

HOW A CPT® CODE

Becomes A Code

The path to becoming a CPT code is a long one. As a practicing clinician, YOU play a vital role in the process!

DEFINING THE NEW CODE

Specialty societies, such as ASHA, work with experts in the field to develop a clinically relevant code description using guidelines set by the CPT Editorial Panel.

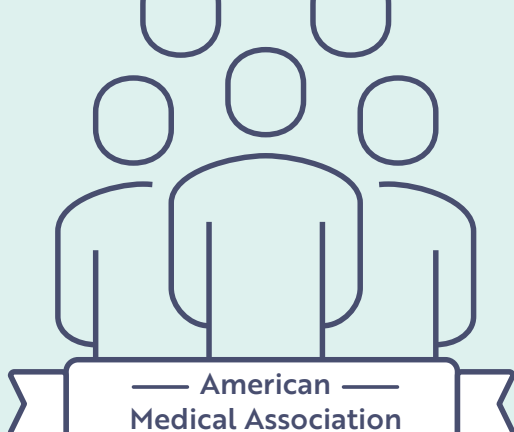
ALL CPT CODES

- Describe health care services and procedures
- Ensure uniform communication within the health care industry
- Are developed, maintained, and copyrighted by the AMA
- Are updated annually



CPT Code

- Unique and well-defined
- Clearly distinguished from existing CPT codes
- FDA approved, if required
- Performed by many qualified health care professionals across the country
- Consistent with current, typical practice
- Clinically efficacious, as documented in peer-reviewed literature



The new code application is submitted to the AMA by specialty societies like ASHA, or other interested parties.



Each proposal is considered at 1 of 3 AMA CPT Editorial Panel meetings each year.

Applicants must be prepared to defend their proposal to the Panel.

The new code is **APPROVED** by the CPT Editorial Panel



Next, the value of the code must be determined

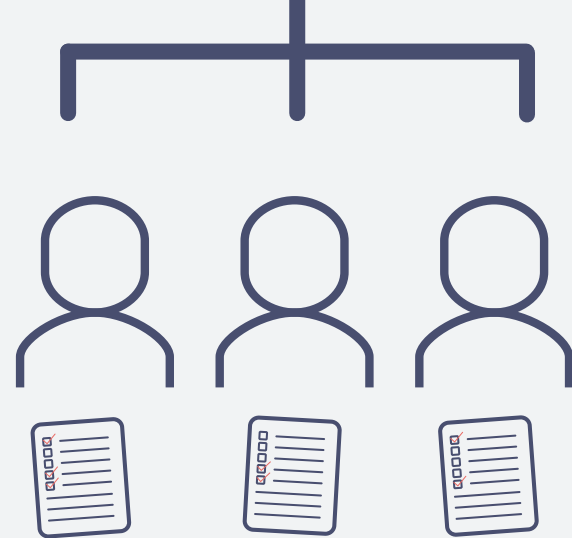


Once a new code is approved, the specialty societies that represent the primary providers of the service or procedure conduct a survey to determine the **value** of the CPT code.

THE VALUE IS BASED ON FACTORS SUCH AS:

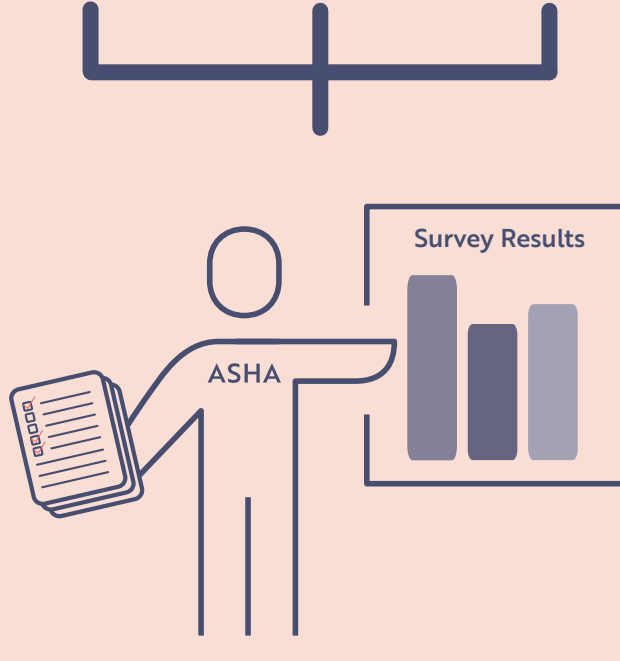
- Time it takes to complete the service or procedure
- Intensity and complexity of the service or procedure
- Level of professional skill needed

