# Physician Reimbursement: Path to Payment

Members often call the 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 payors.

## *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 proposal for review to the AUA Coding and Reimbursement Committee (CRC), which meets twice a year to evaluate coding proposals received from industry as well as individual urologists and is considered 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.

## *Is there more than one type of CPT code?*

There are three kinds of CPT codes that the CRC reviews, described below.

**Category I CPT Code:** A Category I code is necessary to qualify for payment. All of the following criteria must be met in order for the CRC to submit a proposal to the AMA CPT Editorial Panel for a Category I CPT code:

- Service/procedure has received approval from the Food and Drug Administration (FDA);
- Service/procedure is a distinct service performed by many physicians/practitioners across the United States;
- Clinical efficacy of the service/procedure is well established and documented in U.S. and foreign peer review literature according to AMA established literature requirements;
- Suggested service/procedure is neither a fragmentation of an existing procedure/service nor currently reportable by one or more existing codes; and
- Suggested service/procedure is not requested as a means to report extraordinary circumstances related to the performance of a procedure/service already having a CPT code.

**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 Code:** These are temporary codes for emerging technology, services and procedures, and allow data to be gathered on their use over time. Oftentimes, the collection of data facilitated by this code provides a foundation for later consideration of a CPT Category I code along with the additional research studies completed by a requestor.

- Appropriate in circumstances where the criteria for a Category I code are not met.
- Requires only one of any of the following be established:
- a protocol for a study of procedures being performed;
- support from the specialties who would use the procedure;
- availability of U.S. peer-reviewed literature; or
- descriptions of current United States trials outlining the efficacy of the procedure.

## *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, AUA staff then submits the coding application 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 code proposal 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) and practice expense or PE (44 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 29 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 coding change 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 e-mail 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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