"We Should Have a Code for That"

Here's a look at CPT structure and process.

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One of the most frequent questions on podiatric coding is,"Why don't we have a code for XX?" What the XX stands for varies from year to year, but the basic question has not changed in the last 25 years. The XX once was extracorporeal shock wave therapy. We got that code passed. Then it was neuroma sclerosing injections. We got that code passed. Then it was a better description of wound debridement and skin substitute applications. We got those codes passed. Now it is lesser metatarsophalangeal joint implants and plantar plate repair. So far, those procedures have not yet been granted a Common Procedural Terminology (CPT) code.

CPT Structure

Most doctors know that CPT is a shorthand form of describing services provided by physicians and qualified healthcare professionals (QHPs). What they may not know is that CPT is owned and operated by the American Medical Association (AMA). The AMA holds the copyright to all CPT codes. Through a panel of seventeen voting members, each representing a designated provider or payor group encompassing the modern American healthcare system, the CPT Panel reviews code sets that represent new, modified, or deleted services. The panel acts on Coding Change Proposals (CCPs) with input from approximately one hundred and fifteen advisors representing most of the medical associations and specialty societies in the United States. Many CCPs generate advisor input from multiple specialties, such as the wound debridement codes and evaluation and management (E&M) codes. In contrast, some CCPs are specialty-specific, such as audiology codes. A CCP may be designed to add a new code, re-

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vise an existing code, or delete an existing code.

CPT codes are divided into three major categories. Category I codes represent active common services. Category II codes are data collection codes including vaccine reporting codes, and Category III are experimental and/or emerging services.

CPT Advisors are nominated by their specialty society and confirmed by the AMA Board of Trustees. The podiatric profession is represented at the CPT Panel meetings by two advisors.

The meetings rotate around the country. The meetings typically occur in February, May and October of each year. At any given meeting, there are usually from one to five codes that relate to services foot and ankle specialists perform. The codes approved at the February meeting are effective the following January 1st. The codes approved at the May and October meetings become effective January 1st of the second calendar year from that meeting. For example, CCPs approved in February 2018 become effective January 1, 2019. CCPs approved in May 2018 or October 2018 become effective January 1, 2020. The CPT process encourages interaction between society advisors, and podiatry has been prominent and visible at the meetings promoting the profession.

CPT Process

When a desire for a new code emerges, a CCP is developed and submitted to the CPT panel for review. CCPs are typically submitted by specialty societies but may be submitted by an individual person or industry representatives. There are strict requirements that must be met for a CCP to be accepted. These include, but are not limited to, a robust review of peer reviewed literature regarding the service, widespread performance of the service, society support and that the code meets the guidelines of the CPT section in which it will be placed. Typically, between 30 and 100 CCPs are reviewed by the panel during each of the tri-annual meetings.

Once a CCP is accepted for presentation, it is assigned to a panel member. This panel member is responsible for understanding the CCP and being able to explain it to the panel at the meeting. All advisors have an opportunity to review the proposal and comment on it. Based upon the advisor comments, multiple options of the CCP may be developed for panel review. One final option is presented at the panel meeting during which the makers of the CCP have the opportunity to comment and answer panel member questions. CPT adheres to a strict conflict of interest policy for anyone who speaks in favor of or against a proposal.

The presented option may be changed in discussion during the meeting. A CCP may be tabled, which gives the originator of the proposal an opportunity to tweak the proposal and come back for another attempt at approval. The proposal may also be withdrawn prior to the panel reviewing it at the meeting. After all discussion has been exhausted, the panel confidentially votes on approval or rejection. The result of the vote is not made public during the meeting. The result of the panel's decision is made public two to three weeks after the meeting conclusion when the minutes of the meeting are released.

Most of the time, obtaining a new CPT code is advantageous to the providers performing the service. Most insurance companies will not reimburse the provider for a service that does not have a Category I CPT code, but may start paying for a service once a CPT code is approved. Sometimes, this may be a win/lose situation. Extracorporeal shock wave therapy is an example of this. When the procedure was first performed, there was no appropriate CPT code. Therefore, insurance companies would not cover the procedure. Most providers charged and received cash for the procedure. Once the CPT code was valid, some insurance companies started paying for the service. That was a win. However, many insurance companies paid substantially less for the procedure than the providers were getting directly from the patients prior to getting a code approved. That was a loss. Prior to the approval of a specific code for destruction of a Morton's neuroma (alcohol sclerosing injection), providers were billing a general code for peripheral nerve destruction which reimbursed well. After passage the new code specific for the Morton's neuroma destruction was valued substantially less than the general code. Another win/loss.

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It's important to review the CPT structure and process in order that we can better understand why and how we have codes for the services we perform. If you are performing a procedure that does not currently have an appropriate code (MTPJ implants), or an existing Category III procedure(s) that needs a new Category I code (STJ implant), or a revision of an existing code (plantar plate repair), your CPT team encourages you to publish your findings so that your CPT team has the literature to support the code change you desire. **PM**

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