Physician Payment Basics

Reimbursement for physician services is a complicated mix of various process mechanisms. The overall reimbursement process can be separated into components of coding, coverage, and ultimately, reimbursement.

CODES

Codes are what physicians use to get paid, and they include clinical vignettes to describe the exact service. Codes are most often developed by professional medical organizations and are submitted to the American Medical Association's (AMA) Current Procedural Technology (CPT) Editorial Panel for review and deliberation. The CPT Panel has ultimate authority to determine which codes are approved for use in the following year.

COVERAGE

Medicare covers certain services either nationally, under a national coverage determination (NCD) or locally, through the local coverage determination (LCD) process. Approximately 90 percent of the items and services covered by Medicare are covered under the LCD process.

Private payers have their own coverage processes and usually rely on technology evaluation committees to determine whether an item or service meets criteria for coverage. In addition, private payers also look to Medicare to inform coverage decisions.

REIMBURSEMENT

Determining how much a physician gets paid for a particular service is a complex process. The AMA Relative Value Update Committee (RUC) reviews and recommends relative value units to be assigned to each code. The RUC examines such things as physician work, practice expense in providing the service, and malpractice expense. The RUC recommends to the Centers for Medicare and Medicaid Services (CMS) a value (relative value units or RVUs) for a code and the services covered under it. CMS may accept or reject the recommendation. The majority of the time, CMS accepts the RUC recommendation.

The RUC focuses on:
(1) Codes and families of codes for which there has been the fastest growth,
(2) Codes or families of codes that have experienced substantial changes in practice expenses,
(3) Codes that are recently established for new technologies or services, as is the case for cardiac CT services,
(4) Multiple codes that are frequently billed in conjunction with furnishing a single service,
(5) Codes with low relative values, particularly those that are often billed multiple times for a single treatment,
(6) Codes which have not been subject to review since the implementation of the Resource Based Relative Value system (RBRVS) (the so-called 'Harvard-valued codes'), and
(7) Other codes determined to be appropriate by the Secretary of Health and Human Services.

HOW YOU INFLUENCE THE REIMBURSEMENT PROCESS

Cardiac CT / coronary CTA services were identified by the AMA RUC as a new technology and are therefore on a list for review. When a new, existing or revised code is scheduled for review and valuation, a random selection of physician members will receive a survey with an opportunity to answer questions regarding the detailed physician work and practice expense involved in the provision of a designated medical service. If you receive a request to complete a RUC survey, it is absolutely crucial that you fill it out any survey you receive in a thorough and accurate manner. The data collected from this survey instrument will form the basis of compelling evidence submitted to the RUC to support a potential increase in the RUC-recommended values for cardiac CT/coronary CTA services.

SCCT will conduct an educational campaign about the importance of these surveys. **YOUR** participation is critical to the success of the field!