Cultivating equity in the CPT landscape, with Barbara Levy, MD

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Featured topic and speakers

In this episode of Moving Medicine, a discussion on how effectively addressing health equity requires addressing CPT, the language of medicine itself. CPT® Editorial Panel member Barbara Levy, MD, will share why diversity, equity and inclusion matters in CPT, and how it supports optimal health of patients and populations.

Speakers

- Barbara Levy, MD, CPT® Editorial Panel member
- Kenyetta Jackson, MPH, health equity director, Health Solutions, AMA

Host

- Todd Unger, chief experience officer, AMA

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Transcript

Dr. Levy: I really think we need the voices of a diverse group of people in order to understand how the code set should be changed, should be improved, how our processes can be different. And because CPT serves all of us at large, I think it’s very important that we have those voices, that we hear them, that we listen to them and that we incorporate
some of those things into our process.

**Unger:** That’s Dr. Barbara Levy, CPT Editorial Panel member and clinical professor of OB-GYN at both George Washington University and UCSD Health. She also served as vice president for health policy at the American College of Obstetricians and Gynecologists for seven years. On this episode of Moving Medicine, Dr. Levy shares why diversity, equity and inclusion matter in Current Procedural Technology, or CPT, for short. She’s interviewed by AMA health equity director for Health Solutions, Kenyetta Jackson. Here’s Kenyetta.

**Jackson:** Hello and welcome to Moving Medicine. I’m Kenyetta Jackson, the health equity director for AMA Health Solutions. Effectively addressing health equity requires addressing CPT or current procedural terminology. CPT is the language of medicine itself and we are here to discuss the language and its implications in health equity with Dr. Barbara Levy. How are you doing today, Dr. Levy?

**Dr. Levy:** I’m doing great, Kenyetta. It's great to talk with you.

**Jackson:** Great. Thank you. Dr. Levy is a CPT Editorial Panel member. Dr. Levy will share why diversity, equity and inclusion matters in CPT and how it supports optimal health of patients and populations. So to get us started, how did you progress on your CPT journey?

**Dr. Levy:** Well my journey, Kenyatta, was a little bit convoluted and it started back in the 1990s when I was actually a leader in a small professional association that was dedicated to minimally invasive gynecologic surgery. So I'm an OB-GYN and I was a leader in that organization. And as some of the audience may know, minimally invasive surgery wasn't really a thing back in the 1980s, but laparoscopic surgery, surgery through small incisions through the belly button became very, very popular. And in 1989, the first laparoscopic hysterectomy was performed.

Well, we in this small professional association didn't really have a clue about how codes were developed and we were complaining one day to a leader in the American College of Obstetricians and Gynecologists that we didn't have any codes to describe these new procedures that we were doing, or really, they were the same procedures, but through a different access. And CPT rules basically say that if you are not performing a procedure exactly as written in CPT, then you have to use an unlisted code. Well, that leader in ACOG, the College of OB-GYN, challenged us and said, "Well, put your money where your mouth is and send someone to ACOG’s coding and nomenclature committee," which is the way the committee was named at that time. And this small organization sent me.

So I went to my first meeting at ACOG and I was drinking from a fire hose. I had absolutely no idea how a code becomes a code. I didn't know anything about the new RBRVS that had come into play in 1992-1993. My patient population was not predominantly Medicare, so it wasn't something that I spent some time learning and I learned a huge amount. And interestingly, as a liaison to ACOG’s committee,
I stayed on that committee as long as my home organization wanted to pay for me to go. And the small laparoscopy association decided that it was really important to have representation. And so I sat on that committee of ACOG for a very long time as a liaison.

A few years after joining that committee, I got a phone call one Sunday morning from Dr. Ben Hare, who was ACOG's first representative voting member of the RBRVS update committee of the AMA. So Ben called me one Sunday morning and said, "I really need you to think about coming to the RUC, the RBRVS Update Committee of the AMA. It is a whole bunch of old white guys sitting around a table adjudicating things that have to do often with women's health, and I really think that you would be a great representative."

