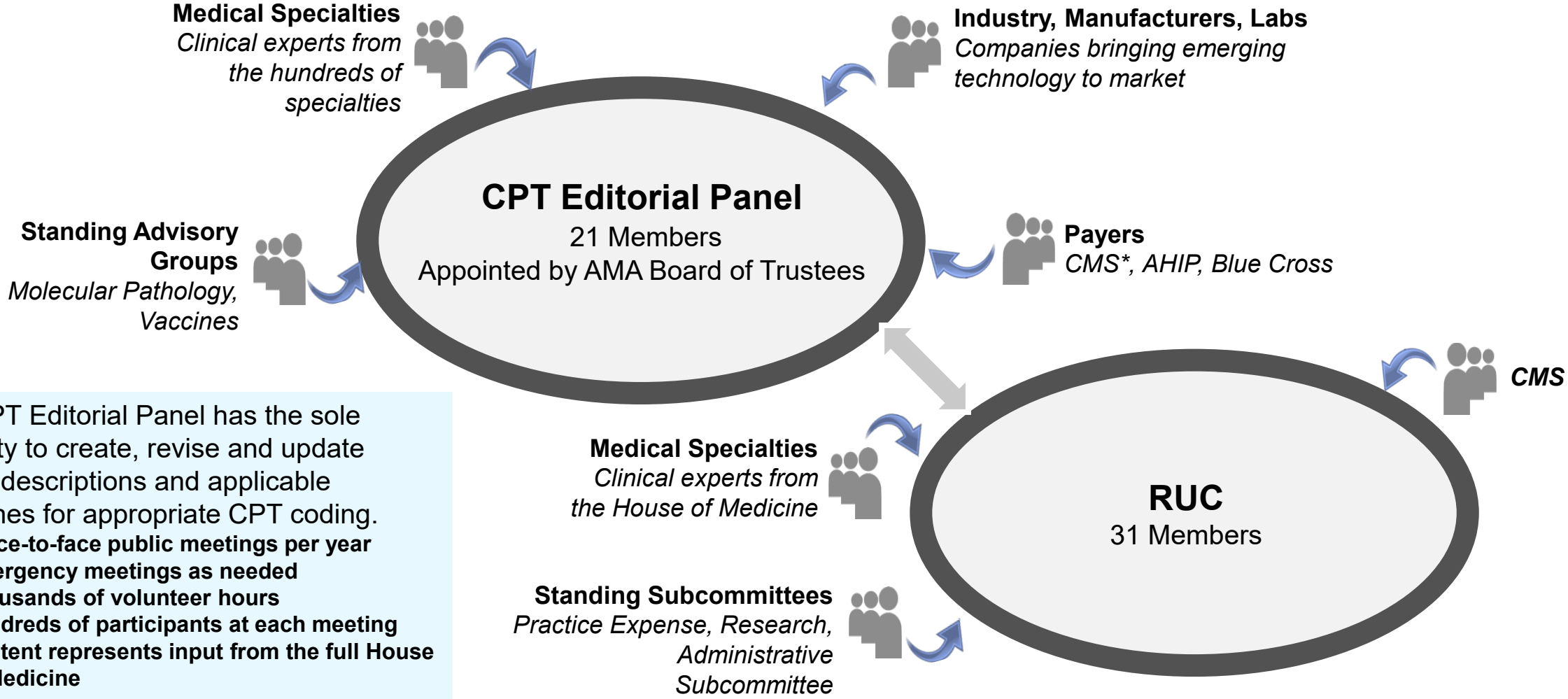
CPT & RUC: a Process Overview

Mark S. Synovec, MD
CPT Editorial Panel Chair

CPT® Editorial Panel relationship to the RUC

Evidence-based | **Deliberation driven** | **Well-defined criteria** | **Clinical expertise**



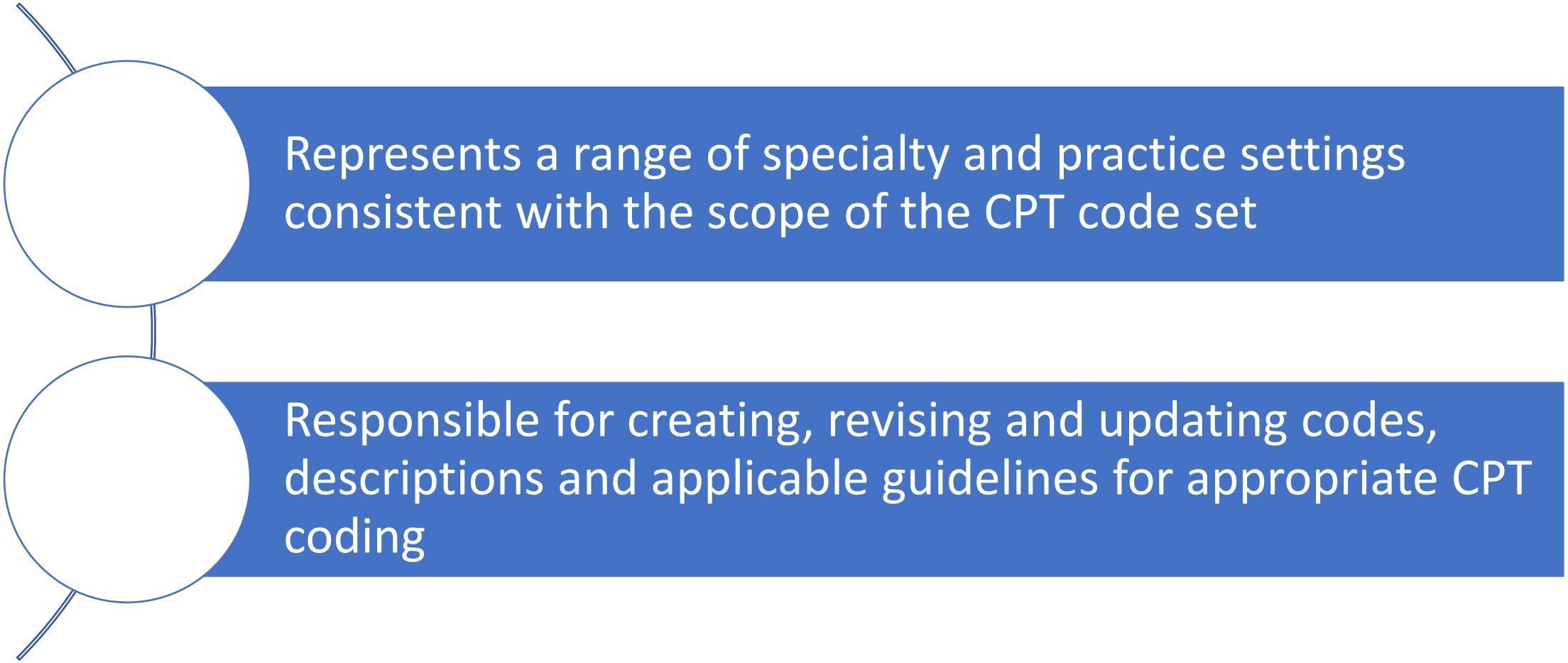
The CPT Editorial Panel has the sole authority to create, revise and update codes, descriptions and applicable guidelines for appropriate CPT coding.

- **3 face-to-face public meetings per year**
- **Emergency meetings as needed**
- **Thousands of volunteer hours**
- **Hundreds of participants at each meeting**
- **Content represents input from the full House of Medicine**

*CMS has observer status. Also, members do not advocate for their specialty or organization once named to the Panel.

CPT Overview

CPT Editorial Panel Function



Focus on Transparency

- All Panel meetings are **hybrid** and open to the public
- **Agenda items are posted** roughly 60 days prior to each Panel meeting
- After each meeting, a **Summary of Panel Actions** is posted to the AMA website
  - www.ama-assn.org/about/cpt-editorial-panel/summary-panel-actions

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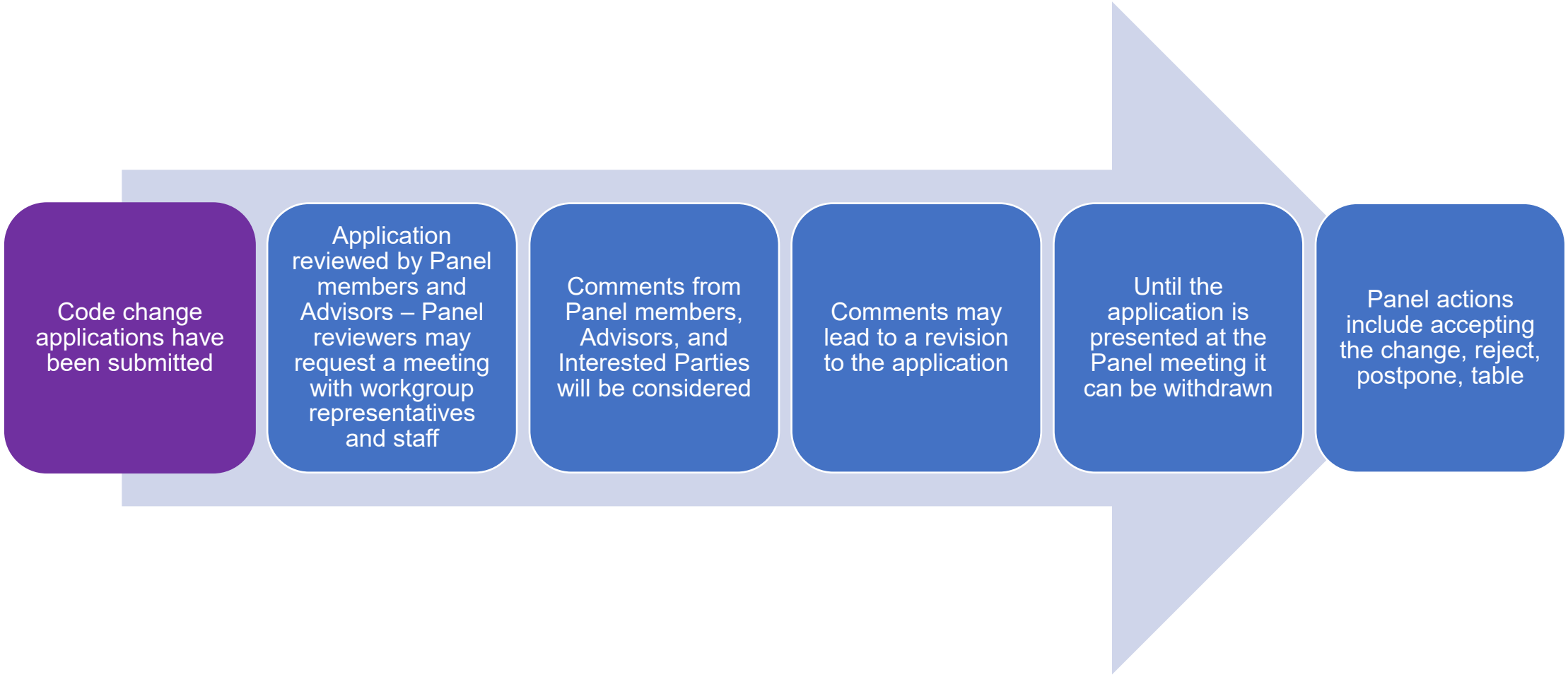
Code Change Application Process



