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Understanding the CPT® Editorial Panel Process: Opportunities and Challenges

+Insights

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Given the complexity and evolving nature of the CPT® Editorial Panel process, thorough research and deliberation is critical when submitting an application for a new or revised CPT® code.

The CPT® Editorial Panel met in San Francisco, California, on May 14 and 15, 2015. As published by the American Medical Association (AMA), the agenda for the meeting included proposals to create new CPT® codes and revise or delete existing codes. Entities interested in the outcomes of CPT® Editorial Panel meetings that typically attend the meetings include physicians representing their medical specialty societies, representatives from industry, and public and private payers.

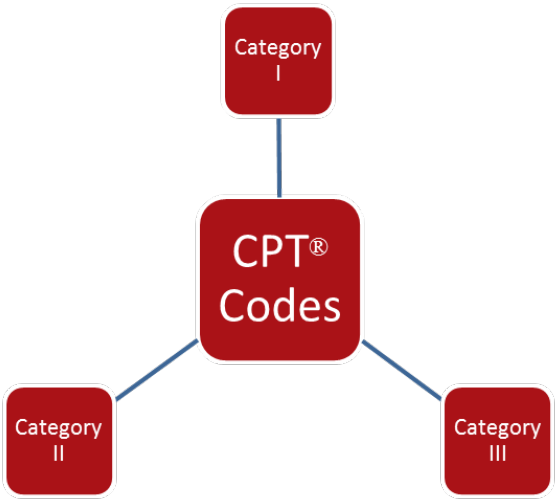
The May meeting was the final meeting for CPT® Chair Peter Hollmann, M.D. As posted on the McDermott + Consulting website, the AMA recently announced the appointment of Kenneth P. Brin, M.D., Ph.D., as the new chair of the CPT® Editorial Panel. Dr. Brin, the current vice chair of the CPT® Editorial Panel, is a cardiologist based in the Chicago area. In the same press release, the AMA also announced the appointment of Peter Smith, M.D., as chair of the AMA/Specialty Relative Value Scale Update Committee (RUC). AMA formed the RUC to act as an expert panel in developing relative value recommendations to the Centers for Medicare & Medicaid Services (CMS). CMS considers these recommendations in the annual update to the Medicare physician fee schedule. Dr. Smith is professor and chief of cardiothoracic surgery at Duke University.

CPT® is an acronym for Current Procedure Terminology, a code set developed in 1966 that describes medical, surgical and diagnostic services performed by physicians and other qualified health care professionals. AMA owns the copyright for CPT®, and the code set is maintained by the AMA CPT® Editorial Panel. By arrangement with CMS, CPT® is part of the Healthcare Common Procedure Coding System (HCPCS), which has been designated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as a standard code set for physician and outpatient services. CPT® is a critically important tool for a wide range of health care stakeholders: industry trying to determine how their products will be reported on claims; physicians, other providers and suppliers of health care services reporting their services on claims; and payers developing payment and coverage policies.

There are three categories of CPT® codes. Category I codes represent services that are widely performed, have approval from the U.S. Food and Drug Administration (FDA) (if required) and are supported by a sufficient level of evidence published in the peer-reviewed literature. Category II codes are tracking codes intended to be used for performance measurement. Finally, Category III codes are temporary codes for new and emerging technologies, and were created to allow for data collection for new procedures or services and to limit use of established Category I codes for new technologies that are not described by the existing codes. Category III codes differ from Category I codes in that they may not be performed by many health care providers across the United States, do not require FDA approval and do not need to meet the level of supporting evidence required for assignment of a Category I code. While having a code is never a guarantee of coverage, a number of payers have policies under which any Category III codes are generally excluded from coverage, because the Category III designation by the CPT® Editorial Panel is considered a sign that the procedure described by the code is investigational.

Composition of the CPT® Editorial Panel

The CPT® Editorial Panel is composed of 17 members. Of those, 11 are physicians nominated by their national medical specialty societies and approved by the AMA Board of Trustees. In addition, there is one representative each from the Blue Cross Blue



Shield Association, America's Health Insurance Plans (AHIP), American Hospital Association (AHA) and CMS. The final two seats are reserved for members of the CPT® Health Care Professionals Advisory Committee (HCPAC).