Well, I looked at my life, my small child, my teenager, my husband who was a heart surgeon, my activities in my private practice, and I thought, oh, just what I need is one more thing to do. I mean, so typical for all of us, and in the back of my head was my German immigrant father's voice saying, "If somebody opens a door for you, you walk through it."

So I agreed to go to my first RUC meeting, and that was worse than a fire hose. I don't know what's worse than a fire hose, but I had no idea about the language, any of the structures, the processes that the RUC was using. But as time went on, I became the RUC voting member for the college of OB-GYN. And through many years of service and work, actually became the chair of that committee. So I chaired the RBRVS Update Committee from 2009 to 2015, at which point I thought about all of the years that I had dedicated but how much I had learned over that period of time. And I wasn't really ready to just leave and stop really contributing. I felt that contributing on the behalf of women's health was really important for women's health, but also medicine was changing so rapidly that I really wanted to be involved with that change. So when the opportunity to put my name in the hat to become a CPT Editorial Panel came forward, I put my name in the hat and became a member of the panel. So I didn't come through the normal process of being an advisor to CPT and working up through that process. I came in really sideways through the RBRVS Update Committee.

Jackson: Thank you so much, Dr. Levy. It's been incredible for me to learn so much about your journey, and also, I'm inspired by that instruction that your father gave you to walk through any door that's been opened. Yes. Given your wealth of personal and professional experiences, what do you see as relationships between the CPT process and health equity?

Dr. Levy: So, recognizing that CPT is the language of medicine... On the Panel, as we are looking at code descriptors and we're looking at the literature to support codes, equity is always in the back of my mind, like what was the patient population in whom these studies was done, and does the code descriptor adequately help professionals, physicians and qualified health care professionals understand what the literature supports and what perhaps it doesn't support with respect to the patient population?
So that's kind of a new way of looking at things, but in my mind a randomized clinical trial is only as good as the people that are involved in the trial. And if the people are all white and male then it's very hard to apply that intervention service procedure, whatever it is, to my patients who are all female or to people in other populations. So in my mind, and I'm often bringing this up at the Panel, we have to look at all aspects of a procedure to determine whether it's ready for application across the entire house of medicine and our entire patient population.

Jackson: Sure. Dr. Levy, just in follow-up to that, how would you describe any opportunities for CPT to be used in actualizing optimal population health? And I know that's a huge question, but I also know that from some of our previous conversations, I know that you have some great insights on that question.

Dr. Levy: Well, I think that our processes should always be changing. We should always be thinking about the criteria that we use to establish Category I or Category III code. And I think we at the Panel are in a position to request or even require of applicants that they give us the information about the populations that were studied and the populations for whom a particular procedure is intended, so that at the Panel then we can look at those things, we can look at a descriptor and make sure that health care professionals will understand which populations of patients were studied and whether or not in their judgment they think that it applies to their particular patient.

So that is not an aspect of our criteria at this moment, but I think it's an opportunity for us to really make sure that the data that we are looking at and the documentation that we use to determine whether a procedure is—I call it ready for prime time—but if it's ready to be considered as a Category I service that we help health care professionals understand perhaps the limitations of the science behind that code and what opportunities there are to gain more knowledge.

Jackson: Absolutely. I look forward to a time when we can see some of those developments.

So I'm going to switch gears a little bit. As co-chair of the CPT, RUC, E&M work group, you had the unique opportunity to lead a group of stakeholders in transforming the evaluation and management codes, undoubtedly the most used portion of the CPT code set across multiple specialties and care settings. As such, changes in these codes impact on provision of care for a highly diverse population across many dimensions such as age, gender, race and ethnicity, geography and economic status, and surely other dimensions as well. How were health equity and DEI considered in the code set revision work?

