information they need and letting us know what they need to understand their treatments is really important," she said.

Reference

1. Freedman RA, Kouri EM, West DW, et al. Racial/Ethnic Disparities in Knowledge About One's Breast Cancer Characteristics. Cancer. 2015;121;724–32.

HOW A CPT CODE COMES TO BE

Current Procedural Terminology (CPT) was developed by the American Medical Association (AMA), and the codes have been in use for more than 40 years.[1] A CPT code is "a listing of descriptive terms and identifying codes for reporting medical services and procedures."[1] The CPT Editorial Panel is responsible for ensuring that CPT codes remain up to date and reflect the latest medical care provided to patients. The panel meets three times each year to get direct input from practicing physicians, medical device manufacturers, developers of the latest diagnostic tests, and advisors from more than 100 societies.[1]

While radiation oncology administrators know how important CPT codes are, they may not be aware of or understand the process of how codes are created, reviewed and valued. Dr. Corbin Johnson, an assistant professor and radiation oncologist at the Vanderbilt-Ingram Cancer Center, has been active in coding and code utilization with the American Society for Radiation Oncology (ASTRO) for many years. Since 2014, he has served as the alternate CPT advisor for the ASTRO CPT Committee. Dr. Johnson provided insight about the code creation and review process.

Dr. Johnson compared the process of getting a code approved to that of getting a bill through Congress: "That's the best analogy, where someone proposes a bill, and then the bill is either amended, commented upon, supported, or supported with amendments, and the bill has to be re-written, then it's taken to a vote, and finally they determine a time to implement it."

A code can be proposed by virtually any interested party; for example, a company that has a new procedure or product; people who have conducted studies and proposed a new methodology that's not described by the current code set; or a specialty society such as ASTRO, SROA, etc.

The duration of time from a code's proposal to acceptance ranges from 18 months to two years. Dr. Johnson outlined the process:

1. An application is made to the AMA for a new CPT code; certain criteria must be met in order for the application to proceed.
2. Once a code is proposed, usually two reviewers from the CPT Editorial Panel review it. At the next CPT meeting, the code is presented to the entire CPT Panel, and the panel reviewers provide a summary of what they thought of the code. The representatives of the group that proposed the code are available to answer any questions from the reviewers.
3. The CPT Panel reviewers give their presentation on the code and they either move to support the proposal or to not support it depending on their findings. Any member of the Editorial Panel may then ask questions about the proposal to the representatives of the group that proposed the code; and then the discussion is opened to any of the specialty societies or interested parties in attendance for comments.
4. After the discussion on the proposal is completed, the entire CPT Panel votes to either pass, reject or table the

DO YOU HAVE QUESTIONS ABOUT CPT CODES?

If administrators have questions about using codes, they can consult ASTRO'S Code Utilization and Application Subcommittee (CUAC Subcommittee). The CUAC Subcommittee is charged with answering questions about the appropriate use of the new codes, but it doesn't answer questions regarding the creation of new codes. ASTRO's contact person is Erin Young, erin.young@astro.com. Email your questions to Ms. Young and she will place them on the CUAC agenda. Questions are presented to the CUAC Subcommittee, and then a response is generated.

ASTRO's Radiation Oncology Coding Resource, written for non-radiation oncologists, contains useful tables and crosswalks.

proposal for a later meeting. The results of the vote are not known until they are published in the Panel minutes about a month later, and at that point whether a proposal has been accepted or rejected is known.

5. Sometimes a code is revised during the course of a meeting, and then it is put to a vote to be accepted, rejected or tabled to a future meeting.
6. Once a code is accepted, valuation is the next step. The people who proposed the code will present the code and value recommendations to the AMA/Specialty Society Relative Value Scale Update Committee (RUC). The RUC will accept the values as presented or with modifications, and then send its recommendations to the Centers for Medicare & Medicaid Services (CMS). CMS will screen their database and accept, reject or modify the valuation. Finally, the code is published with a proposed start date with or without a valuation.

A new code can be created or a code revised as a result of periodic reviews conducted by CMS or the AMA of the current code set. Dr. Johnson said the entities"…look for patterns in coding, and if they see a pattern that they have questions about, then that code receives additional scrutiny, and it may be revised. If the revision is sufficiently great; that is, a significant change in the meaning of the code, it gets a new code number."

CMS and the AMA also look at how often codes are billed together. If codes are billed together often, then the question arises whether the codes should be separate or combined into one code. Specifically, CMS and the AMA are examining whether there is a correlation between the codes and the strength of the correlation.

There is a perennial screening process where a certain number of codes are screened each year. This screening occurs because the data set would be unmanageable otherwise.

"If you can imagine that you always just add codes and never take any out or never condense any codes, the proliferation of codes would be mindboggling," Dr. Johnson said.

CPT codes are also examined for use and frequency, and if a code is used very infrequently, the code may simply be deleted. Once a code is deleted, it's usually gone permanently.

"We recently went through several revisions of the radiation oncology codes, but because there were issues with valuations of the codes, we received temporary codes called G codes," Dr. Johnson said. "The G codes actually have a one-to-one correlation with the deleted CPT codes, and they are thought to be a bridge until the valuations are set for the new codes."

As Dr. Johnson explained, typically G codes are only in existence for a year, but they can be renewed. Radiation oncology received a number of G codes in 2015 that have been continued for 2016. CMS had concerns about the data in the RUC database for the new codes, so the G codes continue.

Since teletherapy isodose planning codes are frequently billed with dosimetry codes (CPT 77300), CMS decided to revise the definition of the primary isodose planning code to include dosimetry. Because there was a significant change in the definition of the isodose planning codes, they were assigned new code numbers 77306-77307. Also, for 2016 a large number of brachytherapy codes have been revised. Now, dosimetry charges are included in the planning charge for teletherapy and brachytherapy. Electronic brachytherapy (code 0182T) has been deleted and replaced with two new electronic brachytherapy codes (0394T and 0395T) with separate definitions.

If enough information is received indicating that a code is not properly valued, the code will be revalued, Dr. Johnson said. For example, code 77332 (the simple for the radiation treatment device) is valued more than the intermediate, which would imply a 50% higher level of complexity for the simple than for the intermediate. One wouldn't expect a more complex device or procedure to be valued less than the simple one. One explanation for this anomaly is the relatively limited data on the appropriate value for code 77333.

As part of this process, surveys are periodically sent to radiation oncologists asking for information to gauge things such as: "How much did your linear accelerator cost?" and "What are your costs to perform this procedure?"

"The survey return rate is extraordinarily low, so we have to give our best estimate of the costs or the value of a service or an item on a very small data sample," Dr. Johnson said. "If you receive a survey from ASTRO asking for information regarding practice expenses, please fill it out and return it. You may have a major impact on the valuation of the codes. I also encourage those interested in the valuing of services, coding and public policy to become involved in ASTRO."

Reference

1. American Medical Association. CPT Process – How a Code Becomes a Code. 2016.