Separate from the Panel but providing advice to the Panel are a group of CPT® advisors that serve to give specialty-specific advice on coding and nomenclature. These individuals are nominated by the national medical specialty societies that are represented in the AMA House of Delegates and the CPT® HCPAC. This group is referred to as the CPT® Advisory Committee. The CPT® Advisory Committee does not meet formally as a committee to make recommendations to the Panel. Instead, new coding requests are disseminated to advisors and the advisors submit their recommendations in writing for the Panel to consider.

Figure 1: CPT® Code Application Process

The Panel meets three times a year, and meetings are open to the public. Meeting registration and agenda information are available online.

CPT® Process

The CPT® code application process is the process by which the Panel makes changes to the CPT® code set. An application can be submitted to create a new code, revise an existing code, delete an existing code, request a change from Category III status to Category I status, or extend the time period that a Category III remains active. The application may be submitted by any interested party, including an individual person, institution or company; physician medical specialty society; private or public payer; government agency; AMA CPT® Editorial Panel member or staff; or RUC member or staff.

The CPT® code development process continues to evolve and may change over time; the process described below is current at the time of publication.

Step 1: Application Submission

The CPT® code application can be downloaded from the AMA website. Instructions for completing the application are also posted online. Completed applications are submitted via e-mail to ccpsubmit@ama-assn.org. Submitters must complete a disclosure of individual or corporate interests. This disclosure does not limit the ability of an individual to submit or support a code change application.

Upcoming application submission deadlines are below. There is typically a three-month gap between the date of submission and the meeting at which the application is reviewed. There is an even more significant gap, between 18 and 26 months, between the date the application is submitted and the date the code becomes effective.

Application Submission Deadline	Date of CPT® Meeting	Code Effective Date
July 8, 2015	Oct. 8-10, 2015	Jan. 1, 2017
Nov. 4, 2015	Feb. 4-6, 2016	Jan. 1, 2018
Feb. 12, 2016	May 12-14, 2016	Jan. 1, 2018
June 29, 2016	Sept. 29-Oct. 1, 2016	Jan. 1, 2018
Nov. 3, 2016	Feb. 1-4, 2017	Jan. 1, 2019
March 2, 2017	May 31-June 3, 2017	Jan. 1, 2019
June 15, 2017	Sept. 12-16, 2017	Jan. 1, 2019

Step 2: AMA CPT® Editorial Panel Staff Reviews All Applications

If the Panel has previously reviewed the issue, staff will inform the requestor of the Panel's previous decision. If it is a new issue, staff will submit the application to the CPT® Advisory Committee for review.

Step 3: Review by the CPT® Advisory Committee

CPT® Advisory Committee members may decline to comment, support the application, propose changes to the application or submit comments opposing the application. Even if an application does not receive any support, it is still presented at the CPT® Editorial Panel meeting for discussion and possible decision. CPT® Panel members have 30 days in advance of the meeting to review the

applications and CPT® Advisory Committee comments.

Application submitters will be notified of the recommendations from the CPT® Advisory Committee approximately 14 days prior to the Panel meeting. Ten days prior to the meeting, application submitters will receive the agenda item for their application, which will include any alternative options submitted by reviewers and a summary of all comments from the CPT® Advisors.

Step 4: Review of Application at CPT® Editorial Panel Meeting

The application is reviewed and voted on at the meeting. The requestor is invited to the table when the agenda item is under review. Prior to Panel discussion, all presenters are required to provide signed statements of confidentiality and disclosure of potential conflict of interest. While the Panel process does not allow for a formal presentation by the requestor, Panel members may, and often do, pose questions to the requestor. Typically, two Panel members are assigned as lead discussants to an application. The Panel chair will call upon these members to begin the application review process. Often discussants are chosen based on their familiarity with the issue. For example, if the application is related to imaging, the lead discussant may be a radiologist. When the application is presented, the lead discussants may offer the application for consideration by the Panel with support, without support or for discussion purposes.

Lab and Pathology-Related Applications

Lab and pathology-related applications are reviewed by the Pathology Coding Caucus (PCC). The PCC is chartered by the College of American Pathologists and is made up of representatives from approximately 10 pathology and laboratory groups. The PCC develops consensus recommendations that are presented to the Panel prior to its vote on the application. For molecular-pathology-related applications, another group, the Molecular Pathology Advisory Group, reviews the application, provides technical input to the PCC and the Panel, and makes recommendations responding to the application.

