

CMS, CPT & the RUC:

Understanding How You Get Paid

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History of Physician Reimbursement

Prior to 1992

Physician payments based on

Charges

1992

federal government established a standardized physician payment schedule based on a **resource-based relative value scale (RBRVS)**.

-Physician payments are determined by the resource costs needed to provide a service

cost of providing each service is divided into three components: **physician work, practice expense and professional liability insurance.**

-Payments are calculated by multiplying the combined costs of a service by a conversion factor (determined by the Centers for Medicare and Medicaid Services).

-Payments are also adjusted for geographical differences in resource costs.

-**Physician work** component accounts, on average, for **52 percent** of the total relative value for each service.

-The initial physician work relative values were based on the results of a **Harvard** University study.

-The factors used to determine **physician work** include the **time** it **takes** to perform the service; the **technical skill and physical effort**; the required **mental effort and judgment**; and **stress** due to the potential risk to the patient.

-The physician work relative values are updated each year to account for changes in medical practice.

- Legislation previously required the Centers for Medicare and Medicaid Services (CMS) to review the whole RBRVS scale at least every five years, now this is a rolling process

Practice expense component of the RBRVS accounts for an average of **44 percent** of the total relative value for each service.

1999 - CMS began a transition to resource-based practice expense relative values for each CPT code that differs based on the site of service.

2002 the resource-based practice expenses
were fully transitioned.

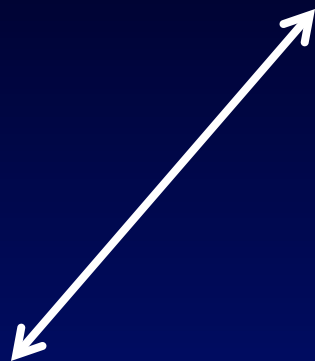
All components of the RBRVS are resource-
based.

Annual updates to the physician work relative values are based on recommendations from a committee involving the AMA and national medical specialty societies.

The AMA/Specialty Society RVS Update Committee (**RUC**) was formed in 1991 to make recommendations to CMS on the relative values to be assigned to new or revised codes in Current Procedural Terminology (CPT®).

Nearly 8,000 procedure codes are defined in CPT, and the relative values in the RBRVS were originally developed to correspond to the procedure definitions in CPT. Changes in CPT necessitate annual updates to the RBRVS for the new and revised codes.

CMS



CPT



RUC

CPT Committee

- AMA volunteer committee that is advisory to CMS
- Develops a code with a descriptor and a clinical vignette
- Assigns Category I, Category II, or Category III status based on clinical evidence
- CMS does not pay for this service
- AMA owns the CPT codes

37227

SFA/Pop Atherectomy, PTA, Stent

Long Descriptor:

Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed

Vignette:

A 75-year-old male with a long history of smoking, cardiovascular disease, and severe pulmonary disease is seen for non-healing ulcer of the right foot. Diagnostic testing reveals total occlusion of the right superficial femoral artery with reconstitution of the popliteal artery above the knee. There is also 3-cm segment of stenosis of the popliteal artery below the knee. Treatment of both these lesions involves some combination of stent and atherectomy procedure(s).

Relative Value Update Committee

31 member committee of the AMA

21 appointed by major medical Societies

Anesthesiology

Cardiology

Dermatology

Emergency Medicine

Family Medicine

General Surgery

Geriatrics

Internal Medicine

Neurology

Neurosurgery

Obstetrics/Gynecology

Ophthalmology

Orthopaedic Surgery

Otolaryngology

Pathology

Pediatrics

Plastic Surgery

Primary Care*

Pulmonary Medicine*

Psychiatry

Radiology

Rheumatology*

Thoracic Surgery

Urology

Vascular Surgery*

* Indicates rotating seat

Relative Value Update Committee

- Reviews presentations and recommendations made by specialty societies that have formally expressed interest in code being discussed (the specialty society MUST have a certain level of AMA membership to be eligible to have a RUC advisor position)
- Makes recommendations to CMS regarding appropriate RVU' s for each code

Closed meeting not a public forum

Endovascular and the RUC



"The story of a birdmark, H&C"

What is that birthmark?

