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ACROInsights – CPT® and RUC: Part of the AMA Process

The goal of this series of articles is to ensure that radiation oncologists are aware of and provided with the knowledge to ensure day-to-day processes are being addressed in a compliant manner. This installment will discuss the processes of the American Medical Association (AMA) current Procedural Terminology (CPT®) and Relative Upscale Value Subcommittee (RUC) in creation and valuation of healthcare services. The information contained within this ACROinsights article is meant as general guidance and is not intended to replace appropriate legal or authoritative guidance.

AMA – CPT® and RUC

In the early 1960's there was no standardized nomenclature for surgical services, leading the US insurance industry to approach the American Medical Association (AMA) to create a taxonomy of surgical services that were consistent, relevant, and allowed for modifications and updates. The Current Procedure Terminology (CPT®) code set was developed and has been progressively expanded to include all procedures and services performed by physicians. Subsequently, the nomenclature was expanded to include non-physician health care providers. CPT® codes are the now the officially accepted service descriptors for effectively all governmental and private payers. The CPT® Manual, and complementary publications and courses are published and provided by the AMA and the CPT® Editorial Panel is charged with updating and maintaining the CPT® code set. The Panel is comprised of 21 voting members: the AMA Board of Trustees (BOT) appoints 12 members who are nominated by the national medical societies with the 12 largest numbers of delegates to the AMA House of Delegates (HOD). Because the code set is used by payers, they also hold seats on the editorial panel, including representatives of the Blue Cross and Blue Shield Association, American Health Insurance Plans, and the American Hospital Association. All of these seats are permanent, while rotating seats are held by an at-large medical specialty society nominee and representative of private insurers. The AMA BOT also appoints the panel chair and vice-chair. Advisers to the panel represent all specialty societies with seats in the HOD, including ACRO. Advisers serve to communicate with and for their society members, educate them as to panel activities, work with panel staff to develop applications, and critically, to represent their societies when new code applications or modifications in existing codes are being considered. The CPT® Editorial Panel convenes three times a year to review applications submitted for addition, revision or deletion. The Panel will review and vote to approve or not the coding sequence, definition, clinical vignette(s), and associated guidance at each meeting. If the code is designated as category I (5-digit numeric) and has been approved, it is referred to the AMA/Specialty Society Relative Value Scale Update Committee (RUC) for survey and valuation.[i]

CPT® Editorial Panel Process

New code or code revision applications are submitted to the CPT® Editorial Panel by specialty societies, developers, or vendors, but traditionally, applications must have appropriate specialty society support to advance. The majority of code applications request a Category I designation, for what are generally considered as standard procedures and services. Specific criteria must be met for a new code to be considered for a Category I determination: and eventually revised or created.

Per the AMA website, new or revised Category I codes must meet the following criteria:

- All devices and drugs necessary for performance of the procedure or 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.

In the event an application for a new or revised code cannot meet the Category I criteria, it may be possible to apply for a Category III code for emerging technologies or procedures. Criteria for Category III designation include:

- 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 1 CPT® or Health Care Provider Advisory Committee (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:
    - At least 1 Institutional Review Board approved protocol of a study of the procedure or service being performed
    - A description of a current and ongoing United States trial outlining the efficacy of the procedure or service or
    - Other evidence of evolving clinical utilization

Category III codes may remain at that level for up to 5 years, during which time they may be brought back to the panel for reconsideration as Cat. I, retained at Cat. III for a further period, or sunset and removed from use.

Category II codes were created by the CPT® Panel at the request of the Center for Medicare and Medicaid Services (CMS) to provide an administrative basis for reporting various health outcomes and quality measures. Cat. II codes have no associated valuation or directly associated reimbursement.

Applications which are tabled or not approved can be resubmitted for future CPT® Editorial meetings. Typically, this will require updated information to meet required criteria. Applications for Category I codes that are approved by the CPT® Editorial Panel will be forwarded to the RUC for valuation. Applications designated as Category III codes approved by the Panel are not included in the standard processes of the RUC as they have no assigned physician work or practice expense relative value units (RVUs) established. Category III codes are reimbursed based on determinations by individual Medicare Administrative Contractors (MAC) under the Medicare Physician Fee Schedule and commercial payers, who may deny payment. Medicare, under the Hospital Outpatient Prospective Payment System (HOPPS) will set rates for Category III codes in the outpatient hospital setting.

RUC Process

In the 1980's, policy makers within the Health Care Financing Administration (HCFA), later designated as CMS, began to consider the increasing gap in payments to providers who performed procedures, as opposed to those whose practices focused on evaluation and management (at that time, called cognitive practices). It was felt that

the differences in reimbursement were disincentivizing primary care providers and was leading to increasingly unpredictable budget concerns. To respond to this issue, CMS awarded a number of contracts to health care economics groups and ultimately selected the model designed by Hsaio et al for adoption. That model called for values to be assigned to physician (or other provider) work, plus values for practice expenses and medical liability costs. Because it was apparent that determination of "relative values" would create some controversy and potential dissention within the house of medicine, CMS determined to allow the process for establishing the values to be carried out within the AMA structure, and in 1992, the RUC was empaneled. The AMA BOD appoints the RUC chair and an AMA representative. The remaining 27 seats include 20 permanent specialty society representatives, 3 rotating specialty society representatives, representatives of the American Osteopathic Association (AOA), the Health Care Provider Advisory Committee (HCPAC), the CPT® Editorial Panel, and the Practice Expense Subcommittee. Because RUC recommendations are merely advisory to CMS, CMS representatives serve as observers, without vote. The specialty societies that participate in the CPT® process also participate in the RUC process by surveying their members for specific codes they may perform, that have been designated (or revised) as Cat. I by the CPT® Panel and require valuation.

RUC surveys are distributed to members of the appropriate societies with questions asking physicians their familiarity with the new or revised codes, the amount of time they spend providing the service, and the intensity and complexity of the procedure relative to other previously valued procedures. The surveys are designed by RUC staff with limited specialty society input and societies are forbidden from advising members how to respond. The data is compiled to calculate the recommended work RVUs and the pre-, intra-, and post-service times.

In addition to the physician work components the direct practice expense (PE) of each individual code is also calculated. This value includes defining the specific staff who assist in and work under the direction of the physician in providing the service, and the various key components which are common to health care services. A critical factor in this determination is the time and professional designation of each staff member participating in the specific service. Any supplies and equipment which are part of the procedure are also included in the practice expense valuation for services in the non-facility (free-standing) setting.

The PE values recommended by the specialty societies are presented to the PE subcommittee for review and approval of the direct PE components, and then to the full RUC panel. Values recommended by the specialty societies may be revised as part of the discussion. Once the values are approved, the recommendations are sent by the AMA to CMS prior to the February 10th deadline each year to ensure there is time for CMS to consider proposals within the next proposed rulemaking process.[ii]

The Take Home Message

The CPT® and RUC processes for creating, revising, and valuing Category I and III codes are not rapid and may appear arcane. It can take two or more years from the time a Cat. I code is submitted to the CPT® Editorial Panel before the code is available for use. This extended interval should not be a deterrent to new code development and introduction as the CPT® and RUC processes provide opportunities for ACRO members to provide their insight and expertise into the definitions and valuation of new and revised procedures and technologies. Participation in RUC surveys is an equally critical component of the process to assure the greatest opportunity for appropriate code valuation.

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[i] American Medical Association Current Procedural Terminology. https://www.ama-assn.org/practice-management/cpt.
[ii] AMA/Specialty Society Relative Value Scale Update Committee. https://www.ama-assn.org/about/rvs-update-committee-ruc/rvs-update-committee-ruc