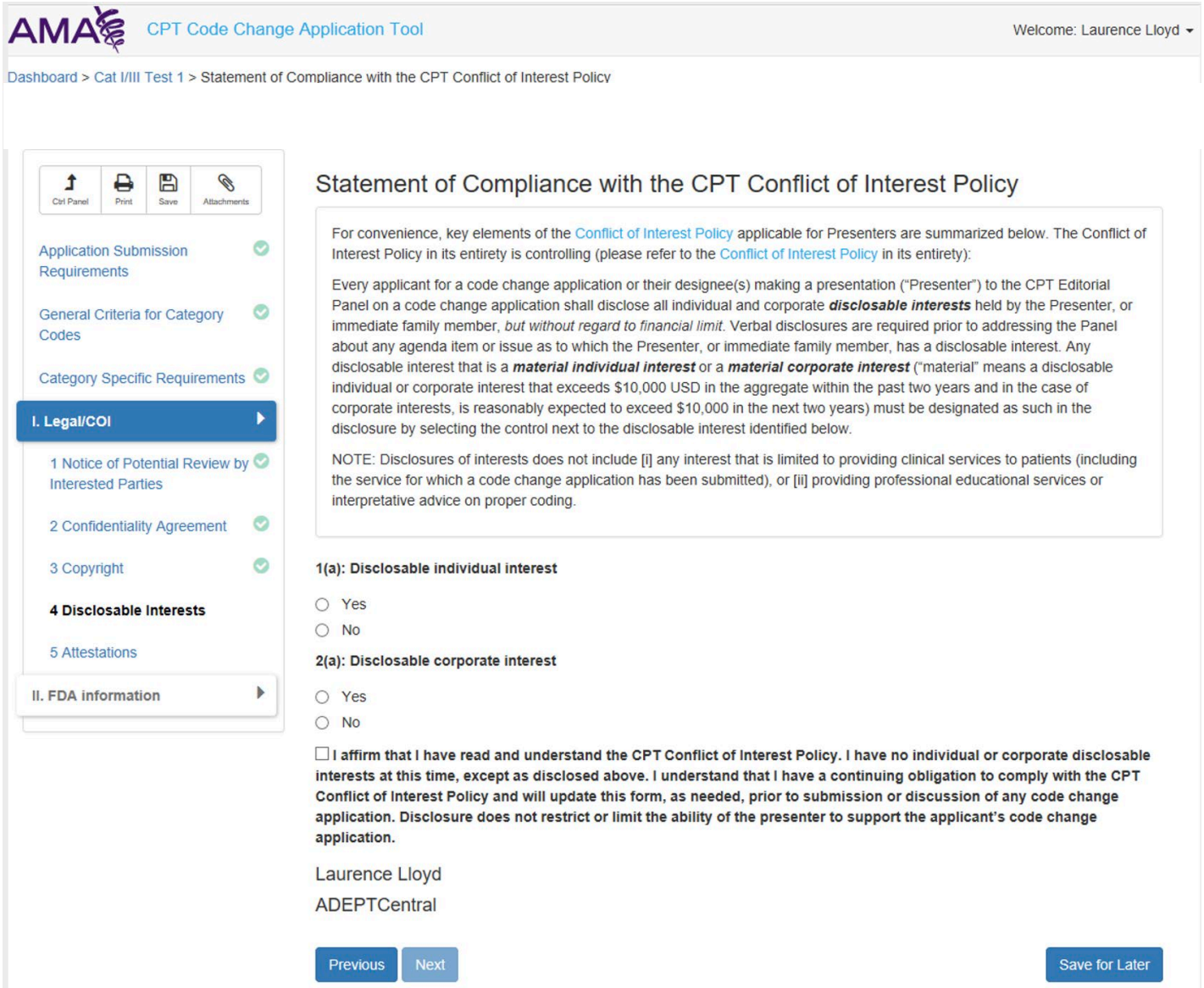
Code Change Application Process

- **CPT® Smart App**
  - Can be submitted by ANYONE that can complete the application
  - Typically submitted by manufacturers, Medical Specialty Societies or healthcare providers
  - https://www.ama-assn.org/practice-management/cpt/code-change-instructions
  - This process is used for:
    - Category I (long and short form)
    - Category III
    - Laboratory submissions (including Admin MAAA)

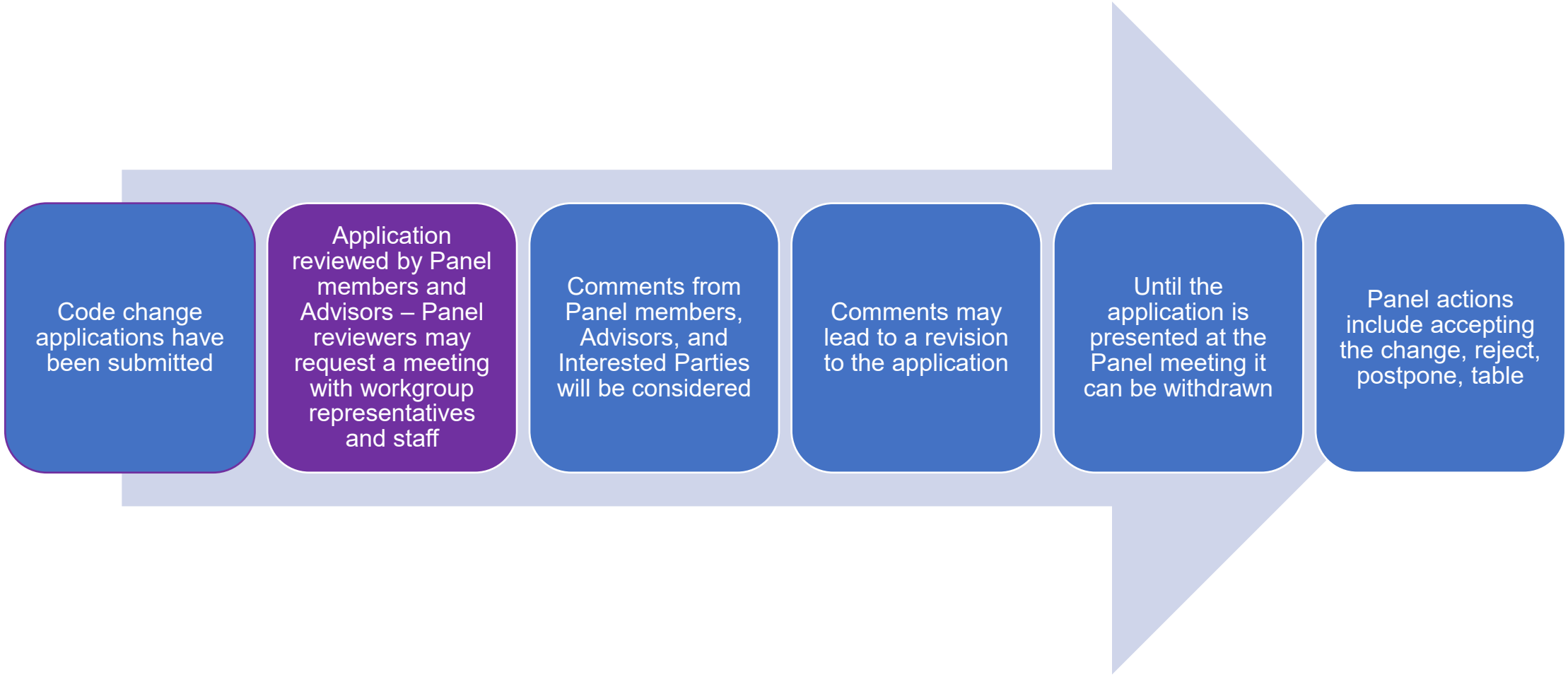
Code Change Application Process

- **CPT® Smart App**
  - The application process is self-guided with explanations embedded into the process
  - The AMA has further created an online tutorial that can be taken in toto, or by review of specific section (e.g., literature requires).
  - Can be completed over time and can have review/input by multiple applicants for the same application.

