Physician Payment

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.

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

In October 2013, the RUC will conduct a review of new technology codes including cardiac CT services (CPT codes 75571 – 75574). After this review you may be asked to complete a physician work survey – potentially late this year or early in 2014. The survey from AMA will ask you to complete questions that will in part determine reimbursement values for cardiac CT/coronary CTA. The questions will be used to update information about the physician work involved in providing these services and will indirectly capture information on the practice expense and malpractice liability expense involved in the provision of cardiac CT services. **It is absolutely crucial that you call this survey to the attention of your staff and that you, the physician, fill it out accurately and completely. This survey will form the basis of RUC recommended values for cardiac CT/coronary CTA services. The consequences of inaction on your part could result in a low survey response rate, incomplete and inaccurate survey responses, as well as data not representative of the work associated with your practice. If this happens, the survey results may be skewed and may result in lower physician work values.**