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# Current Procedural Terminology Chapter, Module

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## Abstract

Current Procedural Terminology (CPT ® ) is a medical code set used for describing and reporting medical, surgical, and diagnostic services and procedures. Copyrighted and published by the American Medical Association (https://www.ama-assn.org/practice-management/cpt)since 1966 and updated yearly by the Performance Measures Advisory Group (PMAG), these codes foster better data collection so that performance measurement is facilitated, and are often used for accreditation purposes to explain results and practices. Originally developed... **Read More**

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**A note from the author of this resource about free resources:** When using free resources, the responsible coder will triangulate a finding with other sources to verify accuracy. Insurance plans frequently produce free coding cheat sheets which may serve convenience purposes; the responsible coder seeks vetted resources with effective dates and stated policy impacts from official resources. One issue with educational materials associated with medical and clinical coding is that since code sets are updated often, free or low-cost reference guides are not readily available; even if available, the likelihood the resource has undergone rigorous review is low. Such limitations also apply to this free resource, in that the rating system made available at the OER Commons hosting site is only as good as the level of user participation that supports it. In addition, although this material is licensed with a reuse and remix license and is thus available for updating, the original author is not responsible for following up with subsequent or derivative versions to insure accuracy nor is in a position to demand that updated materials be stored at the OER Commons site. Because of the potential legal consequences of filing inaccurate claims, and the potential loss to research data pools and data quality improvement initiatives, responsible coders should consider professional resources as the gold standard in their practice.

*Overview of Current Procedural Terminology*

Current Procedural Terminology (CPT®) is a medical code set used for describing and reporting medical, surgical, and diagnostic services and procedures. Copyrighted and published by the American Medical Association (https://www.ama-assn.org/practice-management/cpt) since 1966 and updated yearly by the Performance Measures Advisory Group (PMAG), these codes foster better data collection so that performance measurement is facilitated, and are often used for accreditation purposes to explain results and practices. Originally developed as a method of communication between physicians and third-party payers and intended to be used for reimbursement, current applications include usage in: benchmarking activities (Garber, Ledonio, & Polly, 2015), risk prediction and trend analysis (Ehlers et al., 2017), planning activities (Shayver, et al., 2011), and use of quality indicators (Shiner, et al., 2012). Kahn, et al., (2016) argue that efforts to harmonize coding, including CPT codes between independent claims databases has impacted secondary usage of electronic health record data including better operational analytics, quality improvement, and research.

Stakeholders new to CPT should recognize that recommendations are continually made for the code set and that new standard and professional editions are issued in October after input is solicited by the CPT Advisory Committee (for more information on the committee, read their description: https://www.ama-assn.org/about/cpt-editorial-panel/cpt-code-process) and undergoes extensive review by the CPT Editorial Panel (for more information on the committee, read their description: https://www.ama-assn.org/about/cpt-editorial-panel). To indicate the extent of change from the previous version, Leslie-Mazwi, et al. (2016) note that 140 new codes were added, 134 were revised, and 93 were deleted. Despite these changes, criticisms persist that the codes are not complex or granular enough to meet specific research needs (Kreitz, et al., 2017; Li, Shaul, & Sydorak, 2018; Young, et al., 2017). While CPT is similar to the International Statistical Classification of Diseases (ICD) coding system, that system is based on diagnosis while CPT reflects performed services.

*Coding Categories*

Three code levels: Category I, II, and III serve a continuum of purposes. Category I, a five-digit numeric code, is used for medical procedures and services that are widely performed and approved by the United States Food and Drug Administration (FDA) under a rigorous approval process that has validated the clinical value of the procedure or service. Examples of codes are: 27303 (abscess bone incision/excision of femur) and 36215 (cerebrovascular angiography, first-order). Two digit modifiers indicate additional services such as -59 (same day service performed) and -33 (preventive service). Category 1 codes have six sections:

1) evaluation and management (codes 99201-99499);
    a. Physician visit codes
    b. Consultation codes

c. Emergency Department Services
d. Critical Care
e. Nursing Facility Care

2) anesthesiology (codes 00100-01999 and 99100-99150);
a. Anatomic format
b. Includes anesthesia administration:
c. General
d. Regional
e. Supplementing local
f. Other supportive services
g. Includes
h. Preop and postop visits
i. Care during the procedure
j. Administration of fluids and/or blood
k. Monitoring services

2) surgery (codes 10000-69990);
a. Body system
b. Body part
c. Type of procedure
d. Body part within procedure

4) radiology (codes 70000-79999);
a. Diagnostic radiology
b. Diagnostic ultrasound
c. Radiologic guidance
d. Breast mammography
e. Bone/joint studies
f. Radiation oncology
g. Nuclear medicine

5) pathology and laboratory (codes 80000-89398); and
a. Organ and disease panels
b. Drug testing
c. Therapeutic drug assays
d. Evocative/suppression testing
e. Consultations
f. Urinalysis
g. Molecular pathology
h. Multi analytic assays with algorithmic assays
i. Chemistry
j. Hematology and coagulation
k. Immunology

l. Transfusion medicine
m. Microbiology
n. Anatomic pathology
o. Cytopathology
p. Cytogenetic studies
q. Surgical pathology
r. In vivo laboratory procedures
s. Other procedures
t. Reproductive medicine procedures

6) medicine (90281-99099, 99151-99199, and 99500-99607).