Code Change Application Process

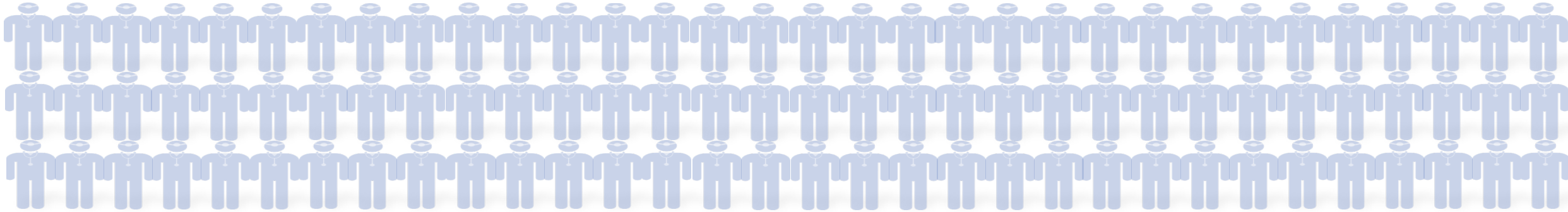


Code Change Application Process



CPT Advisors

- CPT Advisory Committee
  - Over 100 Medical Specialty Societies with membership in the AMA House of Delegates
- CPT Health Care Professionals Advisory Committee (HCPAC)
  - Organizations representing non-physician healthcare professionals



CPT Health Care Professionals Advisory Committee (HCPAC)

- Non-physician health care professionals who are designated as CPT Advisors to represent their societies/organizations
- Members are required to use CPT codes to send and receive health care information
- 19 organizations on the HCPAC committee

CPT and HCPAC Advisory Roles

- To serve as a resource to the Panel by giving advice on nomenclature relevant to the members' specialty and clinical input on the medical appropriateness, efficacy and utilization of services and procedures within the member's specialty
- To periodically engage stakeholders outside of the process in potential changes to CPT
- To assist in the preparation of clinical and technical aspects of educational and informational coding resources
- To promote and educate specialty society members on the use of the CPT code set

Standing Advisory Groups

Standing workgroups review and make recommendations to the CPT Editorial Panel regarding code change applications.

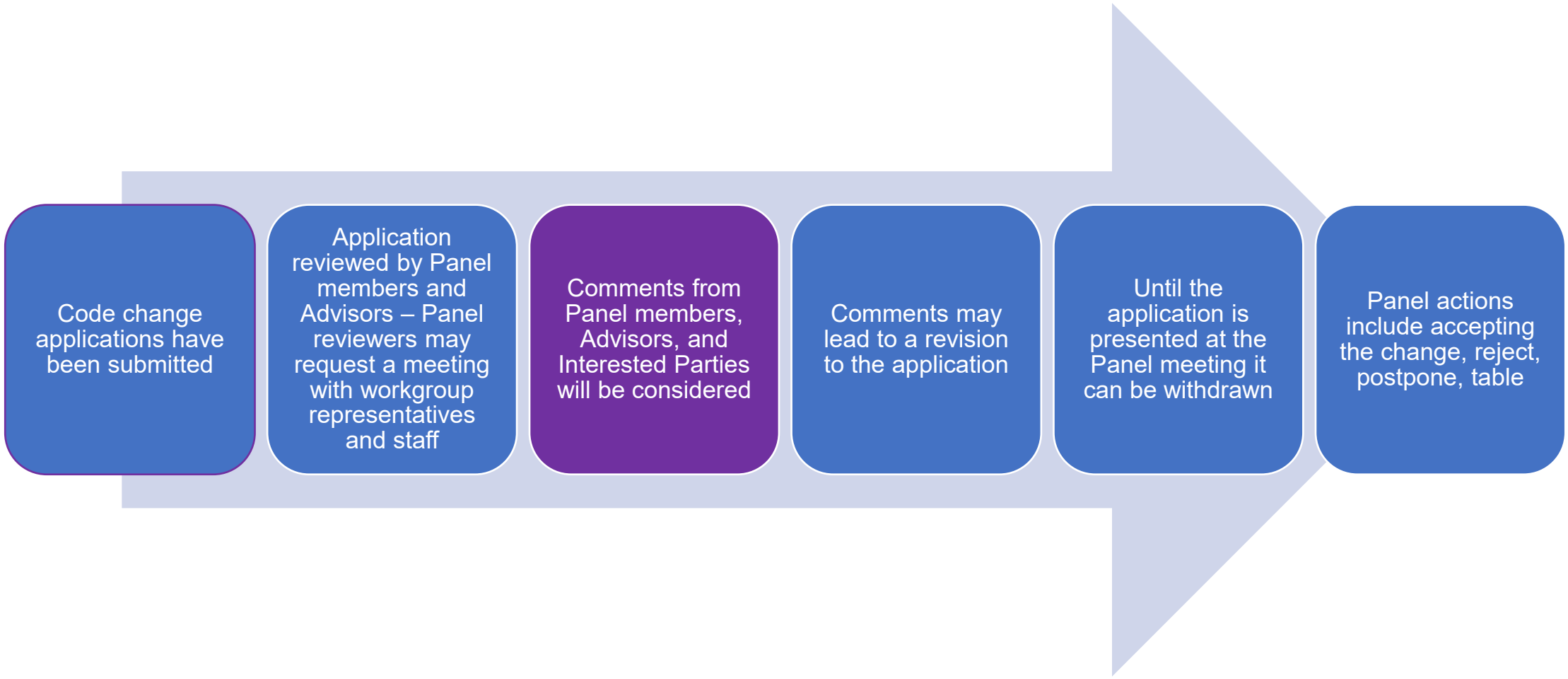
Molecular Pathology Advisory Group (MPAG)

Proprietary Laboratory Analyses Technical Advisory Group (PLA-TAG)

Pathology Coding Caucus (PCC)

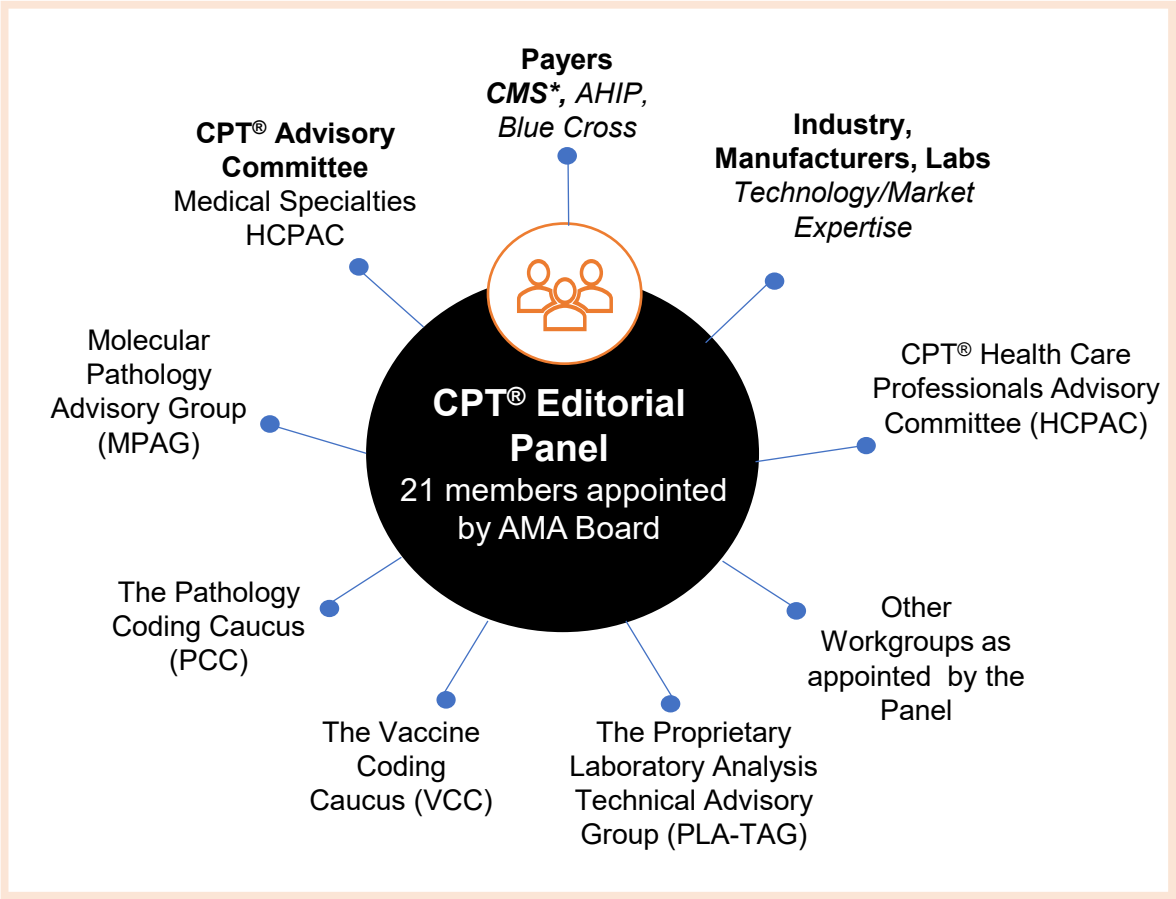
Vaccine Coding Caucus (VCC)

Code Change Application Process



CPT Editorial Panel – 21-Member Body

- **The CPT® Editorial Panel** has the sole authority to create, revise and update codes, descriptions and applicable guidelines for appropriate CPT coding
- **CPT Editorial Panel members** do not advocate for their specialty or organization once named to the Panel



***CMS has observer status**

CPT Editorial Panel Composition

- Chair (Christopher L. Jagmin, MD, FAAFP)
- Vice Chair (Barbara Levy, MD)
- Twelve (12) seats occupied by members from the national medical specialty societies represented in the AMA's House of Delegates (HOD)
- Two (2) seats occupied by members from the Health Care Professionals Advisory Committee (HCPAC)
- Three (3) seats occupied by members nominated by the Blue Cross and Blue Shield Association, America's Health Insurance Plans, American Hospital Association
- One (1) seat occupied by a member of an at-large organizational member
- One (1) seat occupied by a member of an an umbrella organization that represents private health care insurers
- Two (2) Centers for Medicare and Medicaid Services (CMS) liaisons (*non-voting status only*),