Panel Decision

The Panel can respond to an application in several possible ways. It can accept as written, accept with modification (*e.g.*, altered descriptor wording, different code category), reject or postpone the request. If an application is postponed, it can be discussed later during the same meeting or at a future meeting. The requestor will receive a letter from AMA staff approximately one month after the conclusion of the meeting to notify the requestor of the outcome of the Panel's consideration.

All meeting participants are required to sign a confidentiality agreement that bars them from sharing information.

Step 5: Public Release of Panel Decisions

The Panel releases a limited amount of information to the public about decisions made during the meeting. Panel decisions are

posted online following each meeting. This document is a high-level summary indicating which agenda items were approved and does not include complete code descriptor language or any other details from the meeting. In general this is the only information released about meeting deliberations, since all meeting participants are required to sign a confidentiality agreement that bars them from sharing information about what was discussed during the meeting.

Step 6: New and Revised Codes Released

CPT® codes are updated annually and effective for use on January 1 of each year. New CPT® books are available in the fall of each year preceding their effective date.

Category I Vaccine Product Codes, Molecular Pathology and Category III Codes

These codes are typically released for reporting either January 1 or July 1 of a given CPT® cycle. Codes released on January 1 are effective July 1, allowing six months for implementation, and codes released on July 1 are effective January 1.

Category II Codes

These codes are generally released three times yearly (March 15, July 15 and November 15) following approval of the Panel minutes after each Editorial Panel meeting. The codes are effective three months after their release.

CPT® codes are updated annually and effective on January 1 of each year.

Issues to Consider Before Submitting a CPT® Application

Obtaining a new CPT® code is a long process, and obtaining a new code does not guarantee coverage or a certain reimbursement rate. Prior to embarking on a pursuit for a new code, several issues should be considered:

- Is the service/procedure clearly identified and distinguished from a service/procedure currently described in CPT®?
- How would reimbursement for this service/procedure be expected to compare under a new code versus the existing coding options?
- How would coverage for this procedure/service be expected to compare under a new code versus the existing code options?

The CPT® Editorial Panel has developed specific criteria that must be met. In general, for a Category I code, the service/procedure must have FDA clearance (if required), be performed by many providers across the United States, and have a sufficient level of evidence in the published peer-reviewed literature to support its clinical efficacy. The specific criteria are available online.

Understanding the factors that go into the approval of a specific CPT® code can be confusing and challenging to stakeholders. While it is difficult to predict the specific issues that may arise with any given CPT® application, there are three critical considerations that are consistently part of the Panel's deliberations.

Literature

Strong, current and relevant evidence is always important. For services related to new technology, literature is especially important. If the Panel concludes that the literature does not meet the standards for a Category I code, it may approve the application for a Category III code instead. Once the Panel takes up an agenda item, the applicant cannot withdraw the item, so any application moving forward may be at risk for assignment to Category III even if the applicant did not request assignment of a Category III code. For all of these reasons, it is important to be familiar with the CPT® literature guidelines, which are detailed in the CPT® application. Also, since the number of publications that may be included with the application is limited, the submitter should be strategic in selecting the articles to be submitted with the application.

Rationale

A critical question in the application requests a "specific reason why this code change is necessary." This is the opportunity for an applicant to present his or her case to the Panel. The Panel is looking for a clear and detailed explanation of the need for this code based on coding and clinical reasons. A response must go beyond "no code currently available" or reimbursement-related issues, such as "current payment rate does not adequately reimburse this service."

Advisor/Specialty Society Support

Support from the community of providers who will be reporting this service/procedure is essential. Not only does their opinion carry weight with the Panel, they often have a deep knowledge of the coding conventions for the specialty as well as the Panel process. It is usually important for a stakeholder considering submission of a CPT® application to approach the representatives from the relevant specialty society prior to submitting an application. Many societies have special processes in place to receive and vet requests from industry and other stakeholders on coding and reimbursement issues. These procedures commonly are posted on the website of the respective specialty society.

The CPT® Editorial Panel process is an evolving one. In recent years, the Panel has increased the transparency of the process by opening up meetings to the public and posting agendas and high-level meeting summaries online. The complexity of the process and the importance of having an appropriate CPT® code that suitably describes a service/product make it critical for anyone considering requesting a new or revised code to approach the process in a careful manner, allowing time for thoughtful research and deliberation. More information on the CPT® process is available online.

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