How a Code Becomes a Code

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HCPCS (Healthcare Common Procedure Coding System)

- Level I
  - AMA CPT® Codes
- Level II
  - Developed and maintained by CMS

Level I Codes (CPT)

- Uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals
- Identify services and procedures for which they bill public or private health insurance programs
- Does not include codes needed to separately report medical items or services that are regularly billed by suppliers other than physicians.

Level II Codes

- Standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office
- Comprehensive and standardized system that classifies similar products that are medical in nature into categories for the purpose of efficient claims processing

CPT Process: Members

- CPT Editorial Panel
  - 17 members; 11 physicians nominated by National Medical Specialty Societies
  - 1 physician from each of the following: BCBSA, AHA, AHIP, CMS
  - Remaining 2 seats reserved for members of the Health Care Professionals Advisory Committee
  - Supporting the CPT Editorial Panel in its work is a larger body of CPT advisors, the CPT Advisory Committee; the members of this committee are primarily physicians nominated by the national medical specialty societies represented in the AMA House of Delegates

Process for Changes

- Medical specialty societies, individual physicians, hospitals, third-party payers and other interested parties may submit materials for consideration by the Editorial Panel
- Requestor submits a coding change request (CCR) form
- Reviewed by AMA staff, referred to appropriate specialty societies
- If the advisors' comments indicate that action by the CPT Editorial Panel is warranted, a second step is then taken by AMA staff to prepare an agenda item that includes a ballot for the request to be acted upon by the CPT Editorial Panel

If a new code makes it successfully through the CPT Editorial Panel…

It is referred to the AMA/Specialty Society Relative Value Scale Update Committee—the “RUC”

The RUC: Overview

- The purpose of the RUC process is to provide recommendations to CMS for use in annual updates to the new Medicare RVS
- This process was established in the course of the AMA's normal activities and as a basis for exercising its First Amendment right to petition the Federal Government as part of its research and data collection activities, for monitoring economic trends and in connection and related to the CPT development process

The RUC: Composition

- 29 members – 23 appointed by National Medical Specialty Societies, approved by AMA BOT
- Remaining 6 seats - RUC Chair, the Co-Chair of the RUC Health Care Professionals Advisory Committee Review Board, and representatives of the AMA, American Osteopathic Association, the Chair of the Practice Expense Review Committee and CPT Editorial Panel
- The AMA Board of Trustees selects the RUC chair and also the AMA representative to the RUC

The RUC: Process Notes

- Codes are valued “relative” to other codes
- While codes are procedure/service specific, they are not “specialty specific”
- If the full RUC votes to approve the valuation for a code (i.e. RVUs), the recommendation is sent to CMS
- CMS may or may not accept the recommendation

A Note on Timelines…

- Lengthy process to successfully complete the entire CPT and RUC process
- May take ~two years to complete

A Note on Modifiers…

- Both Level I and Level II code sets also contain “modifiers”
- Used to indicate something unique about the service/procedure
- CMS has modifiers for reporting services rendered when patient is on a clinical trial

THANK YOU