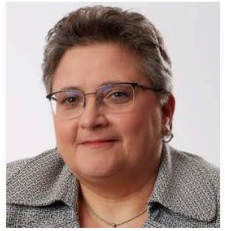
CPT® Editorial Panel—Members

Chair

Christopher L. Jagmin, MD, FAAFP
Family Medicine

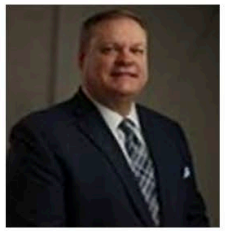
Vice-Chair

Barbara S. Levy, MD, FACOG
OBGYN



Linda M. Barney, MD
General Surgery

Aaron Bossler, MD, PhD
Pathology



Daniel E. Buffington, PharmD, MBA
Pharmacology

Joseph Cheng, MD
Neurosurgery

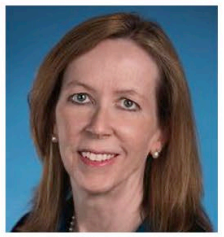
Samuel L. Church, MD
Family Medicine

Richard A. Frank, MD, PhD
Internal Medicine / AI

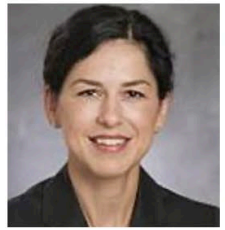
Padma Gulur, MD
Anesthesiology

Michael O. Idowu, MD, MFH
Pathology

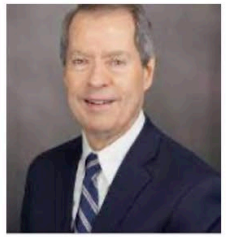
David Kanter, MD
Pediatrics



Janet C. McCauley, MD, MHA, CPC
OBGYN

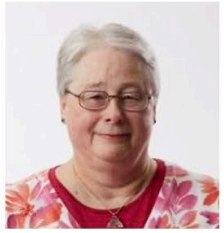


JoEllyn C. Moore, MD
Cardiology

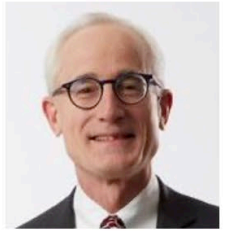


Douglas C. Morrow, OD
Optometry

Daniel J. Nagle, MD, FACS, FAAOS
Hand Surgery



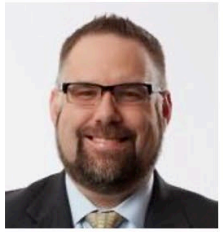
Judith A. O'Connell, DO, FAAO
Osteopathic



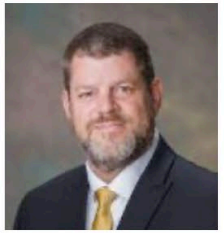
Robert N. Piana, MD, FACC
Cardiology

Daniel Picus, MD, FACR, RCC
Radiology

Gregory Przybylski, MD
Neurosurgery

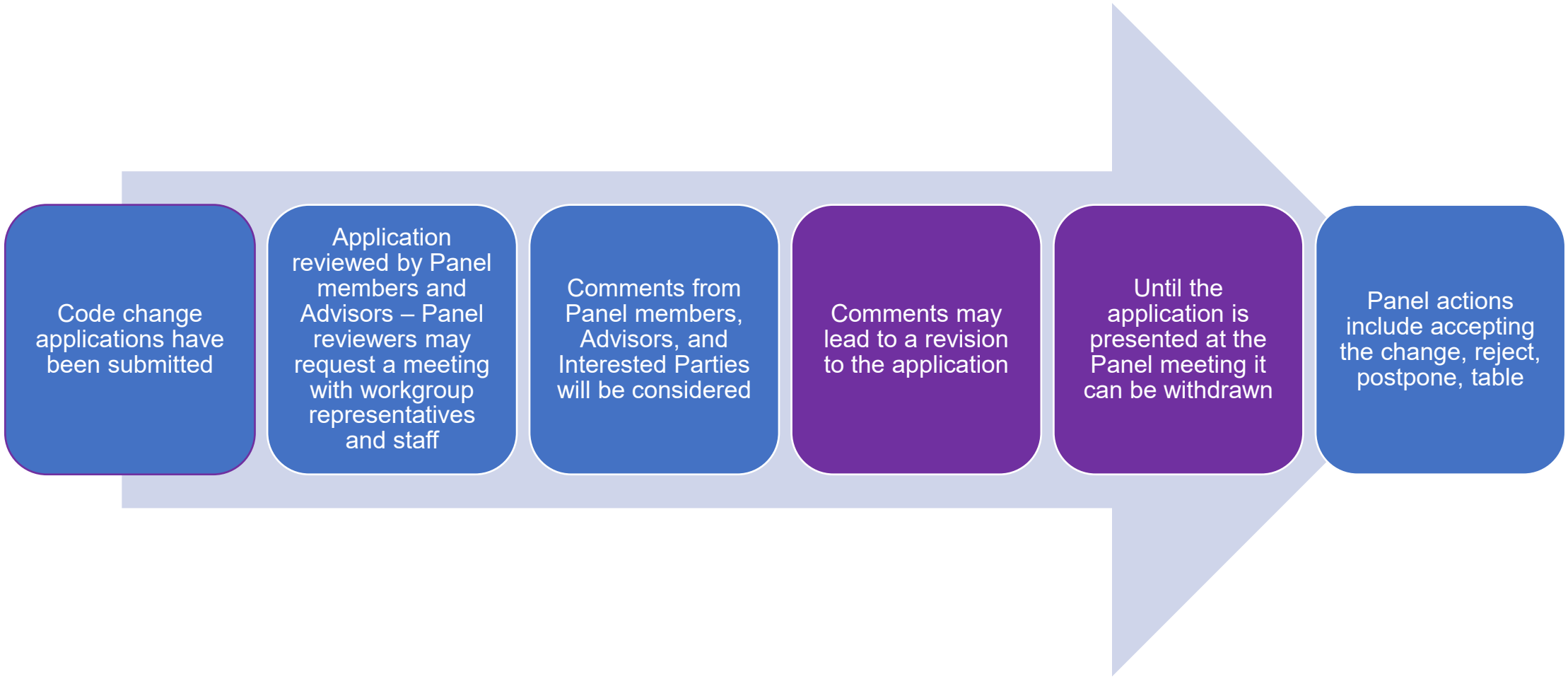


Lawrence Simon, MD
Otolaryngology

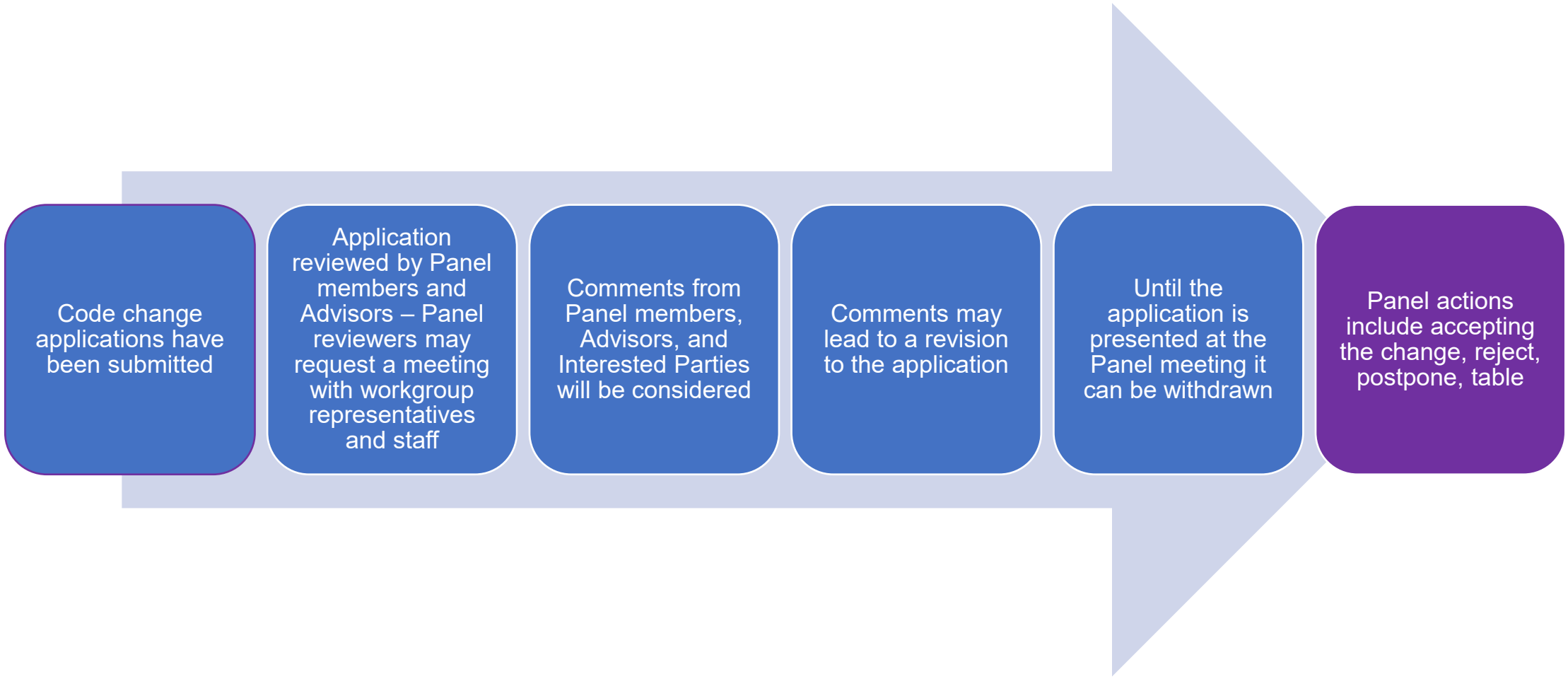


Timothy L. Swan, MD
Interventional Radiology

Code Change Application Process



Code Change Application Process



CPT Panel Review Criteria

The CPT Panel uses a set of objective criteria to determine the appropriateness of code requests

Each Panel member reviews each application and votes based upon that review, using their own clinical judgment

General Criteria for CPT Category I and III Codes

All Category I or Category III code change applications must satisfy each of the following criteria:

- The proposed descriptor is unique, well-defined, and describes a procedure or service which is clearly identified and distinguished from existing procedures and services already in CPT;
- The descriptor structure, guidelines and instructions are consistent with current Editorial Panel standards for maintenance of the code set;
- The proposed descriptor for the procedure or service is neither a fragmentation of an existing procedure or service nor currently reportable as a complete service by one or more existing codes (with the exclusion of unlisted codes). However, procedures and services frequently performed together may require new or revised codes;
- The structure and content of the proposed code descriptor accurately reflects the procedure or service as typically performed. If always or frequently performed with one or more other procedures or services, the descriptor structure and content will reflect the typical combination or complete procedure or service;
- The descriptor for the procedure or service is not proposed as a means to report extraordinary circumstances related to the performance of a procedure or service already described in the CPT code set; and
- The procedure or service satisfies the category-specific criteria.

