## Completing a RUC Survey: Your Survival Guide

If you are selected to complete a survey—feel honored! You have the opportunity to properly value an important pediatric service, an opportunity that may never happen again. The information provided below will be helpful in understanding the survey process.

## Physician Work

1. Physician work includes the following elements:
   a. Time it takes to perform the service
   b. Mental effort and judgment
   c. Technical skill and physical effort
   d. Psychological stress associated with risk of adverse outcome
2. Physician work does **not** include those services provided by support staff (eg, registered nurse, licensed practical nurse, billing staff, technicians, or receptionists).
3. Physician work is valued by examining the services given to the patient during 3 distinct periods—the preservice period (prior to the face-to-face contact), the intra-service period (the face-to-face time or the actual procedure), and the post-service period (services provided after the patient contact including the completion of records and even a time for a follow-up call to the patient).
4. A list of *CPT* reference codes is then compared with the service being surveyed, allowing a comparison of time and the estimation of complexity/intensity on a 1 to 5 scale. At least some of the codes on this reference list will be familiar to the surveyed physician and, therefore, should allow a good comparison. One considers the following components of physician work:

   a. Mental effort and judgment, which relates to the
      1. Number of possible diagnoses and/or number of management options to be considered
      2. Amount or complexity of medical records, diagnostic tests, and/or other information that must be reviewed
      3. Urgency of medical decision making

   b. Technical skill and physical effort, which includes the
      1. Technical skill required
      2. Physical effort required

   c. Psychological stress, which encompasses
      1. The risk of significant complications, morbidity and/or mortality
      2. How the outcome depends on the skill and judgment of the physician
      3. The estimated risk of a malpractice suit with a poor outcome

5. To complete the physician work portion, one then estimates the new code's work RVU and provides an estimate of the number of times the procedure has been performed by the surveyor. Finally, the surveyor is asked to comment whether the vignette used for the survey is "typical" for the service.

## Direct Practice Expense

Certain practice expenses are deemed "direct" by CMS, and survey data is solicited for this component as well. Direct practice expense includes clinical staff time, medical supplies, and medical equipment used in performing the patient service. Administrative staff expenses and other "indirect" practice expenses are accounted for through specialty-specific hourly expenses as determined by CMS.

1. The site of service is defined as the setting where the main component of the service is provided. Services can be provided in
   a. **In-office settings:** Includes physician offices, free-standing imaging centers, independent pathology laboratories.
   b. **Out-of-office settings:** Includes all other settings (hospitals, ambulatory surgical centers, nursing homes, community mental health centers, state or local public health centers, rural health clinics, etc). The RUC typically does not recognize the presence of practice expense in out-of-office settings.
2. Clinical staff time. This is the time spent by health care professional clinical staff who are employed/contracted by the physician to provide clinical activities, and who cannot bill separately. These clinical activities include reviewing and/or obtaining a history, room/equipment preparation, patient examination, charting, review of laboratories, patient education, room/equipment cleaning, follow-up phone calls.
   a. Administrative activities performed by office staff are not included (eg, scheduling, registration, pre-certification, report to referring physician, billing and collection, etc).
   b. Preservice work is included, including work performed days before the procedure such as a preoperative workup.
      · Does not include consult evaluation where decision to provide procedure was made or other distinct E/M services.
   c. Intra-service refers to work related to the actual time the service occurs.
   d. Post-service refers to clinical staff efforts related to post-procedure work during global period.
      · Does not include unrelated E/M services during postoperative period or other unrelated services provided by the same physician.
3. Medical equipment and supplies include
   a. Expendable or disposable medical supplies such as examination table paper, gloves, gown, etc
   b. Durable medical equipment
   c. Procedure-specific equipment (eg, electrocardiogram machine, colposcope, fiberoptic light)
   d. Medical equipment overhead (eg, stethoscope, blood pressure monitor) used in virtually all services and valued less than $500
   e. Does not include clinical supplies that can be billed for separately (eg, vaccines) or administrative or office supplies

To complete this section of the survey, the respondent is asked to identify a *CPT* code that uses similar resources as the surveyed code.

For further information regarding the CPT and RUC processes, please contact the Division of Health Care Finance and Practice at (800) 433-9016, extension 7931.