Component coding

Bundling vs. Component Coding

- Specialty societies have been mandated to bundle everything possible
- RUC assigns codes to work on, and timelines
- Bundling is viewed as a cost saving activity
 - (the new code WILL be less than the sum of its parts)
- Several screens used by RUC to identify codes requiring revaluation
 - “Harvard Time”
 - Increased frequency of specific code usage
 - Codes frequently coded together
 - Initially screen was for codes reported together 95% of the time
(Now 75% of the time)

Lower Extremity Revascularization

- 16 codes, 37220-37235
- 0-day Global
- These codes are all inclusive bundled codes
- A single code is used for each vessel treated
- The codes apply to a unilateral limb
- PTA is included in all codes

LE codes as of 2011

Iliac territory

37220 (37222) *PTA (add-on)*

37221 (37223) *PTA/Stent (add-on)*

SFA-Pop Territory

37224 *PTA*

37225 *Atherectomy (includes PTA)*

37226 *PTA/Stent*

37227 *Atherectomy/PTA/Stent*

Tib-Peroneal Territory

37228 (37232) *PTA (add-on)*

37229 (37233) *Atherectomy (add-on)*

37230 (37234) *PTA/Stent (add-on)*

37231 (37235) *Atherectomy/PTA/Stent (add-on)*

LE codes 2011

SFA-Pop Territory

37226 PTA/Stent

previously reported by

35474, 36247, 37205, 75962, 75960, 75716, 75625

	<i>Professional</i>	<i>Global</i>
<i>2010</i>	<i>\$1,032</i>	<i>\$6,911</i>
<i>2011</i>	<i>\$ 685</i>	<i>\$9,308</i>

% change -34%

+35%

Technical component % change +47%

LE codes in 2011

	Global	Prof
Iliac territory		
37220 PTA	\$3,145	\$464
37221 PTA/Stent	\$4,634	\$561
SFA-Pop Territory		
37224 PTA	\$3,774	\$510
37225 Atherectomy (includes PTA)	\$10,597	\$689
37226 PTA/Stent	\$8,852	\$550
37227 Atherectomy/PTA/Stent	\$14,319	\$832
Tib-Peroneal Territory		
37228 PTA	\$5,364	\$624
37229 Atherectomy	\$10,517	\$807
37230 PTA/Stent	\$8,269	\$773
37231 Atherectomy/PTA/Stent (add-on)	\$13,239	\$840

LE codes 2018

<i>SFA-Pop Territory</i>	<i>Professional</i>	<i>Global</i>
<i>37225 Atherectomy</i>	<i>\$652</i>	<i>\$10,642</i>
<i>37227 Ath/PTA/Stent</i>	<i>\$784</i>	<i>\$14,394</i>
<i>Tib-peroneal Territory</i>		
<i>37229 Atherectomy</i>	<i>\$760</i>	<i>\$10,502</i>
<i>37231 Ath/PTA/Stent</i>	<i>\$817</i>	<i>\$13,009</i>

Practice Expense

Subcommittee of RUC

Facility and Non-facility Direct cost accounting

44% of total physician payment in Facility setting

4 to 20 times the physician payment
in Non-facility setting

Accounting for every minute of staff time
And every 4x4 used in a typical patient

		22520		Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic		
		Approved Feb 2009		Percutaneous vertebral augmentation, including cavity creation (fracture reduction and core biopsy included when performed using mechanical device, 1 vertebral body, unilateral or bilateral) cannulation (eg, kyphoplasty); thoracic		
	CMS	Staff				
LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility
GLOBAL PERIOD						
TOTAL CLINICAL LABOR TIME			240	72	279	72
TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	21	30	21	30
TOTAL SERVICE PERIOD CLINICAL LABOR TIME			180	6	219	6
	L037D	RN/LPN/MTA	83	43		
	L051A	RN	97	73		
	L041B	Rad Tech		102		
TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	39	36	39	36
PRE-SERVICE						
Start: Following visit when decision for surgery or procedure made						
Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	5	5	5	5
Coordinate pre-surgery services	L037D	RN/LPN/MTA	3	10	3	10
Schedule space and equipment in facility	L037D	RN/LPN/MTA	3	5	3	5
Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	7	7	7	7
Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3	3	3	3
Other Clinical Activity (please specify)						
End: When patient enters office/facility for surgery/procedure						
SERVICE PERIOD						
Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure						
Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	5		3	
Obtain vital signs	L037D	RN/LPN/MTA	5		5	
Provide pre-service education/obtain consent						
Prepare room, equipment, supplies	L037D	RN/LPN/MTA	5		5	
Setup scope (non facility setting only)						
Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA	3		3	
Sedate/apply anesthesia	L051A	RN	2		2	
Intra-service						
Assist physician in performing procedure	L037D	RN/LPN/MTA	53			
Assist physician in performing procedure	L041B	Rad Tech			58	
Assist physician in performing procedure	L051A	RN	80		58	
Assisting with fluoroscopy/image acquisition (75%)	L041B	Rad Tech			44	
Circulating throughout procedure (25%)	L037D	RN/LPN/MTA			15	
Post-Service						
Monitor pt. following service/check tubes, monitors, drains	L051A	RN	15		15	
Clean room/equipment by physician staff	L037D	RN/LPN/MTA	3		3	
Clean Scope						
Clean Surgical Instrument Package						
Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MTA	2		2	
Review/read X-ray, lab, and pathology reports	L037D	RN/LPN/MTA	2		2	
Check dressings & wound/ home care instructions / coordinate office visits /prescriptions	L037D	RN/LPN/MTA	5		5	
Discharge day management				6		6
Other Clinical Activity (please specify)						
End: Patient leaves office						