CPT Category I Criteria

A proposal for a new or revised Category I code must satisfy all of 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, whereas a service commonly performed for a rare condition may have low 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.

CPT Category III Criteria

The following criteria are used by the CPT/HCPAC Advisory Committee and the CPT Editorial Panel for evaluating Category III code applications:

- 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 one CPT or 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 Editorial Panel; **OR**
- There is a) at least one Institutional Review Board approved protocol of a study of the procedure or service being performed, b) a description of a current and ongoing United States trial outlining the efficacy of the procedure or service, or c) other evidence of evolving clinical utilization.

The Category I Literature Requirements

- Specific Category I Criterion:

  "The ***clinical efficacy*** of ***the procedure or service*** is documented in literature that meets the requirements set forth in the CPT code change application."

- The CCA requirements are:
  - Furnish electronic versions (PDF or Word) of the peer-reviewed articles (full text)
  - Identify Level of Evidence, journal origin (US or foreign), and Impact Factor
  - Identify study duration, design type, and total patients (US- or non-) studied
  - Write a brief description of study's relevance
  - Identify articles with conflicting data/opinions
- Abstracts are allowed as supplemental information for the application but will not be accepted as a substitute for full length journal articles

Quantitative vs. **Qualitative** Factors in the Category I Literature Requirements

Quantitative Factors

- Minimum number of peer-reviewed articles
- Overlapping patient population
- Overlapping authors
- Minimal Level of Evidence (for at least one article)

All but the final factor are quick and easy to confirm

Qualitative Factors

- Impact Factor of the journal (or alternative quality metric)
- Duration of study (long enough?)
- Total patients studied (sufficient?)
- Relevance of the articles to the procedure or service
- Significance of conflicting publications

Require a Panel member's independent clinical judgment

Category I Literature Requirements Matrix

Category I Literature Requirements					
	Utilization	Typical	Typical	Limited, Specialized or Humanitarian	Limited, Specialized or Humanitarian
	Technology	New	Existing or Non-Contributory	New	Existing or Non-Contributory
Maximum # of Peer-Reviewed Publications Per Distinct Service(s) / Technique(s)		5	5	5	3-5
Minimum # with No Overlapping Patient Populations and No Overlapping Authors		2	2	1	1
Minimum Level of Evidence for at least One Article		Systematic review of **cohort studies**	Systematic review/Evidence obtained - **case control studies**	Evidence obtained from a **case control study**	Evidence obtained from **case series**

Code Change Application Process

Actions approved by the Panel are announced ~2 month after the meeting and published according to the schedule.

2025 cycle for CPT code set and RUC recommendations

CPT code set ⟷ **RUC**

CPT code application submission deadline	CPT public agenda	CPT meeting	Surveys available to specialty societies	RUC agenda available	RUC meeting
Nov. 2, 2022	Dec. 2, 2022	Feb. 2–4, 2023	Feb. 20, 2023	Apr. 5, 2023	Apr. 26–29, 2023
Feb. 6, 2023	Mar. 3, 2023	May 4–6 2023	May 22, 2023	Aug. 30, 2023	Sep. 27–30, 2023
Jun. 14, 2023	Jul. 14, 2023	Sep. 21–23, 2023	Oct. 9, 2023	Dec. 13, 2023	Jan. 17–20, 2024

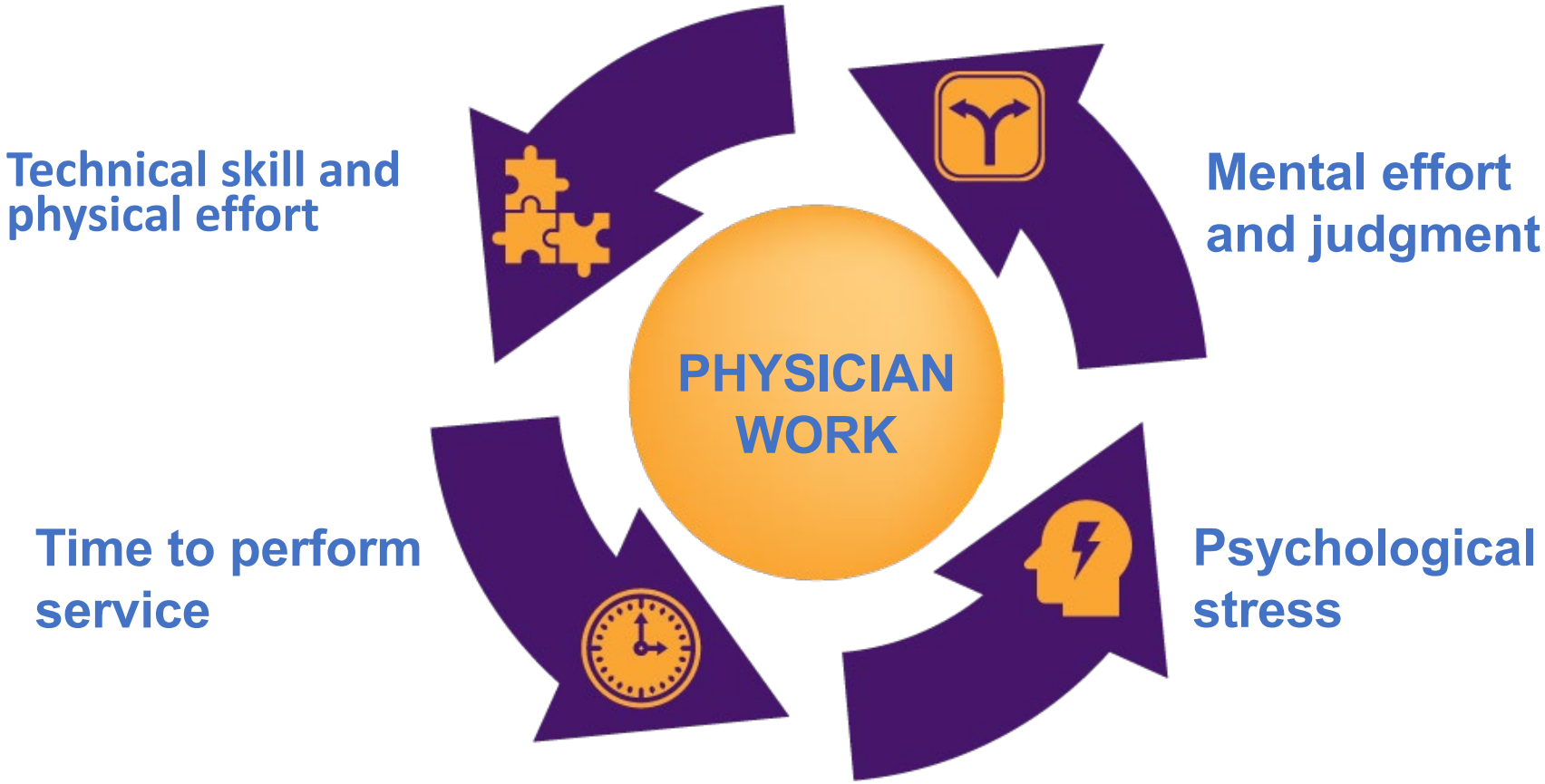
CPT codes and RUC recommendations for 2024 are made public in the CMS Medicare Payment Schedule Proposed Rule July 2023

Resource-Based Relative Value Scale (RBRVS) and AMA/Specialty Society RVS Update Committee (RUC) Process

Medicare RBRVS

The resources required to provide a services is divided into three components:

Components of physician work



Data is collected by national medical specialty societies using a standardized survey process.

Physician Work Survey

- **Vignettes**
  - Submit proposed vignette along with existing vignette either approved by CPT or in RUC database
- **Survey Sample**
  - RUC expects all societies to use a random sample.
  - Unless there is a pre-defined exception, targeted lists require review and approval.
  - Vendor lists always require review and approval.
- **Survey Instrument**
  - Customization of the standard survey templates requires approval

RUC Survey Instrument

- **Purpose:** To obtain data on the amount of physician work involved in a service.
- **Role of Advisory Committee:** Specialty society's advisory committee is responsible for generating relative value recommendations using the established RUC survey methodology. This involves conducting the survey, reviewing the results and preparing recommendations for the RUC.
- Survey respondents are asked to evaluate the work involved in the survey code relative to their selected key reference service.

Survey Response Thresholds

- RUC established thresholds for the number of survey responses required:
  - Codes with ≥1 million Medicare Claims = **75 respondents**
  - Codes with Medicare Claims from 100,000 to 999,999 = **50 respondents**
  - Codes with <100,000 Medicare = **30 respondents**
  - Surveys below the established thresholds for services with Medicare claims of 100,000 or greater will be reviewed as interim and specialty societies will need to resurvey for the next meeting.