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# Anatomy of a New Code: The CPT and RUC Survey Processes

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

# The CPT Process: So You Want a New Code

## Best Reasons for New Codes

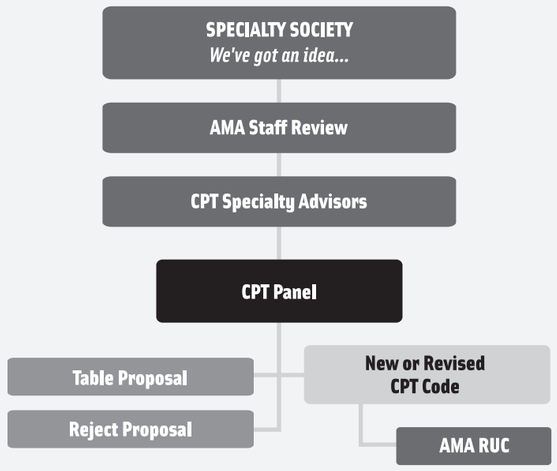
1. New clinical service or technical procedure not found in the current version of *Current Procedural Terminology (CPT®)* and not sufficiently represented or reported with existing *CPT* codes.
2. Change of an existing service or procedure when the existing *CPT* code no longer adequately describes the service or the typical patient (or the associated physician work or practice expense!).
3. When the *CPT* code generally used for a service or procedure does not represent the technical difficulty or physician work when dealing with a specific population (eg, neonates).

## How to Start: The AAP's CPT Code Development Process

1. Define the service or procedure and the "typical patient" as clearly as possible. Consult with other AAP sections or specialties that may also have an interest in the idea for a new code or who may be affected by the proposed change to gather support. Early in the process, review the AMA *CPT* code application to note the information you will need to find when you discuss your idea with others. A copy of the application is available at http://www.ama-assn.org/ama/pub/category/3866.html or from AAP staff (800/433-9016, ext 7931).
2. Establish the relative prevalence or frequency of the proposed procedure or service. Preferably, there should be some broad institutional experience and geographic distribution. If this is a cutting-edge procedure performed primarily at one facility, it is not likely to find its way into *CPT.* Furthermore, if the code proposal is accepted by *CPT,* we will be required to survey at least 30 physicians who are familiar with the procedure/service. *If we are unable to identify a sufficient number of qualified physicians who are willing to complete the AMA/Specialty Society Relative Value Scale Update Committee (RUC) survey, the Committee on Coding and Nomenclature (COCN) may likely choose not to proceed with the proposal until a critical mass of those able to be surveyed has been identified.*
3. Develop a written "clinical vignette" describing the typical patient and the service. Developing an effective vignette is vitally important because this vignette will also be used during the RUC process to establish physician work and practice expense. References from the literature may prove to be helpful in establishing the frequency, scope, and relative difficulty (eg, complications) of the procedure.
4. Obtain input from your colleagues (eg, fellow AAP section members, adult specialty society) throughout this process. The AAP COCN staff and the COCN member who serves as a liaison to your AAP section are available to assist in the development and refinement of the vignette and the completion of the *CPT* proposal application.
5. Where members of other professional societies also provide the service to the typical patient, we must consider whether those groups will support this application, and actively seek their assent before we submit the proposal to the AMA. *In the case of pediatric subspecialty services, the support of the associated adult specialty society is frequently essential if there is to be a successful application. While the AAP will provide support in contacting other professional societies and requesting their support, it is our experience that this support is best obtained by members of the relevant AAP section who may have professional relationships within that adult specialty society.*
6. If the request for a new code is being driven by special technical considerations related to a specific population (and altered physician work effort for that population), the vignette must be able to establish a meaningful and objective difference (anatomic, physiologic, etc) from the general population. It has been our experience in efforts to establish "pediatric codes," or age distinctions in generic codes, that we must be prepared to provide clear evidence for the difference between the 2 groups (eg, infants vs adults). Medical literature can also be helpful in providing the evidence for this distinction.
7. The completed vignette and *CPT* application should be submitted to COCN for review. The COCN will determine whether the vignette and application provide a reasonably compelling case for the proposed code, and whether it would be feasible to move forward with the application. The COCN will also edit and further refine the proposal (if needed) in preparation for submission to the AMA. It should be noted that if COCN does not support submission of the proposal, the author(s) will not be able to submit the proposal as representatives of the American Academy of Pediatrics. Rather, they will be limited to submitting the proposal as individuals.



