CMS) for reimbursement consideration. The volunteer members of the RUC are supported by staff and advisors from over 100 national medical specialty societies and health care professional organizations, representing the entire medical profession.

What is the RUC process? How does it relate to the CPT process?

Once a CCP is accepted by the CPT Editorial Panel, the next step in the CPT process is to determine the reimbursement for the code, through a survey of physician work and determination of direct practice expense (PE). The survey results are submitted to the RUC for negotiation for a mutually acceptable value to be submitted to CMS for final approval and publication in the Federal Register Final Rule. The approved CPT code and their associated RVUs are then published in current coding manuals for use by physicians and their coding staff.

Why are these RUC surveys important? What information do they provide?

The results of these surveys provide the basis for the reimbursement rate determination. The AUA, like other specialties, conducts surveys for the RUC of its membership to obtain physician work and PE inputs on specific codes that are pertinent to important procedures and services performed by our members. Thus, direct information from those specialists familiar with the procedure is essential for accurate reimbursement rates. A minimum of 30 completed surveys from a specialty's physicians is required for further consideration of a code.

Why should I complete a survey?

Completion of surveys is essential. Survey results received from the physicians who are familiar with the service or procedure in question provide the foundation for accurate valuation of the code, and the subsequent reimbursement assigned. Without this input, the appropriate level of work, skill and mental effort needed to perform the procedure cannot be properly assessed. Only experienced physicians can supply this critical information. Thus, when you receive an email from the AUA requesting your participation in a RUC survey, it is critical that you respond. Your answers help determine proper reimbursement for urology codes.

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