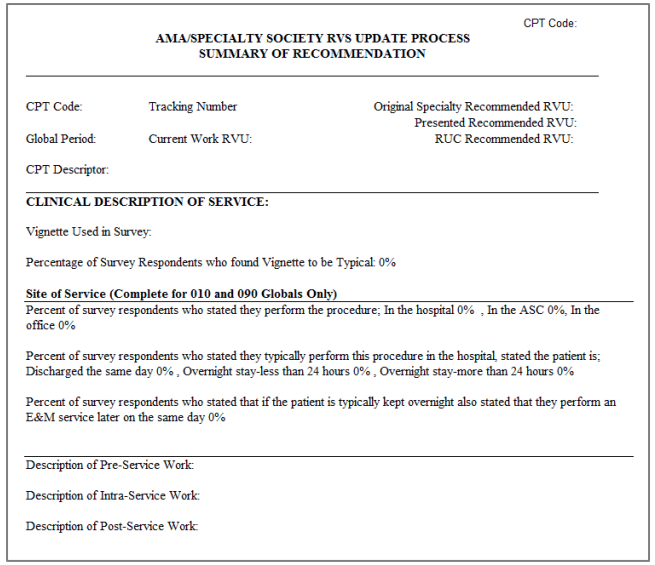
Reference Service List (RSL)

- The survey instrument asks respondents to use a reference service list (RSL) as reference point to evaluate the work involved in the survey code.
- Guidelines for developing reference service lists:
  - **Include codes from Multispecialty Points of Comparison (MPC) list**
  - **Include RUC recently validated codes. Avoid codes that are Harvard or CMS/Other.**
  - Include a broad range of services (i.e. 10-20 services) both in terms of RVUs and types of services provided by the specialty
  - Services well understood by survey population
  - Codes with the same global period as the survey code
  - Include several high volume codes

Overview of Survey Instrument Sections

1. Review code descriptor and vignette; answer if vignette represents typical patient
2. Contact and financial disclosure information
3. Review reference service list (RSL) and identifying a reference procedure
4. Estimation of pre-, intra- and post-service time and post-operative visits (if applicable)
5. Rate Intensity and Complexity (time, mental effort and judgment, technical skill, physical effort, psychological stress)
6. Estimate work RVU (relative value unit)

Summary of recommendations (SOR) form



CPT Code:

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: Tracking Number: Original Specialty Recommended RVU:
Presented Recommended RVU:
Global Period: Current Work RVU: RUC Recommended RVU:

CPT Descriptor:

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey:

Percentage of Survey Respondents who found Vignette to be Typical: 0%

Site of Service (Complete for 010 and 090 Globals Only)
Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

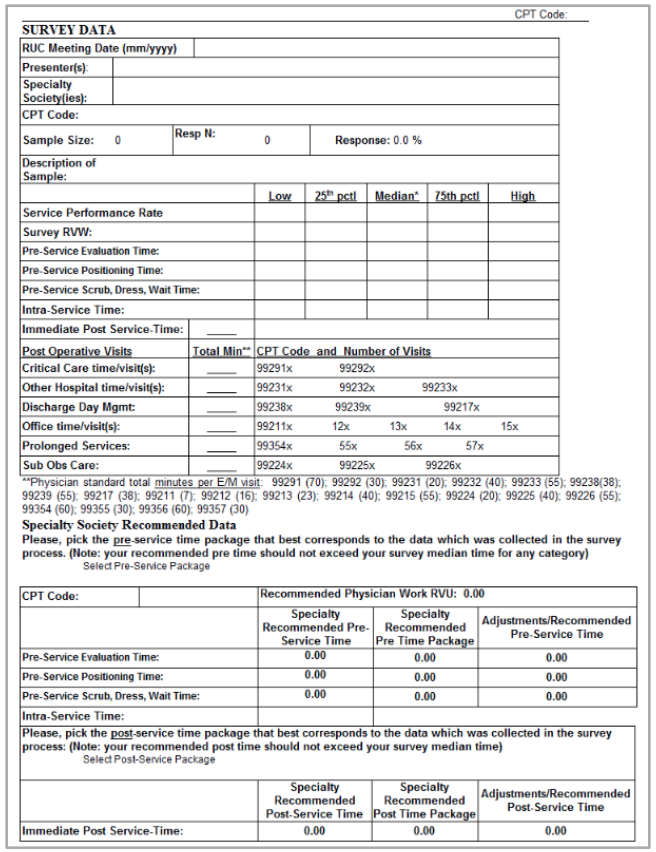
Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work:

Description of Post-Service Work:



CPT Code:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	
Presenter(s):	
Specialty Society(ies):	
CPT Code:	
Sample Size: 0	Resp N: 0 Response: 0.0 %
Description of Sample:	

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate					
Survey RVW:					
Pre-Service Evaluation Time:					
Pre-Service Positioning Time:					
Pre-Service Scrub, Dress, Wait Time:					
Intra-Service Time:					

Immediate Post Service-Time:	____	
Post Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	____	99291x 99292x
Other Hospital time/visit(s):	____	99231x 99232x 99233x
Discharge Day Mgmt:	____	99238x 99239x 99217x
Office time/visit(s):	____	99211x 12x 13x 14x 15x
Prolonged Services:	____	99354x 55x 56x 57x
Sub Obs Care:	____	99224x 99225x 99226x

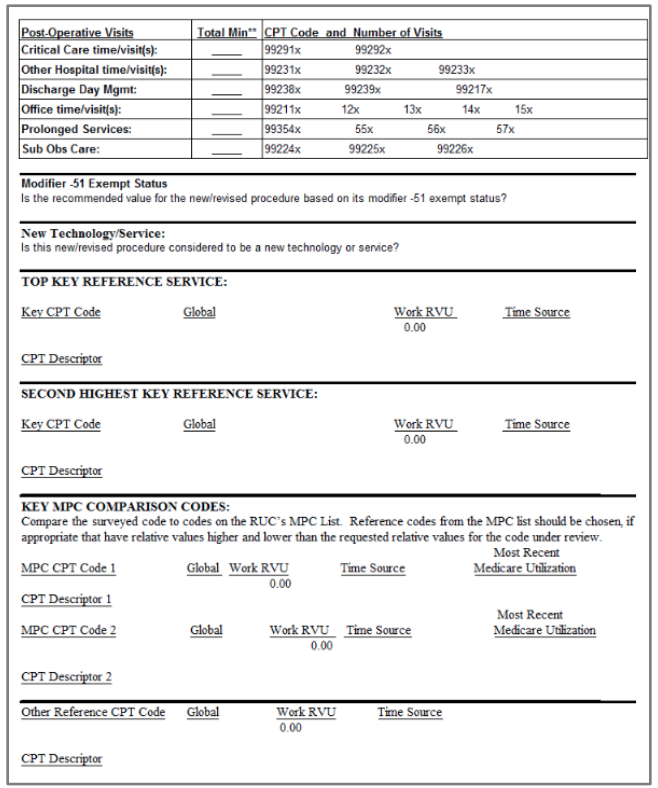
**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data
Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)
Select Pre-Service Package

CPT Code:		Recommended Physician Work RVU: 0.00		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments/Recommended Pre-Service Time
Pre-Service Evaluation Time:		0.00	0.00	0.00
Pre-Service Positioning Time:		0.00	0.00	0.00
Pre-Service Scrub, Dress, Wait Time:		0.00	0.00	0.00
Intra-Service Time:				

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)
Select Post-Service Package

	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time
Immediate Post Service-Time:	0.00	0.00	0.00



Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	____	99291x 99292x
Other Hospital time/visit(s):	____	99231x 99232x 99233x
Discharge Day Mgmt:	____	99238x 99239x 99217x
Office time/visit(s):	____	99211x 12x 13x 14x 15x
Prolonged Services:	____	99354x 55x 56x 57x
Sub Obs Care:	____	99224x 99225x 99226x

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status?

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service?

TOP KEY REFERENCE SERVICE:

Key CPT Code Global Work RVU 0.00 Time Source

CPT Descriptor

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code Global Work RVU 0.00 Time Source

CPT Descriptor

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1 Global Work RVU 0.00 Time Source Most Recent Medicare Utilization

CPT Descriptor 1

MPC CPT Code 2 Global Work RVU 0.00 Time Source Most Recent Medicare Utilization

CPT Descriptor 2

Other Reference CPT Code Global Work RVU 0.00 Time Source

CPT Descriptor

Components of practice expense

Clinical staff

(nurse, X-ray technician, etc)

Medical supplies

(gloves, syringes, etc)

Medical equipment

(exam table, CT scanner, etc)

