Building a Better CPT

Save to myBoK

by Sue Prophet, RHIA, CCS

The Health Insurance Portability and Accountability Act (HIPAA) presents numerous challenges to HIM processes and systems. Not least among these areas is coding. Among the concerns is whether the CPT system will be sufficient to meet the demands of HIPAA. The American Medical Association's CPT-5 Project has been working to ensure that it will be.

The project, which includes numerous HIM professionals, has worked to make improvements in the structure and processes of CPT codes to respond to challenges presented by emerging user needs and HIPAA. The group is currently making recommendations for changes to the content, structure, and processes of CPT and for the development of education and communication initiatives. Changes resulting from the project will be made gradually and are expected to be completed for CPT 2003.

Results of the project will include:

- enhancements to the editorial process to allow greater participation and contributions from national medical specialty societies and to expedite the development of new and revised CPT codes
- practical changes to the structure of CPT to reflect the coding demands of the modern dynamic healthcare system
- assurance that CPT meets all of the requirements of a standard code set and is unambiguously selected by the Secretary of Health and Human Services as the standard for reporting physicians' services under HIPAA

How It Works: Project Structure and Process

The CPT-5 Project was comprised of six workgroups and an Executive Project Advisory Group (PAG). The PAG provided overall project coordination, reviewed recommendations from various workgroups, and then forwarded its recommendations to the CPT Editorial Panel for ultimate approval and implementation. The CPT Editorial Panel made the final decisions regarding changes to be made as part of CPT-5.

The six workgroups were:

- **managed care**—identified explicit improvements in CPT codes to better reflect that more patient care is now provided in managed care settings
- **research**—identified CPT improvements relative to the needs of data for research, accreditation, and quality improvement monitoring and outcomes measurement
- **nonphysician practitioners**—reviewed and evaluated weaknesses of the current system for coding the provision of health services by nonphysician healthcare professionals and developed recommendations for specific ways CPT can better meet the needs and accommodate the data reporting uses of these providers
- **maintenance and education**—reviewed and evaluated the existing maintenance and updating process, including the timetable for updates, reuse of codes, timing of the incorporation of new technology, and the format and content of the code book and its index; reviewed the current publication timetable for the CPT book and the general timetable for release of annual CPT updates; and made sure that the CPT editorial panel process could support timely CPT revisions due to medical practice changes and technology enhancement
- **structure and hierarchy**—investigated feasibility of adopting a coding hierarchy; reviewed and evaluated official CPT coding rules and guidelines and the application to correct coding edits; and evaluated any weaknesses and limitations on the computerization of CPT and the application of CPT to computerized patient records
- **sites of service**—reviewed and evaluated weaknesses of the current system for coding in different sites of service

The workgroups made 127 recommendations for changes to the content, structure, and processes of CPT and for the development of education and communication initiatives.

The PAG approved 96 of these recommendations, and the CPT Editorial Panel accepted 80 of them.

It is important to note that changes will be made gradually. The changes resulting from the CPT-5 Project will be phased in over the next three years and will be completed in CPT 2003 (which will be released in fall 2002). All enhancements and modifications to CPT will be made through the existing CPT editorial panel process.

The research and development portion of the CPT-5 Project is expected to last through 2000, followed by an implementation and evaluation phase. The research and development phase will include these activities:

- **define requirements**—identify the coding needs of the healthcare environment, specifically for managed care, healthcare research, different sites of service, non-physician practitioners, computerized patient records, and correct coding
- **assess capacity**—analyze the present and future ability of CPT to meet the coding demands of the healthcare system and the necessary steps to remedy capacity shortfalls
- **develop recommendations**—articulate changes that need to occur in the structure or process of CPT to enable it to meet coding requirements
- **analyze impact**—study the interactive effects as well as intentional and unintentional consequences of recommended changes to CPT

Final Recommendations

The final recommendations approved by the CPT editorial panel include:

- **improve** code descriptors to eliminate ambiguous terms
- **add** codes for home health services and evaluation and assessment services for nonphysician health professionals
- create new sections for performance measurement codes and for tracking codes for new technology, including investigational services; a more open editorial panel process; an advisory group for performance measures; medium code descriptors; a process for Web delivery of CPT electronic files; and XML-enabled, browser-based versions of CPT
- **develop** counseling or preventive medicine service codes/core concept extenders; code combinations for included and excluded services; a CPT communication campaign; Web enhancements to facilitate communication among editorial panel members and CPT advisors; process for online public submission of coding change request form; CPT education initiatives; an enhanced CPT index (including development of a searchable, electronic index); a terminology model containing explicit hierarchical relationships and information on coding rules/guidelines; and a terminology glossary to standardize definitions and differentiate the use of synonymous terms and an annual list of deleted codes
- **develop and maintain** content in a relational database (to incorporate data modeling tools and vocabulary structures to resolve terminology conflicts, develop consistent synonymy, assist the editorial process by formalizing code development, make explicit the hierarchical relationships within CPT, add associated information about the codes such as rules of use, includes/excludes and explanatory notes, and facilitate print publications)

The tracking codes for performance measurement will be known as Category II CPT codes. These codes are optional and are intended to facilitate data collection by coding certain services or test results that are agreed to be contributing to positive health outcomes and quality patient care. These codes will be assigned an alphanumeric identifier in the last digit (e.g., 1234A) and they will be located in a separate section of CPT, following the Medicine section.

