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## *The CPT Approval Process*

CPT is an acronym for Current Procedural Terminology (CPT ®). CPT codes are published by the American Medical Association (AMA). A CPT code is a five digit numeric code that describes a variety of medical procedures and services under public and private health insurance. There are three categories of CPT codes, Category I, II and III. This document is designed to help you understand CPT and what is required to change or create a CPT code.

### **Category I CPT Codes**

Category I CPT codes describes a procedure or service identified with a five-digit CPT code and a descriptor for that code. The descriptor for the Category I CPT is based on contemporary medical practices and being performed by many clinical physicians in multiple locations across the U.S. The AMA has criteria that they look at for approving a CPT code. The criteria for category I CPT codes are:

- That the service/procedure has received approval from the Food and Drug Administration (FDA) for the specific use of devices or drugs;
- That the suggested procedure/service is a distinct service performed by many physicians/practitioners across the United States;
- That the clinical efficacy of the service/procedure is well established and documented in the U.S. peer review literature
- That the suggested service/procedure is neither a fragmentation of an existing procedure/service nor currently reportable by one or more existing codes; and
- That the suggested service/procedure is not requested as a means to report extraordinary circumstances related to the performance of a procedure/services already having a specific CPT code.

### **Category II CPT Codes-Performance Measurement**

Category II CPT Codes are supplemental tracking codes that can be used for performance measurement. The use of these codes is optional and cannot be a substitute for Category 1 codes. The tracking codes (Category II CPT codes) purpose is to reduce the work-load of health care professionals by decreasing the need for record abstraction and chart review. They are intended to facilitate data collection about the quality of care rendered by coding certain services and test results that support nationally established performance measures and that have an evidence base as contributing to quality

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patient care. Tracking codes (like all CPT codes) are released biannually (January 1 and July 1) on the AMA website, <http://www.ama-assn.org/go/cpt>. Criteria for Category II tracking codes are the following

- Measurements that have been developed and tested by a national organization;
- Evidence-based measurements with established ties to health outcomes;
- Measurements that address clinical conditions of high prevalence, high risk or high cost; and
- Well-established measurements that are currently used by large segments of the health care industry

### **Category III CPT Codes-Emerging Technology**

Category III codes are used for new and emerging technologies and are a temporary code. The purpose of these codes is to facilitate data collection and assess the new service and/or procedure. The data collected from these codes is used for the FDA approval process or to substantiate widespread use. The criteria may not be the same for Category III codes as they are for Category I. The criteria for Category III codes are the following;

- A protocol for a study of procedures being performed;
- Support from the specialties who would use the procedure;
- Availability of U.S. peer-reviewed literature;
- Descriptions of current United States trials outlining the efficacy of the procedure

Again, if these codes are approved they are released biannually (January 1 and July 1) on the AMA internet site, <http://www.ama-assn.org/go/cpt>. If a code is released on January 1, then the code is effective July 1 (code released on July 1 is effective January 1). This allows six months for implementation. Payment for these CPT category III procedures is based on the policies of payers and local Medicare Carriers. It is not reasonable for carriers to deny payment for CPT Category III codes since they are effectively more specific, more functional versions of unlisted codes which payers cover with appropriate documentation. Since Category III codes are a part of the CPT code set, all health care payers must be able to accept Category III codes into their systems to comply with the standards for transactions and code sets under HIPAA. The codes are archived for 5 years and during this time they will be reviewed for Category 1 codes.

### **Who reviews and sets the criteria for codes?**

The CPT Editorial Panel, comprised of 17 members, is responsible for maintaining, revising, updating or modifying the CPT code set. The panel is comprised of eleven physicians who are nominated by the National Medical Specialty Societies and approved by the AMA Board of Trustees; one physician each nominated from Blue Cross and Blue Shield Association, the America's Health Insurance Plans, the American Hospital Association, and the Centers for Medicare and Medicaid Services (CMS); one Performance Measures representative is chosen from nominees solicited from Performance Measures development organizations and appointed by the AMA Board of Trustees, and two member of the CPT Health Care Professionals Advisory Committee. . Five members of the Editorial Panel serve as the panel's Executive Committee. The Executive Committee includes the Editorial Panel chairman and co-

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chairman, and three panel members-at-large, as elected by the entire panel. One of the three members-at-large of the executive committee must be a third-party payer representative. Supporting the CPT Editorial Panel in its work is a larger body of CPT advisors, the CPT Advisory Committee. The members of this committee are primarily physicians nominated by the national medical specialty societies represented in the AMA House of Delegates. The primary objective of the board is the following;

- Serve as a resource to the CPT Editorial Panel by giving advice on procedure coding and appropriate nomenclature as relevant to the member's specialty;
- Provide documentation to staff and the CPT Editorial Panel regarding the medical appropriateness of various medical and surgical procedures under consideration for inclusion in CPT;
- Suggest revisions to CPT. The Advisory Committee meets annually to discuss items of mutual concern and to keep abreast of current issues in coding and nomenclature;
- Assist in the review and further development of relevant coding issues and in the preparation of technical education material and articles pertaining to CPT' and
- Promote and educate its membership on the use and benefits of CPT.