Dr. Levy: So a couple of things. Our main goals with the revision work were to reduce the burden of documentation and increase the amount of time that health care professionals actually spent with patients and doing decision-making and shared decision-making with our patients. That said, we also really wanted to ensure that there was a way for health care professionals to account for the time and energy that they spend with underserved populations, either in changing their decision-making … and
an example for that is if I have a patient who has let's say a deep cut and we clean it up in the emergency room and typically you would send that patient out with instructions about how to take care of it at home, but my patient is homeless, then they're going to be some differences in both the instructions and perhaps in my medical decision-making. I might decide that someone with an injury that needs that type of care might need to be in an observation setting or an inpatient setting because of that social determinative health.

So in the development of new ways of accounting for physician work, which is really what we're doing here, we created a structure so that one could use a level of service based on either the level of medical decision-making or based on the time—and it's the total time on the date of the service—recognizing that physicians, qualified health care professionals, spend quite a good deal of time sometimes doing care coordination, calling other people, trying to help our patients get the care that they need.

We also included in the table of risk for medical decision-making an opportunity to incorporate the risk associated with social determinants of health into the methodology for choosing a level of service so that when our patients’ risk is increased by social determinants of health, that can be applied. If other aspects are also high risk or of moderate intensity, it can help to code at a higher level of service.

So everything we did was in an effort to include the cognitive work and the time that medical professionals spend to care for different populations.

**Jackson:** Sure. Thank you for explaining that and sharing that with us. I'm sure that our listeners will find that to be very valuable information as we all kind of look at opportunities to integrate health equity into this work, particularly coding in nomenclature.

I know that we've had some conversations before about the importance of diversity, equity and inclusion in the CPT pipeline for continued advancements and success in this area. Why do you see this as significant?

**Dr. Levy:** Well, I really think we need the voices of a diverse group of people in order to understand how the code set should be changed, should be improved, how our processes can be different. So for many, many years our process has been driven by those of us who have been active in organized medicine for a long period of time. And we bring really important points of view to the table, but there are other points of view out there. And because CPT serves all of us at large, I think it's very important that we have those voices, that we hear them, that we listen to them and that we incorporate some of those things into our process.

**Jackson:** Thank you, Dr. Levy. And just related to that, achieving these goals, such as DEI goals, requires both increasing the interest level among physicians and demonstrating the value of CPT participation to groups of physicians or qualified health care providers who may not have historically
felt welcomed into the process. What advice would you give to physicians who are interested in exploring CPT participation but find themselves in one of those previously unwelcomed groups? And what do you see as opportunities to enhance the process considering this issue?

Dr. Levy: So that's a pretty packed question, Kenyetta.

Jackson: Absolutely. Absolutely.

Dr. Levy: But there are a couple of things. Number one, looking back at my own background, we don’t train medical students and residents to understand anything about the CPT process. And so for myself, I knew I used the codes, but I had no idea how a code is developed, changed, edited. And I think it's very important for especially disenfranchised physicians, people who have a lot of burnout, to understand that they can actually participate in the process and make change.

So it looks to the outside world, to people who don’t understand CPT, that this is etched in concrete, that it's all fixed and I think somehow we have to get the information out there both through medical education—medical school and residency training program—but also to the house of medicine so that people can understand that it's a totally open process and we are hungry to hear their voices. It is a critical aspect of the work that we do to be sure that the code set is inclusive and representative of the work that all of us do. So I think it's about engagement but it’s also about education.

And then I think the 25-year-plus process that I went through to get educated through the fire hoses that I was drinking from, we’ve got to figure out a way to make that simpler and easier for people to understand and to onboard them a lot faster than we do right now.

So we make a lot of assumptions about what people know or don’t know, and I think it's really important for us to distill our processes into something that's understandable by anybody and then really lay down the gauntlet, if you will, and ask people to participate with us in the process so that it is as inclusive as possible. And that starts at our meetings but it also starts with a lot of education well before a Panel meeting.

Jackson: Absolutely. We always learn so much from working with you and talking with you, Dr. Levy, and of course, it’s been the same for me today. So it was a pleasure speaking with you today and thank you so much for giving us all the information that you have. I'm Kenyetta Jackson and thank you for joining us on Moving Medicine.

Dr. Levy: My pleasure, Kenyetta. It was a pleasure to talk to you.

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