**FIGURE 1. THE CPT PROCESS**

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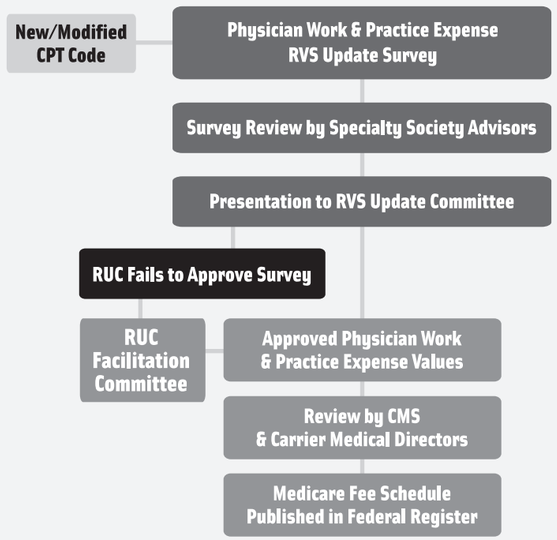
## The AMA CPT Process

1. Once complete, the application is submitted by COCN to AMA *CPT* staff for their review in preparation for consideration by the *CPT* Editorial Panel (Figure 1), a 16-member panel of physicians from various specialties, representatives from private payers, and the Centers for Medicare and Medicaid Services (CMS).
2. On the completion of AMA staff review, the proposal is sent to all AMA member medical specialty societies for their review and comment in advance of the *CPT* Editorial Panel meeting. Because all specialty societies are not represented on the *CPT* Editorial Panel, this provides each society with an opportunity to offer its support (or disapproval) and comment on the proposal. The comments of the specialty society advisors are shared with the sponsoring society and the *CPT* Editorial Panel.
3. The AAP's *CPT* advisor then formally presents the proposal to the Panel at a quarterly *CPT* Editorial Panel meeting. In certain circumstances, we may require the presence of a knowledgeable member of the authoring section to assist in the presentation of the proposal to the *CPT* Editorial Panel.
4. The vote of the Panel generally results in 1 of the following 3 outcomes: (a) approval of the proposal, (b) rejection of the proposal, or (c) postponement of the proposal until a future meeting. The third outcome may allow for further refinement of the proposal and negotiation of support from other societies. The Panel is also empowered to make editorial changes in the proposed descriptor of an accepted code.
5. Approved codes are then referred to the RUC for determination of the new *CPT* code's value.

**FIGURE 2. THE RUC PROCESS**

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## The RUC Process: Establishing the Value of New CPT Codes

1. Your new *CPT* code is next referred to the "RUC" for the assignment of a relative value, based on physician work and practice expense (Figure 2). The RUC is larger than the *CPT* Editorial Panel, representing many specialty societies including the AAP, nonphysician providers, hospitals, payers, and CMS.
2. Like *CPT,* prior to presentation at the RUC, all AMA member medical societies are notified of the new or modified code. Societies are given the option to participate in the survey to determine the physician work and practice expense related to the code, or the opportunity to comment on the survey results prior to the RUC meeting.
3. The sponsoring society (eg, the AAP) and all other interested societies then conduct a survey of the new code using the same clinical vignette developed for the *CPT* proposal. Because the Resource-Based Relative Value Scale (RBRVS) contains separate components of physician and practice expense, physicians are asked to complete a survey that measures both at the practice level. The RUC requires a minimum of 30 respondents for the survey results to be accepted as credible. (Note: While a survey is required to be completed for the physician work component, it is not required for the direct practice expense component. Rather, an expert panel consensus is an acceptable alternative means of developing direct practice expense recommendations.)
4. The COCN then analyzes the completed survey data and establishes relative value unit (RVU) recommendations for physician work and direct inputs for practice expense. The AAP's RUC advisor then presents the survey results and the final AAP recommendations to the RUC. In certain circumstances, we may require the presence of a knowledgeable member of the involved section to assist in the presentation of the proposal and survey results to the RUC.
5. The RUC deliberates on the physician work RVU and practice expense recommendations from the survey. The RUC may choose to (a) approve the proposed values, (b) reject the proposed values, or (c) send the issue to a facilitation committee where a different (usually lower) value is negotiated. If the RUC is unable to approve or negotiate an acceptable value for the physician work and/or practice expense, it may choose to (a) request that the sponsoring society conduct another survey and re-present at a future meeting, (b) refer the code back to CPT for further refinement, or (c) refer the code to CMS for valuation.
6. The RUC-approved values for physician work are then referred to CMS for its consideration. In general, more than 90% of RUC-approved values are accepted by CMS. The CMS also establishes final values for the practice expense components approved by the RUC, as well as a value for the professional liability insurance (malpractice) expense component.
7. The CMS-approved values are then published as part of the final rule in the *Federal Register*. Pending public comment, the values subsequently become part of the RBRVS Medicare Physician Fee Schedule.

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