### **Submitting a Suggestion Regarding CPT**

In order to establish new CPT codes, an individual, a physician, or a specialty group must submit a coding change request form. The CPT Advisory Committee then reviews the proposed code. Attached are the coding change request forms for Category I, II and III code sets from the AMA. The code change request form requires the following information. When you have the information below, refer to the current section of the CPT to which you believe the proposed code change relates.

- A complete description of the procedure/service (e.g., describes in detail the skill and time involved. If this is a surgical procedure, include an operative report that describes the procedure in detail);
- A clinical vignette which describes the typical patient and work provided by the physician/practitioner (see attachment);
- The diagnosis of patients for whom this procedure/service would be performed;
- A copy(s) of peer reviewed articles published in the US journals indicating the safety and effectiveness of the procedure, as well as the frequency with which the procedure is performed and/or estimation of its projected performance; and
- A copy(s) of additional published literature which you feel further explains your request (e.g., practice parameters/guidelines or policy statements on a particular procedure/service);
- Evidence of FDA approval of the drug or device used in the procedure/service if required.

In addition, regarding the code change request, provide the rationale to the following questions:

- Why aren't the existing codes adequate?
- Can any existing codes be changed to include these new procedures without significantly affecting the extent of the service?

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- Give specific rationale for each code you are proposing, including a full explanation on how each proposed code differs from existing CPT codes.
- If a code is recommended for deletion, how should the service then be coded?
- How long (i.e, number of years) has this procedure/service been provided for patients?
- What is the frequency in which a physician or other practitioner might perform the procedure/service?
- What is the typical site where this procedure is performed (e.g., office, hospital, nursing facility, ambulatory or other outpatient care setting, patient's home)?
- Does the procedure/service involve the use of a drug or device that requires FDA approval?

#### To Consider Before Submitting a Code Change Request Form

1. Is the suggestion a fragmentation of an existing procedure/service?
2. Can the suggested procedure/service be reported by using two or more existing codes?
3. Does the suggested procedure/service represent a distinct service?

#### Review Process

The AMA staff first review coding suggestions. If it is a new request it is referred to CPT Advisory Committee. If the committee agrees a new code is not needed the AMA staff inform the requestor on how to use existing codes to report the procedure. If a change should be made then the issue is referred to the CPT Editorial Panel. The CPT Editorial Panel meets quarterly to discuss these items. The Panel can result in three outcomes:

1. Add new code or revise existing nomenclature
2. Postpone/table an item to obtain further information
3. Reject and item

If the requestor wishes to appeal the Panel's decision, the following appeals process may be followed: AMA must receive a written request for reconsideration. The appeal must contain the reasons the requestor believes that the Panel's actions are incorrect, and should respond to the Panel's rationale for taking actions that it did. Once the appeal is submitted it is referred to the CPT executive committee. If the appeal contains more information and is submitted not less than one year after the first consideration, then the Panel will review it again.

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## CPT Code Workflow

1. A new procedure, technology, or performance measurement is introduced.
2. The new item does not fit into an existing code
3. A coding request form is submitted
4. AMA staff review the coding suggestion
5. If it is a new request the CPT Advisory Committee reviews it
6. If the CPT Advisory Committee decides a new code is NOT needed the AMA staff inform the requestor and inform them on how to use existing codes to report the procedure.
7. If the CPT Advisory Committee agrees a change should be made it is then referred to the CPT Editorial Panel
8. The CPT Editorial Panel can result in three outcomes; 1. Add new code or revise existing nomenclature, 2. Postpone/table an item to obtain further information, 3. Reject an item.
9. If the request is rejected the requestor could appeal the rule.
10. To appeal the AMA must receive a written request that contains the reasons why the CPT Editorial Panel's decision was incorrect. This must be done within one year of the initial request.
11. When the appeal is submitted it goes to the CPT Executive Committee for review