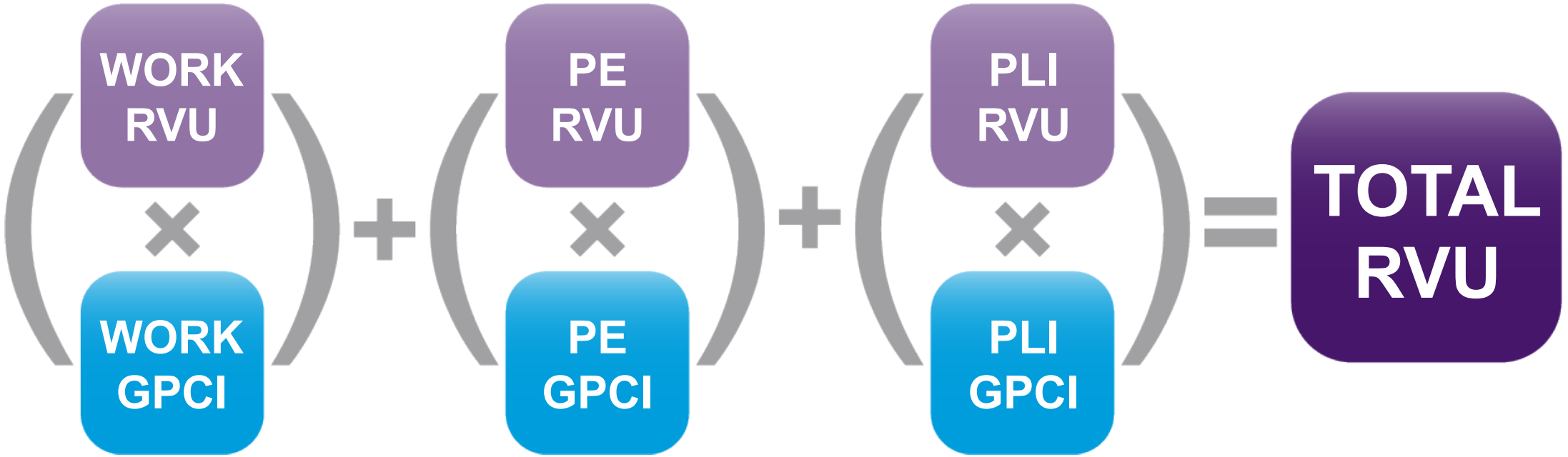
RUC practice expense spreadsheet

RUC Practice Expense Spreadsheet					REFERENCE CODE		CURRENT		RECOMMENDED	
					CPT Code #		CPT Code #		CPT Code #	
Clinical Activity Code	Meeting Date: Revision Date (if applicable): Tab: Specialty:	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute	CPT CODE DESCRIPTOR		CPT CODE DESCRIPTOR		CPT CODE DESCRIPTOR	
	LOCATION				Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
	GLOBAL PERIOD									
	TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME				$ -	$ -	$ -	$ -	$ -	$ -
	TOTAL CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.413	0.0	0.0	0.0	0.0	0.0	0.0
	TOTAL PRE-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.413	0.0	0.0	0.0	0.0	0.0	0.0
	TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.413	0.0	0.0	0.0	0.0	0.0	0.0
	TOTAL POST-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.413	0.0	0.0	0.0	0.0	0.0	0.0
	TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE				$ -	$ -	$ -	$ -	$ -	$ -
	PRE-SERVICE PERIOD									
	Start: Following visit when decision for surgery/procedure made									
CA001	Complete pre-service diagnostic and referral forms	L037D	RN/LPN/MTA	0.413						
CA002	Coordinate pre-surgery services (including test results)	L037D	RN/LPN/MTA	0.413						
CA003	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0.413						
CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0.413						
CA005	Complete pre-procedure phone calls and prescription	L037D	RN/LPN/MTA	0.413						
CA006	Confirm availability of prior images/studies	L037D	RN/LPN/MTA	0.413						
CA007	Review patient clinical extant information and questionnaire	L037D	RN/LPN/MTA	0.413						
CA008	Perform regulatory mandated quality assurance activity (pre-service)	L037D	RN/LPN/MTA	0.413						
		L037D	RN/LPN/MTA	0.413						
	Other activity: please include short clinical description here and type	L037D	RN/LPN/MTA	0.413						
	End: When patient enters office/facility for surgery/procedure									
	SERVICE PERIOD									
	Start: When patient enters office/facility for surgery/procedure:									
	Pre-Service (of service period)									
CA009	Greet patient, provide gowning, ensure appropriate medical records are	L037D	RN/LPN/MTA	0.413						
CA010	Obtain vital signs	L037D	RN/LPN/MTA	0.413						
CA011	Provide education/obtain consent	L037D	RN/LPN/MTA	0.413						
CA012	Review requisition, assess for special needs	L037D	RN/LPN/MTA	0.413						
CA013	Prepare room, equipment and supplies	L037D	RN/LPN/MTA	0.413						
CA014	Confirm order, protocol exam	L037D	RN/LPN/MTA	0.413						

Professional liability

- Costs are driven by the professional liability insurance premiums of the specialties that perform a service and the risk of the service.
- The risk of the service proxy to determine PLI RVUs is the physician work RVU.

Calculating payment: Step 1



Calculating payment: Step 2

Conversion factor (CF) is a monetary payment determined by Medicare each year.
The CF for 2023 = $33.8872

RUC overview

- The RUC is an independent group of volunteer physicians exercising its First Amendment Right to petition the federal government.
- The RUC is comprised of 32 members, 29 voting members (18 of these 29 voting members are from specialties whose Medicare allowed charges are primarily derived from the provision of E/M services).
- The RUC is an expert panel. Individuals exercise their independent judgment and are not advocates for their specialty.

RUC methodology

- RUC's cycle for developing recommendations is closely coordinated with both the schedule for annual CPT code revisions and CMS's schedule for annual updates in the Medicare payment schedule.

- CPT® Editorial Panel meets three times a year to consider coding changes for the next year's edition. CMS publishes the annual update to the Medicare RVS in the Federal Register every year.

- The median number of survey respondents for a RUC survey is 70. Surveys for high volume services have more than 100 physician respondents. The RUC uses extant data (STS and NSQIP).

RUC composition

RUC Chair*

American Medical Association

CPT Editorial Panel*

Practice Expense Subcommittee*

Health Care Professionals Advisory Committee

Anesthesiology

Cardiology

Cardiothoracic Surgery

Dermatology

Emergency Medicine

Family Medicine

General Surgery

Geriatric Medicine

Internal Medicine

Neurology

Neurosurgery

Obstetrics/Gynecology

Ophthalmology

Orthopaedic Surgery

Osteopathic Medicine

Otolaryngology

Pathology

Pediatrics

Physical Medicine & Rehabilitation

Plastic Surgery

Psychiatry

Radiology

Urology

Any Other Rotating Seat

Internal Medicine Rotating Seats (2)

Primary Care Rotating Seat

*Indicates a non-voting seat

RUC subcommittees and workgroups

Administrative Subcommittee
Primarily charged with the maintenance of the RUC's procedural issues

Relativity Assessment Workgroup
Oversees the process of identification of potentially misvalued services

Multi-Specialty Points of Comparison (MPC) Workgroup
Charged with maintaining the list of codes used to compare relativity of codes under review to existing relative values

RUC subcommittees and workgroups

Practice Expense Subcommittee

Reviews direct practice expenses (clinical staff, medical supplies, medical equipment) for individual services and examines the many broad and methodological issues relating to the development of practice expense relative values

Professional Liability Insurance (PLI) Workgroup

Reviews and suggests refinements to Medicare's PLI relative value methodology

Research Subcommittee

Primarily charged with development and refinement of RUC methodology

RUC Advisory Committee

- One physician representative is appointed from over 120 specialty societies seated in the AMA House of Delegates.
- Advisory Committee members assist in the development of RVUs and present their specialties' recommendations to the RUC.
- Each member comments on recommendations made by other specialties.
- Advisory Committee members are supported by an internal specialty RVS committee.

Health Care Professionals Advisory Committee (HCPAC) overview

- The HCPAC allows for the participation of limited license practitioners and allied health professionals in the RUC process.
- The professionals represented on the HCPAC use CPT to report the services they provide independently to Medicare patients, and they are paid for these services based on the RBRVS physician payment schedule.
- The HCPAC recommendations are sent directly to CMS.

Why RUC is important: A balanced system

Government retains oversight and final decision-making authority

Volunteer physicians provide invaluable expertise on complex medical procedures

RUC is a transparent process

RUC meetings are open to anyone who registers to attend.

- More than 300 individuals attend each RUC meeting including:
  - Physicians
  - Specialty society staff
  - Representatives from non-MD/DO health care professions
  - CMS representatives and other government representatives
  - Researchers
  - International delegations
  - Other interested parties

- Published on the web for greater visibility:
  - RUC meeting dates and locations
  - The vote total for each individual CPT® code
  - Minutes of each meeting

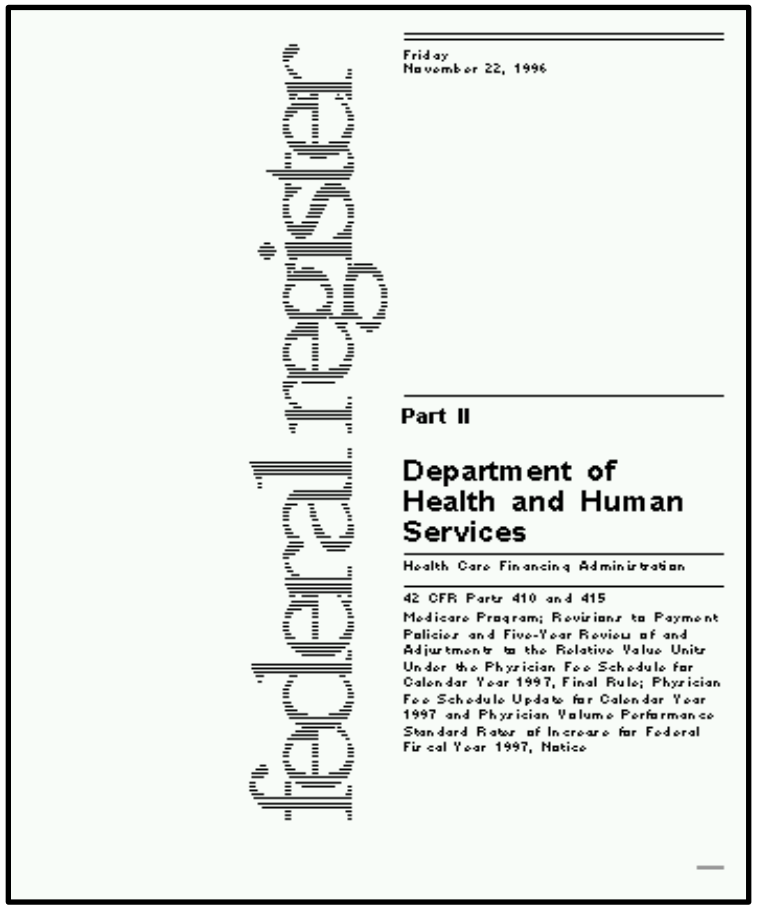
www.ama-assn.org/go/rbrvs

CPT and RUC collaboration to ensure appropriate coding

- RUC's ongoing review of claims data helps to ensure that codes are described clearly:
  - **Utilization of services:** Examine unexpected increases in volume
  - **Specialties performing:** Review codes when unexpected specialties are reporting
  - **Site-of-service:** Review codes where unexpected site-of-service is in claims
  - **Billed Together Data:** How often CPT codes are reported with other services on the same date
  - **Medicare Provider utilization and payment data:** Physician and Other Supplier