POST-SERVICE Period						
Start: Patient leaves office/facility						
Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	3			3
Office visits: List Number and Level of Office Visits						
			pre			post
99211 16 minutes						
99212 27 minutes		16				
99213 36 minutes		27				
99214 53 minutes		36	1	1	1	1
99215 63 minutes		53				
99238 12 minutes		63				
		12				
Total Office Visit Time	L037D	RN/LPN/MTA	36	36	36	36
Other Activity (please specify)						
End: with last office visit before end of global period						
				0		0
MEDICAL SUPPLIES						
				Unit		
pack, minimum multi-specialty visit	SA048		2	1	2	1
pack, post-op incision care (suture and staple)	SA053					1
pack, conscious sedation	SA044		1		1	
scalpel with blade, surgical	SF033		1		1	
cap, surgical	SB001		3		3	
drape, sterile, c-arm, flouro	SB008		1		1	
drape, sterile, for mayo stand	SB012		1		1	
Gloves (sterile)	SB024		2		2	
Sterile surgical gown	SB028		2		2	
Surgical mask	SB034		3		3	
needle, 18-26g, 1.5-3.5in, spinal	SC028		1		1	
needle, 18-27g	SC029		1		1	
bone biopsy device (NEW - Documentation Attached)						1
kit, vertebroplasty (LP2, CD)	SA039		1.5			
kit, kyphoplasty (NEW - Documentation Attached)						1
kit, kyphoplasty Additional Level (NEW - Documentation Attached)						
bone cement w/mixer (NEW - Documentation Attached)						1
bone cement (full dose pack uou) (Osteobond, Simplex)	SH020		1			
barium sulfate, sterile (Biotrace)	SH015		1			
pack, drapes, laparotomy (chest-abdomen)	SA046		1		1	
skin marking pen, sterile	SK075		1		1	
DuraPrep surgical soln (26ml)	SJ017		1		1	
lidocaine 1%-2% inj (Xylocaine)	SH047		20		20	
gauze, sterile 4x4 (10 pack)	SG056		1		1	
steri-strip	SG074		1		1	
Equipment						
room, radiographic-flouro	EL014		83		71	
instrument pack, medium	EQ138		83		71	
table, power	EF031		36	36	36	36
light, exam	EQ168			36		36
Stretcher	EF018		60		60	
x-ray view box, 4 panel	ER067		10		10	
iv infusion pump	EQ032		142		131	
EKG, 3-channel	EQ010		142		131	
pulse oximeter w-printer	EQ211		142		131	

RUC makes Recommendation to CMS

- CMS publishes a Proposed rule in July
- Open to public comment
- Final rule published in November

Proposed Rule 2013

- Cap office reimbursement at ASC rates
 - This could have led to a 50% decrease in some procedures

■ Erroneous Methodology

- PFS is resource based ASC payment is a % of OPPS
- Compared 2014 office to 2013 ASC rates
- This does not appropriately address high cost consumable items
- OPPS is based on average payments for groups of procedures
 - It is not appropriate to cap individual office payments to an average OPPS payment

- 3 LE codes were at risk
 - 37225 Fem/pop Atherectomy
 - Office \$10,673 OPPS \$9,120 diff \$1,553
 - 37228 Tib-per PTA
 - Office \$5,097 OPPS \$4,410 diff \$687
 - 37229 Tib-per Atherectomy
 - Office \$10,415 OPPS \$9,120 diff \$1,295

Beyond 2018

- Over use and abuse generate a response
 - Be a good citizen
- Utilization of non-database equipment will lead to a change in equipment type



POINTS OF VIEW



OPTIMIST

"The glass is half-full."



PESSIMIST

"The glass is half-empty."



REALIST

"Yep. That's a glass, alright."



IDEALIST

"One day, cold-fusion from a glass of water will provide unlimited energy and end war."



CAPITALIST

"If I bottled this and gave it a New Agey sounding name, I could make a fortune."



COMMUNIST

"This drink belongs to every single one of us in equal measure."



CONSPIRACIST

"The government is fluoridating the water for mind-control purposes."



SEXIST

"This glass isn't gonna refill itself, honeybun..."



NIHILIST

"The glass does not exist, and neither do I."



OPPORTUNIST:

"There's a funny t-shirt in here somewhere."