CMS, CPT & the RUC:

How Things Work

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Coastal Vascular Specialists

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.

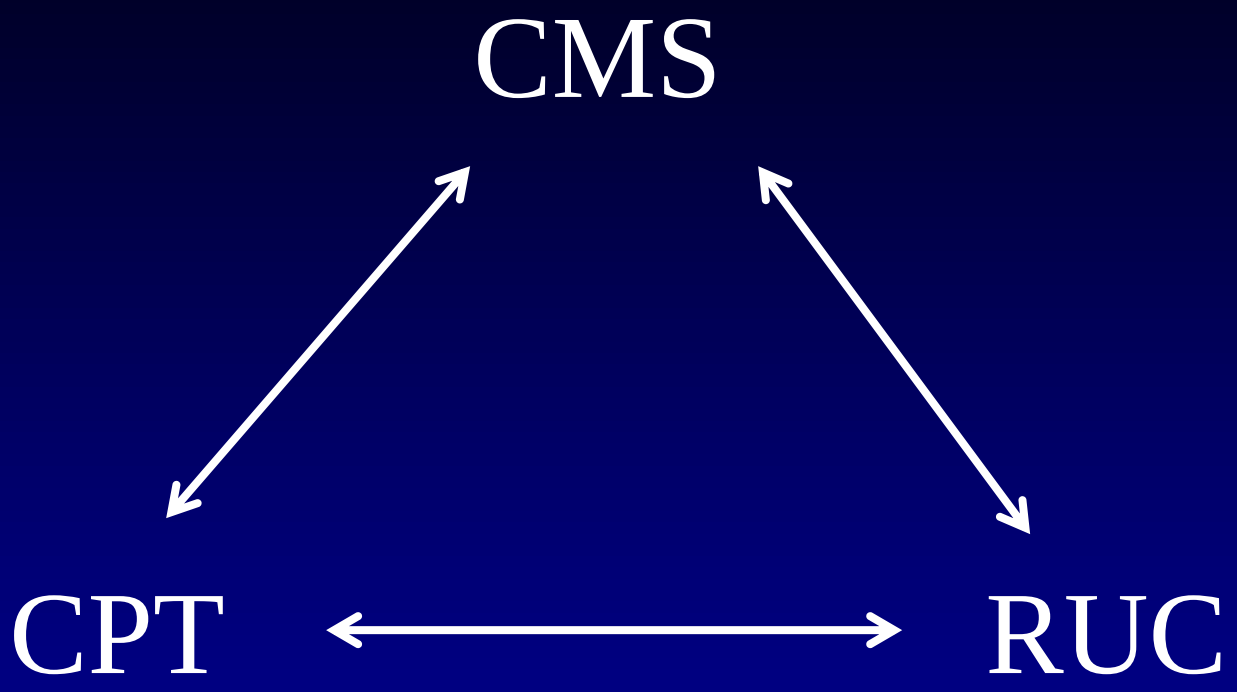
2002 the resource-based practice expenses were fully transitioned.

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 Terminilogy (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

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 bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic*	
LOCATION	**CMS Code**	**Staff 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*		*75*	
	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 flouroscopy/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	
ECG, 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

2018

- Over use and abuse generate a response

  CMS engages consultant to validate or revalue ALL practice expense inputs

  This led to a proposed rule that would decrease endovascular work in the office by 30-40%

2018

- Over use and abuse generate a response

  Luckily CVC, OEIS and SIR were able to provide invoices and PE input corrections to actually reverse the cuts and secure Lower extremity endovascular work

2019

- Over use and abuse generate a response

  Tib Peroneal Atherectomy/PTA caught in a high utilization screen

  The entire Family of lower extremity endovascular work will be brought back for new CPT codes AND new valuation

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."

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