- The RUC will work with the CPT® Editorial Panel to revise:
  - CPT guidelines
  - CPT code descriptors
  - CPT parentheticals, or
  - Develop CPT® Assistant articles for clarification on correct reporting

CPT 1993–2022 RUC recommendations


Friday
November 22, 1996

Part II

Department of Health and Human Services

Health Care Financing Administration

42 CFR Parts 410 and 415

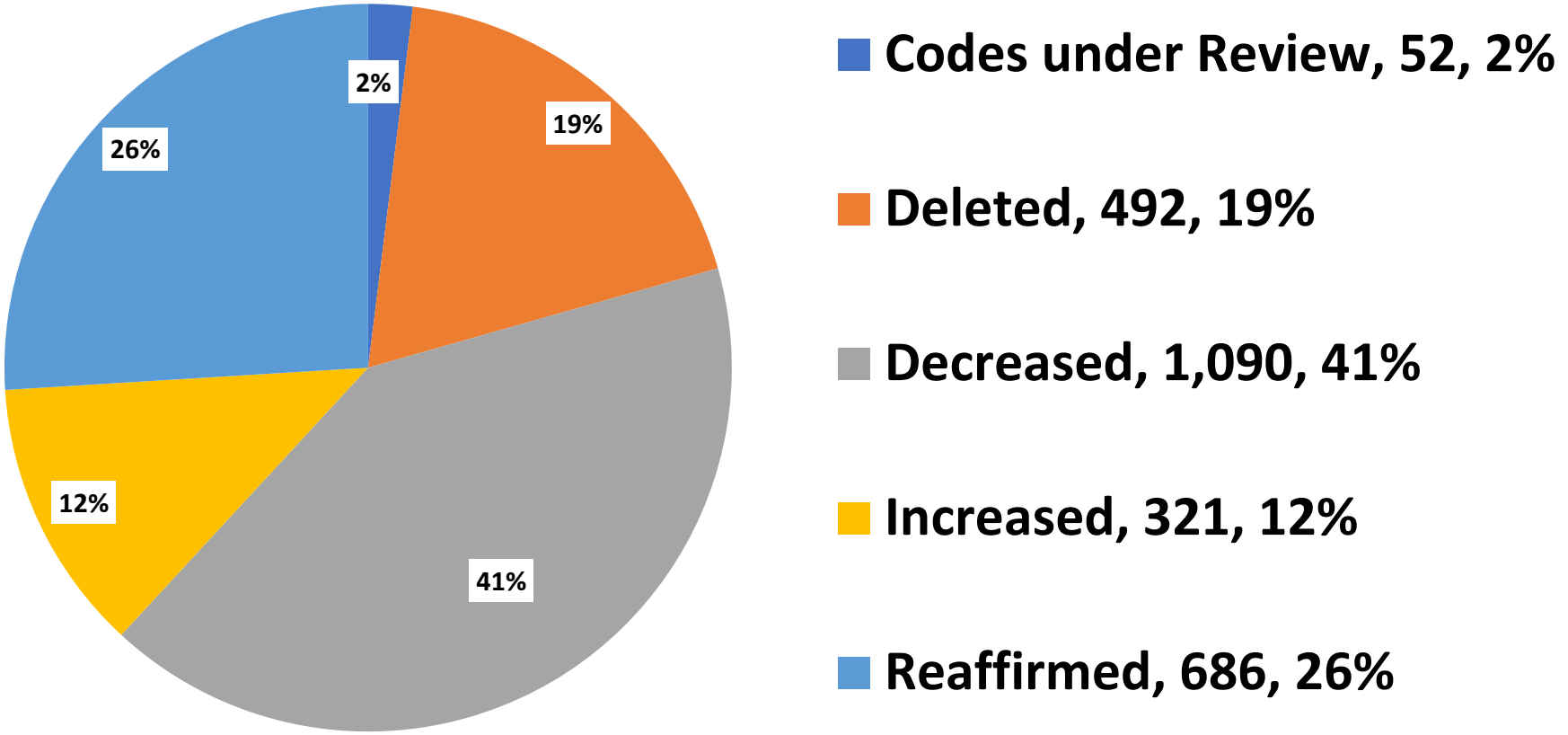
Medicare Program; Revisions to Payment Policies and Five-Year Review of and Adjustments to the Relative Value Units Under the Physician Fee Schedule for Calendar Year 1997, Final Rule; Physician Fee Schedule Update for Calendar Year 1997 and Physician Volume Performance Standard Rates of Increase for Federal Fiscal Year 1997, Notice

- CMS releases a Proposed Rule in July and conducts a 60-day comment period
- CMS publishes a Final Rule in November
- CMS's acceptance rate is typically more than 90% annually

Potentially misvalued services project

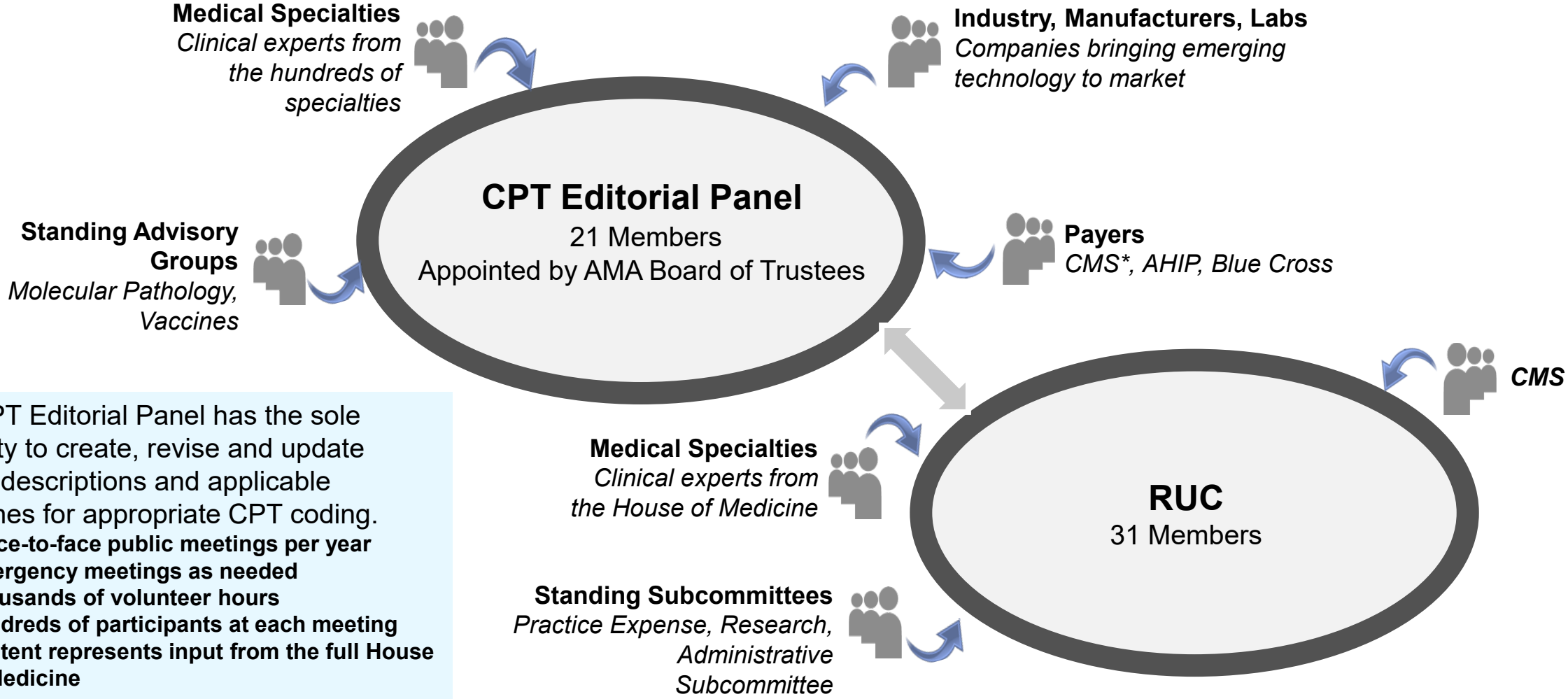
- To provide Medicare with reliable data on how physician work has changed over time, RUC is examining over 2,600 potentially misvalued medical services, accounting for $45 billion in Medicare spending.
- To date, RUC has recommended reductions and code deletions to over 1,500 services, redistributing over $5 billion annually.
- To date, 98% of the Medicare physician payment schedule has been reviewed by the RUC.

Potentially misvalued services project



CPT® Editorial Panel relationship to the RUC

Evidence-based | **Deliberation driven** | **Well-defined criteria** | **Clinical expertise**



The CPT Editorial Panel has the sole authority to create, revise and update codes, descriptions and applicable guidelines for appropriate CPT coding.

- **3 face-to-face public meetings per year**
- **Emergency meetings as needed**
- **Thousands of volunteer hours**
- **Hundreds of participants at each meeting**
- **Content represents input from the full House of Medicine**

*CMS has observer status. Also, members do not advocate for their specialty or organization once named to the Panel.

Physicians' powerful ally in patient care