The AUA, CPT, and RUC: Interactions and Impact

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Objectives

Understand how the AUA impacts on Public Policy and provides Practice support
Understand CPT Code Development
Understand Code Value Determination and the RUC Process
How does the AUA provide support for the members in 2019
How physicians get paid for what they do?

The Reimbursement Process

• Physicians must have the capability of communicating with third party payors for reimbursement of medical claims

• This communication is called medical coding
  – Current Procedural Terminology (CPT) coding = service(s) performed for the patient
  – International Classification of Diseases (ICD) coding = signs, symptoms & diagnosis that represent medical necessity
CPT Code Development

• Suggestion to AUA from:
  • Manufacturer/Physician/Coding & Reimbursement Committee (CRC)/CMS/AMA/RUC
    • What is the CRC?
    • AUA volunteers from every section and urologic specialty who reviews coding and reimbursement issues affecting urology
      Approximately 20 volunteers consisting of voting members and consultants
CPT Code Development

General Criteria for Category I and Category III Codes

• 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 set forth below.
CPT Code Development

**Category I 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 Code Development

Category III Criteria

• 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:
    
    • at least one Institutional Review Board approved protocol of a study of the procedure or service being performed,

    • a description of a current and ongoing United States trial outlining the efficacy of the procedure or service, or

    • other evidence of evolving clinical utilization.
CPT Literature Requirements

• Identify whether this is a U.S. based journal or a non-U.S. based journal, and identify whether the population studied is U.S. or non-U.S. or both;

• Identify the number of patients studied (total of all group(s) including controls) and indicate whether study is a prospective study;

• Provide a concise “relevance statement”.

• General Guidelines for inclusion of the articles are noted in the following:

• Abstracts are allowed to supplement application but will not be accepted in substitution of full length journal articles.

• Foreign journals will be permitted if published in the English language.

• List up to 5 references, of which at least 1 report the procedure/service in a U.S. patient population. Of these, at least 2 articles must report different patient populations or have different authors (no overlapping patient populations or no overlapping authors).

• At least 1 of the publications meets or exceeds the criteria for evidence level III (i.e. obtained from well-designed, non-experimental descriptive studies such as comparative studies, correlation studies, and case control studies). However, Code Change Applications requesting editorial changes to existing Category I codes and applications for bundled codes to describe unchanged existing Category I services (when provided together) need not meet this requirement.
CPT Literature Requirements

- Identify the Level of Evidence by selecting a level from the LOE table;
- **Level Type of evidence (based on AHCPR 1992)**
  - Ia  Evidence obtained from meta-analysis of randomized controlled trials
  - Ib  Evidence obtained from at least one randomized controlled trial
  - IIa Evidence obtained from at least one well-designed controlled study without randomization
  - IIb Evidence obtained from at least one other type of well-designed quasi-experimental study
  - III Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case control studies
  - IV  Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities
  - V   Evidence obtained from case reports or case series
CPT Code Development

• Code Change Proposal sent to the American Medical Association

• AMA CPT Advisory Committee Members review the application for appropriateness

• CPT Editorial Panel meets three times per year to review CCPs
  • Composed of 17 members (11 Specialty Societies, BC/BS Association, America's Health Insurance Plans, the American Hospital Association, the Centers for Medicare and Medicaid Services (CMS) and CPT Health Care Professionals Advisory Committee )
    – No – back to the drawing board
    – Yes – onto the next step – Assigning work RVUs to the CPT code
“Results, Potential Effects and Implementation Issues of the Resource-Based Relative Value Scale”

Wm Hsiao, Ph.D., Peter Braun, M.D.

JAMA, Oct. 28, 1988, Vol. 260, No. 16

• “Standardize Payments, Rationalize Incentives and Influence Physician Decisions.”

• “Provide a Neutral Incentive Structure”

• “Enhance Cost Effectiveness and Ameliorate Manpower Shortage in Primary Care.”
OBRA 1989 Changed Everything

• In the Omnibus Budget Reconciliation Act (OBRA) of 1989, Congress reformed Medicare’s methodology for paying physicians with the adoption of the Medicare **Resource Based Relative Value Scale** fee schedule (RBRVS).

• The previous methodology—“customary, prevailing, and reasonable charges”—based “Medicare-allowed” payment on past payments for the service.

• In contrast, the new Medicare fee schedule attempts to “rationalize payments, basing them on the **resource costs** necessary to provide the service.”
The AMA Relative Value Update Committee known as the “RUC” Started in 1992

- Relative Value Units for Physician “Work”
- Relative Value Units for “Practice Expense”
- Must review relative values of all CPT codes every 5 years
- Does not consider the “efficacy” of procedures – yet ...
- Infighting between specialties as they try to keep their relative values (= $$$) from decreasing
RVS Update Committee (RUC)

• Composition: 29 members – 23 seats filled by professional societies (including AUA)

• RUC solicits survey data regarding individual codes or families of codes. Administered by the appropriate professional society (AUA, ACOG, AANS etc.)

• RUC meets 3 time a year

• Data is presented to the RUC, specialties defend, the RUC votes

• RUC makes recommendations to CMS for final valuation; CMS accepts over 95% of RUC recommendations.
Survey Results = Reimbursement

• Survey allows AUA to collect objective data to supply to AMA and CMS for the appropriate valuation of the physician work involved in the procedure
• The work value translates into reimbursement for the procedures performed and associated E & M services prior and after the surgery
• Also a separate valuation is performed by AUA RUC Panel members for the practice expense needed to perform the service or associated E & M service(s) in the office
Who Gets Surveys?