- Serves as an umbrella category for procedures not reported elsewhere in the CPT structure

Regarding code look-up, an alphabetic index contains multiple code references with listings by:

- Procedure, service, or examination
- Organ or anatomic site
- Diagnosis or condition
- Synonym
- Eponym
- Abbreviation

In addition, a tabular list allows entries to be viewed numerically.

The optional five-character alphanumeric Category II code (https://www.ama-assn.org/practice-management/cpt/category-ii-codes), introduced in 2004, provides supplemental tracking codes typically used for quality performance reporting, with some uses for compliance purposes. Coded as 4 digits followed by a letter as the 5$^{th}$ character, Category II codes do not replace Category I codes. Guidance from insurer-provided publications recommend placement of CPT II codes in the procedure code field, in the same manner as CPT Category I codes with a zero billable charge since their purpose is quality improvement tracking and not reimbursement (BlueCross BlueShield of North Carolina, 2018). The current slate of Category II codes is located at https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/cpt/cpt-cat2-codes_0.pdf:

- Composite measures (0001F-0015F)
- Patient management (0500F-0584F)
- Patient history (1000F-1505F)
- Physical examination (2000F-2060F)
- Diagnostic/screening processes or results (3006F-3776F)
- Therapeutic, preventive or other interventions (4000F-4563F)
- Follow-up or other outcomes (5005F-5250F)
- Patient safety (6005F-6150F)
- Structural Measures (7010F-7025F)

- Non-Measure Claims Based Reporting (9001F-9007F)

Some benefits regarding the use of CPT II codes are: 1) clarification and simplification of chart review for many of the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS) performance measures (see more information at: https://www.ncqa.org/hedis/); and 2) monitoring internal performance for key measures throughout the year which would enable the healthcare provider to participate in pay for performance initiatives. Proactive healthcare providers can identify improvement goals and structure policies and interventions based on specific measures. Specifically, CPT II code usage may qualify a healthcare provider to participate in the Affordable Care Act's quality and value-based payment programs. Field literature and discussion has realized other benefits of utilizing the CPT II codes:

- Improved integration of electronic health records for reporting and effectiveness research (Reams, Powell, & Edwards, 2014);
- Decreasing the amount of unstructured form data to reduce amounts of missing data (Wells, et al., 2013) and increase participation in quality measurement initiatives (Tamang, et al., 2017);
- Coding services has directly impacted treatment pattern identification (Sikirica, et al., 2018) and follow-up tracking (Zheng, et al., 2017) to foster a more comprehensive and proactive use of big data in healthcare.

Category III codes are temporary coding structures used to describe emerging technologies that may eventually morph into an authentic Category I code. Category III codes identify services that may not have FDA approval and may not be eligible for reimbursement unless the medical procedure or service is involved in an approved research activity. Approved for 5 years, Category III codes are assigned a numeric identifier with a T postfix (such as 0552 T - low-level laser therapy, dynamic photonic and dynamic thermokinetic energies). The American Medical Association maintains the current production cycle list and other Category III information at: https://www.ama-assn.org/practice-management/cpt/category-iii-codes.

**Terms for this chapter**:

**Category -** The organization of the CPT code set into functional areas of billing, research, and experimental research.

**Criteria** – conditions which determine which category code should apply to a given service or procedure.

**Modifier -**a two-character code that is added to describe a variation to the procedure itself.

**Questions that extend the learning for students:**

1. Provide a synopsis of a recent civil liability or criminal prosecution that involved medical coding failure in claims reimbursement.

2. What is required to make your coding systems compliant with requirements from the CPT Editorial Panel?
3. What 5 criteria must exist in order for a Category I CPT code to be applied?

*Conclusions*

The future of the CPT code set is promising in that development appears to be ongoing with linkage to helping forward a more proactive and effective global health model, specifically:

- Shi, Pashova, and Heagerty (2017) are exploring how to create a “surveillance network” to benefit 100 million patients by standardizing CPT codes;
- Klann, et al. (2015) has developed an algorithm that approximates standardized codes for legacy records with potential impacts on longitudinal and historical medical research.

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