A performance measurement advisory group will be established to perform initial review of proposals for Category II codes and forward appropriate recommendations for consideration via the normal CPT maintenance process. The group will consist of representatives from various organizations involved in the development of performance measures, AMA CPT staff and clinical quality improvement staff, the CPT editorial panel, health services researchers, and other experts.

Category II CPT codes will not be referred to the Relative Value Scale Update Committee for valuation because no relative value units will be assigned. These codes will be released annually through the usual CPT publication process for that CPT cycle.

The tracking codes for emerging technology will be known as Category III CPT codes and will be assigned an alphanumeric identifier with a letter in the last digit (e.g., 1234B). These codes will be located in a separate section of CPT, following the Medicine section. These codes are intended to be used for data collection purposes to substantiate widespread usage or in the FDA approval process. They are intended to facilitate data collection on and assessment of new services and procedures. Therefore, they do not need to conform to the usual CPT code requirements such as widespread usage, FDA approval, and proven clinical efficacy.

Category III CPT codes will not be referred to the Relative Value Scale Update Committee for valuation because no relative value units will be assigned. Individual payers will make decisions regarding reimbursement for these services. Once approved by the CPT editorial panel, the newly added Category III codes will be made available on a semi-annual basis via electronic distribution on the AMA Web site.

The full set of Category III codes will be included in the next published edition of CPT for that CPT cycle. They will be archived after five years if the code has not been accepted for placement in the Category I section of CPT, unless the CPT editorial panel decides that a category III code is still needed. These codes will not be reused. Category III codes will first appear in CPT 2002.

Other anticipated changes include refinement of CPT instructions and guidelines to be more comprehensive, user friendly, and specific and expansion of the CPT advisory process to include input from health services research, managed care, and third-party payers.

Some of the CPT-5 recommendations have already appeared in CPT 2000. For example, the CPT 2000 index has been improved to include 3,000 new cross-references and refined language. Also for CPT 2000, new medium-length code descriptors have been offered. These are 100 characters or less in length and uniquely describe each code. In addition, the CPT editorial panel deliberations have been opened to the CPT/HCPAC advisory committee.

CPT-5 will not seek to accommodate all of the data needs of the healthcare system, but will concentrate on providing unambiguous definitions, descriptors, and rules for reporting administrative and clinical data. The core elements that define CPT as the language to communicate clinical information for administrative and financial purposes will be preserved.

CPT will continue to include descriptions of clinically recognized and generally accepted healthcare services; a five-character core (five digits for regular CPT codes for the foreseeable future) with concept extenders; and professional responsibility for a mechanism for periodic review and updating.

Reference

"CPT-5 Update: A Progress Report." CPT Assistant 10, no. 2 (2000): 1-3.

Aiming for Quality

According to its statement of purpose, the CPT-5 Project was established to promote certain goals for CPT-5. These goals include:

- CPT-5 describes clearly and comprehensively clinically recognized and generally accepted healthcare services. It will also incorporate a pro- cess for reporting evolving technology and services in a timely manner
- CPT-5 is designed for communicating information about clinical services performed. It addresses the needs of healthcare professionals, patients, accreditation organizations, and payers for administrative, financial, and analytical purposes, including outcome studies, public health initiatives, health services research, and evidence-based clinical practice
- the components of CPT-5 are codes with their descriptors and instructions for uniform interpretation and correct application of coding conventions. There will be readily accessible mechanisms for periodic review and updating of the CPT-5 system components

- CPT-5 will be structured to support easy electronic interface and coordination with other computer-interpretable healthcare terminology systems, electronic medical and health records, other fields on the administrative record, and analytical databases of varying levels of detail
- CPT-5 will be supported by expert coding resources and continued educational programs to promote consistent interpretation and application of coding conventions among healthcare professionals, software vendors, payers, researchers, and other users

In addition, to best meet the requirements and criteria for a standard code set under HIPAA, CPT-5 will strive to fulfill the following objectives:

- maintain CPT's position as the standard for procedural coding for the healthcare community, and ensure that CPT is the US and international procedural coding nomenclature that facilitates reimbursement and analysis of healthcare information
- enhance the use of CPT by practicing physicians
- include improvements that address the needs of nonphysician healthcare professionals in the CPT system and update processes as well as the needs of hospitals, managed care organizations, long-term care, and ambulatory care professional and trade associations, clinical specialty societies, and healthcare researchers
- develop, implement, and disseminate more comprehensive information regarding the correct usage of CPT, including guidelines, policies, and procedures
- develop and implement mechanisms to incorporate timely updates to CPT to reflect changing practice patterns and new technologies
- make systematic improvements that address existing inconsistencies in the numeric sections of the code book
- explore issues related to the current and anticipated deployment of computer-based patient record systems and their relationship to the continued use of CPT; issues related to the reliability of CPT coding, i.e., that different users arrive at the same code for the same service; and issues related to the development of a hierarchical structure for CPT
- explore needs of public and private healthcare payers

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