This is where **YOU** come in!



Surveys are fielded to a random sample of practicing clinicians that perform the service or procedure. Input from clinicians is **VALUABLE** and plays a critical role in the valuation of a CPT code.

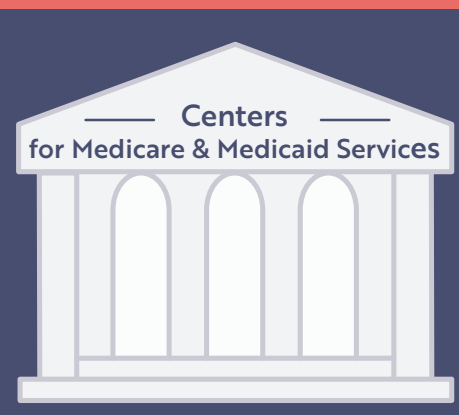
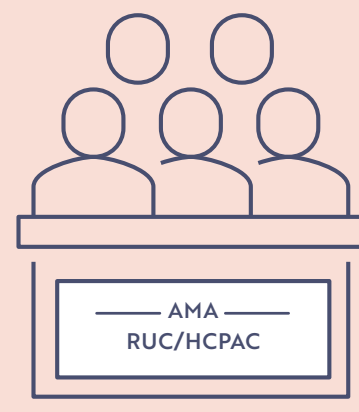
Without **YOUR** feedback, the value of the code may not be properly documented.



The specialty society compiles the results of the survey and submits a value recommendation to the AMA.

Each CPT code value recommendation is considered at 1 of 3 AMA RUC/HCPAC meetings each year.

Applicants must be prepared to defend their recommendation to the RUC/HCPAC.



The RUC/HCPAC submits a CPT code value recommendation to CMS. CMS has the authority to accept or amend the code value.

The CPT code value is **PUBLISHED**

The AMA publishes the new code in the CPT code book and CMS releases the final code value in the Medicare Physician Fee Schedule.

Other payers often follow Medicare, so this process has a significant impact beyond Medicare.

THE ENTIRE PROCESS TAKES OVER 2 YEARS



GLOSSARY OF TERMS AND ACRONYMS

- AMA:** American Medical Association
- CMS:** Centers for Medicare & Medicaid Services
- CPT:** Current Procedural Terminology
- AMA CPT EDITORIAL PANEL:** Maintains the CPT code set. The Panel consists of 17 members representing medical specialties, nonphysician health care professionals, and the health care industry.
- AMA RELATIVE VALUE SCALE UPDATE COMMITTEE (RUC):** Makes CPT code value recommendations to the government. The RUC consists of 31 members representing medical specialties, including a representative of the AMA RUC HCPAC.
- AMA HEALTH CARE PROFESSIONALS ADVISORY COMMITTEE (HCPAC):** Makes CPT code value recommendations to the government. The RUC HCPAC consists of 12 members representing nonphysician specialties that are authorized to independently bill Medicare for services paid under the Medicare Physician Fee Schedule, including audiologists and speech-language pathologists.
- CLINICIANS:** Qualified health care professionals who are randomly selected to participate in a survey conducted by specialty societies, having a crucial role in the valuation of a CPT code.
- MEDICARE PHYSICIAN FEE SCHEDULE:** Fee schedule established annually by CMS for Medicare Part B (outpatient) services.
- SPECIALTY SOCIETY:** National membership organization, such as ASHA, representing a medical or nonphysician specialty.