CPT-5 Supports Performance Measurement, Technology

by Michael Beebe

The CPT-5 Project was structured by the American Medical Association to address challenges presented by emerging user needs, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and needed improvements in CPT. The primary goal of the project was to have CPT chosen by the secretary of Health and Human Services as the national standard procedure code set for physician services under HIPAA. Achieving this goal solidified the role of CPT as the language of medicine and validated the investment of the American Medical Association in the CPT-5 project.

Among the needs the CPT-5 Project addresses are changes to enhance the use of CPT by practicing physicians, managed care and other payer organizations, and researchers. The project has made recommendations for improvements in the structure and processes of the CPT codes with deliberate emphasis on maintaining what works and has made CPT successful, while correcting problems and extending the applicability of CPT into new areas.

As part of the drive to extend the functionality of CPT, the CPT-5 Project formed six issue-specific workgroups. Two of them are relevant here. The research workgroup was charged with identifying changes in CPT to accommodate the needs of clinical and health services researchers for coded data on services delivered. The managed care workgroup's purpose was identifying explicit improvements in the CPT codes to better reflect the fact that patient care is now provided in capitated settings where no bill is generated. These workgroups found that there is an increased interest in having CPT meet the needs for data reporting in the areas of enrollment, encounter, outcomes, and quality data.

The workgroups examined changes that were necessary in CPT codes to allow data to be collected without significantly altering the current structure and payment focus of CPT. As a result, the research and managed care workgroups and the Project Advisory Group of the CPT-5 Project recommended the development of two new code sets: category II codes, intended for performance measurement, and category III codes, intended for new and emerging technology. The CPT Editorial Panel approved the recommendations as well as a process and timeline to implement the category II and III codes. The existing, regular CPT codes are considered category I and as before, the codes describe a procedure or service identified with a five-digit CPT code and descriptor nomenclature. The inclusion of a descriptor and its associated specific five-digit identifying code number in this category is generally based on the procedure being consistent with contemporary medical practice and being performed by many physicians in clinical practice in multiple locations.

Building on a Solid Foundation

In the past, CPT has been used primarily as a billing and administrative code set. This is both a strength and a weakness as it moves forward as a national standard code set for physician services. With its foundation in billing and administration, CPT has developed into a working terminology that describes services as they are performed by the clinician. Also, the code set has a broad user base with well-understood and generally accepted coding conventions. However, other code sets claim greater clinical relevance, specificity, and methodological rigor.

With the elimination of local codes under HIPAA and the increased integration of CPT with clinical and administrative computer systems, greater demands will be placed on CPT beyond billing and administration. CPT must evolve to meet the challenges presented by changes in medical practice and its status as a standard national code set. Given the existing strengths of CPT, the CPT-5 Project would enhance the code set's core functions while expanding its use into other areas where there is a need for coded data on services performed.

CPT Category II Codes

Category II CPT codes are intended to facilitate data collection by coding certain services and/or test results that contribute to positive health outcomes and quality patient care. This category of CPT codes is a set of optional tracking codes principally for performance measurement. These codes may be services that are typically included in an evaluation and management (E/M) service or other component part of a service and are not appropriate for regular category I CPT codes.

The decision to develop category II codes for performance measures was based on a desire to standardize and rationalize the collection of data for performance measurement. The current methods are based on detailed chart review or site surveys, which cost physician offices time and money. With coded data on services that are included as elements of performance measures, physicians have the option of supplying this information to plans through the administrative record. In this way, CPT category II codes will ease the burden on physician's offices to complete surveys and reduce the intrusion caused by chart review. Use of the administrative record for performance measure data allows physicians to supply information without substantially adding to paperwork, because the record under review is currently in use.

CPT category II codes will concentrate on measurements that were developed and tested by national organizations, such as the NCQA, and those that are well established and currently being used by large segments of the healthcare industry across the country. CPT will not develop measures; as with procedures, CPT will only code and standardize the language for existing performance measures.