- Respondents selected by AUA by random sampling
- May be sub-specialty, e.g. prosthetics
- May be general, e.g. cysto with dilation
- Private practice (small & large), hospital-based, and academic
- Need at least 30-50 responses
- Want >100 responses
Survey Tips

• Be honest

• No premium on speed, this is not a contest

• Think of “typical patient” in your practice

• Remember co-morbidities.

• Get help from others – your partners or practice admin.

• With the opportunity to have a major impact, comes the responsibility to do a good job.
Components of a CPT Code
Work RVU

Pre-service time – prior to surgery
  Writing/reviewing records
  Discussion with other physicians
  Scrub, Dress, Wait
Intra-service work –
  Office – patient encounter time
  Surgical - open to close time
Post-service time – recovery room, ICU, hospital
  follow up & office visits
Components of a CPT Code

Physician Work

Time required to perform service
Technical skill & physical effort
Mental effort & judgment
Psychological stress associated with the risk of surgery
Practice Expense

• Cysto with dilation (CPT 52281) – **Supplies**
  • Catheter, foley (1) = $7.82
  • Pack, minimum multispecialty (1) = $1.14
  • Drape, sterile towel (3) $0.85 (3) = $2.55
  • Chux, (1) = $0.23
  • Pack, urology cysto (1) = $24.69
  • Patient education booklet (1) = $1.55
  • Guide wire (1) = $35.60
  • Pack, cleaning and disinfecting cystoscope (1) = $15.25
Practice Expense

• Cysto with dilation (CPT 52281) – **Equipment**
  • Endoscope, flexible (3 year life) = $7,408
  • Light source, Xenon (5 year life) = $6,723
  • Table, power (10 year life) = $6,154
  • Instrument table = $634
### Practice Expense

Cysto with dilation (CPT 52281) – **Clinical Staff Time - minutes**

<table>
<thead>
<tr>
<th>Pre-Service</th>
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<tbody>
<tr>
<td>Complete forms</td>
<td>5</td>
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<tr>
<td>Coordinate Services</td>
<td>3</td>
</tr>
<tr>
<td>Pt Education &amp; Consent</td>
<td>7</td>
</tr>
<tr>
<td>Follow-up phone calls</td>
<td>3</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td><strong>18</strong></td>
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<table>
<thead>
<tr>
<th>Service Period</th>
<th></th>
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<tbody>
<tr>
<td>Review Charts</td>
<td>3</td>
</tr>
<tr>
<td>Greet patient/gowning</td>
<td>3</td>
</tr>
<tr>
<td>Obtain vital signs</td>
<td>3</td>
</tr>
<tr>
<td>Prepare room / Equipment</td>
<td>2</td>
</tr>
<tr>
<td>Set Up Cystoscope</td>
<td>5</td>
</tr>
<tr>
<td>Prepare &amp; position patient</td>
<td>2</td>
</tr>
<tr>
<td>Assist Physician with procedure</td>
<td>16</td>
</tr>
<tr>
<td>Clean room &amp; equipment</td>
<td>3</td>
</tr>
<tr>
<td>Clean Cystoscope</td>
<td>7</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td><strong>44</strong></td>
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<table>
<thead>
<tr>
<th>Post-Service Period</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone Calls &amp; Call-in Prescriptions</td>
<td>3</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>3</strong></td>
</tr>
</tbody>
</table>
The Formula and Impact of Practice Expense

What you are paid is determined by four components of a formula

1. RVU “physician work”
2. RVU “practice expense”
3. RVU “medical liability insurance”
4. GPCI “your geographic location”
The Total RVU is derived as follows:
Total RVU = Work + PE + PLI

\[
\begin{align*}
\$ &= (W_{RVU} \times W_{GPCI}) + (PE_{RVU} \times PE_{GPCI}) + \\
&\quad (PLI_{RVU} \times PLI_{GPCI}) \times (Conversion \ Factor \times Budget \ Neutrality \ Adjustment) = \\
&\quad \text{Your Reimbursement}
\end{align*}
\]

**Cysto In Office (non-facility)**
2.23 + 3.45 + 0.16 = 5.84 RVU
5.84 x $ Conv. Factor = $ 213.71

**Cysto In Hospital or ASC (facility)**
2.23 + 1.21 + 0.16 = 3.60 RVU
3.60 x $ Conv. Factor = $ 130.13
How the Reimbursement Amount Is Determined!

• RUC makes recommendations to CMS
• CMS – approves or revises suggested RUC values
• Federal Register – Publishes final RVU Values in November
• Codes are published in annual CPT Book
• Article on AUA Web site in Coding Tips and in the AUA Health Policy Brief
Reimbursement Process

CPT code (with vignette)

Survey sent to members
(typical work)

Presented at the RUC

Value assigned

CMS: accept (or not)

(x Conversion Factor) = payment
Rezum

Urethra

Other Procedures

53850  Transurethral destruction of prostate tissue; by microwave thermotherapy
53852  by radiofrequency thermotherapy
53854  by radiofrequency generated water vapor thermotherapy
53855  Insertion of a temporary prostatic urethral stent, including urethral measurement
QUESTIONS?