To assist the editorial panel in developing category II codes, the managed care workgroup recommended the establishment of an advisory group to the CPT advisory committee and editorial panel. The editorial panel approved this recommendation and in February 2000 established the Performance Measures Advisory Group.

In October, the AMA Board of Trustees appointed six physicians from the Joint Commission on Accreditation of Healthcare Organizations, the National Committee for Quality Assurance, the Health Care Financing Administration, the Agency for Healthcare Research and Quality, and the AMA's Physician Consortium for Performance Improvement to this group.

The responsibility of the Performance Measures Advisory Group is to review requests for new category II codes and to make recommendations to the CPT Advisory Committee. Proposals for category II codes must receive a two-thirds majority opinion at the advisory group level before they are passed on to the CPT Advisory Committee. In keeping with the existing procedures of the CPT Advisory Committee, at least one advisor must vote affirmatively to forward the proposal for a category II code to the CPT editorial panel.

Category II codes will be assigned an alphanumeric identifier with a letter in the last field (e.g., 1234F) to distinguish them from category I CPT codes. These codes will be located in a separate section of CPT, following the Medicine section. Introductory language will be placed in this code section to explain the purpose of these codes. The use of these codes is optional and not required for correct coding.

CPT Category III Codes

CPT category III codes are a temporary set of tracking codes for new and emerging technologies and are intended to facilitate data collection on and the assessment of new services and procedures to substantiate widespread usage and clinical efficacy or in the FDA approval process. For services/procedures to be eligible for category III codes, the service/procedure must have relevance for research, either ongoing or planned. Because category III CPT codes are intended to be used for data collection purposes, they are not intended for services/procedures not accepted by the editorial panel because the proposal was incomplete, more information is needed, or the advisory committee did not support the proposal.

An important part of the reasoning behind the development of category III codes was the length and requirements of the CPT approval process, which conflicted with the needs of researchers for coded data for tracking emerging technology services throughout the research process. The editorial panel requires at a minimum that:

• Services/procedures be performed by many healthcare professionals across the country

• FDA approval be documented or be imminent within a given CPT cycle

• The service/procedure has proven clinical efficacy

These requirements restrict category I codes to clinically recognized and generally accepted services, not newly emerging technologies. Another important consideration in the development of category III codes is the elimination of local codes under HIPAA. The final rule supports the elimination of local codes and the transition to national standard code sets. Many of the local codes were temporary codes used by payers until services/procedures were more fully substantiated through research and received a CPT code. Thus, category III codes can take the place of temporary local codes used for this purpose.

To bring new category III codes into the field as soon as possible, newly added codes will be made available on a semi-annual basis via electronic distribution on the AMA/CPT Web site. The full set of category III codes will be included in the next published edition for that CPT cycle. The early release is possible for category III codes because payment is based on the policies of payers and not on a yearly fee schedule.

Similar to category II codes, category III codes will be assigned an alphanumeric identifier with a letter in the last field (e.g., 1234T) to distinguish them from regular category I codes. Also like category II codes, category III codes will be located in a separate section of CPT, following the Medicine section. Introductory language will be placed in this code section to explain the purpose of these codes. To maintain category III codes as temporary, they will be archived after five years if the code has not been accepted for placement in the category I section, unless demonstrated that a category III code is still needed. Category III codes will not be reused.

Preparing for the Future

CPT category II and category III code sets are consistent with the goals and intentions of the CPT-5 Project and the history of CPT. To maintain CPT as a national standard, it is necessary to expand the code set's use into new areas where there is a need for coded data on services performed. The CPT-5 Project statement of purpose asserts that CPT will address 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 field of performance measurement is in need of coding and standardization. No other existing code sets are involved in coding performance measures. The AMA and CPT have an opportunity to set information and communication standards for performance measures just as CPT did for procedures. Also, CPT, as a true clinical code set, has an obligation to facilitate the collection of data on emerging technology. As the introduction to CPT states, "The use of CPT codes simplifies the reporting of services. With this coding and recording system, the procedure or service rendered by the physician is accurately identified." Such standardized identification and recording is necessary for performance measures and for the investigation of new technologies.

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