GENERAL CPT (PROCEDURAL CODING)

The Current Procedural Terminology publication is written and maintained by the American Medical Association (AMA). CPT is a listing of five digit numeric codes that describe the services provided to patients in a variety of healthcare settings. CPT codes are used by physician and non-physician practitioners, ambulatory surgery centers, diagnostic centers and laboratory services.

Procedural coding began in 1956 when the California Medical Association created and adopted for use the California Relative Value Study. The modern version of CPT was created by the AMA in 1966. The first version released consisted of four digit codes and was primarily focused on surgical procedures. In 1970, the four digit codes became the five digit codes that exist today. In 2000, CPT codes were recognized by HIPAA as the national standard for reporting procedures in professional and outpatient hospital settings.

CPT codes are updated annually and released for use in January of each new year. Edits, deletions and additions to CPT are maintained by the AMA Editorial Board. The board includes seventeen members, eleven nominated by AMA membership and the additional positions filled by CMS and other insurance representatives such as BCBS. Requests for new codes are submitted to the board and considered for inclusion in future publications. These requests are submitted by providers in the medical field.

CPT codes are used with ICD-10-CM codes to report services provided to patients presenting for diagnosis and treatment and includes codes to report visits, surgery and diagnostic services for professional and outpatient hospital settings. CPT is the key to appropriate payment for providers in all sites of service in where they are seeing their patients (called professional component). Fees are paid on a fee-for-service basis and CPT codes are reviewed by various carriers through edits to ensure proper payment for certain services or procedures for which the carrier will reimburse.

The carrier views the CPT and ICD-10 code linkage to determine appropriate medical necessity for proper payment of CPT services. Remember that the physician performing or ordering the service is responsible for determining medical necessity and that the medical necessity linkage relating to the carrier only defines **who** will be responsible for payment; the carrier, the provider, or the patient.

CPT Coding Categories

CPT contains three categories of codes used to report services and procedures performed by a variety of healthcare providers. Category I codes are the CPT codes used consistently, Category II codes are used for data collection purposes (not mandatory) and Category III codes are used for new technology that has yet to be assigned a permanent CPT code in Category I.

While Category I and Category III codes are mandatory, Category II codes are not. Each specific procedural category and the details of each code series are described below.

CPT Category I Codes

CPT Category I codes are used to report procedures and visits provided by a variety of healthcare providers and contains the majority of the CPT codes used to report such services. CPT Category I codes are five digit numeric codes and are broken down into six main sections. These sections and their numeric equivalents are as follows:

99201–99499 Evaluation and Management

00100-01999 Anesthesiology

99100-99140 Extenuating Circumstances

10021-69990 Surgery

70010-79999 Radiology

80047-89398 Pathology/Laboratory

90281-99607 Medicine

CPT Category II Codes

Category II codes are used to report quality of care and performance measurements such as patient management plan of care, patient history assessments, clinical assessments and diagnostic/screening processes and results.

The Category II codes are *optional* and are not required for appropriate code assignment. These codes should not be used to replace CPT codes for reporting services rendered for reimbursement or for reporting codes for clinical research and other purposes. Category II code structure consists of four numbers and end with the letter F. There are nine sections of Category II codes. These sections and their alpha-numeric equivalents are as follows:

0001F-0015F Composite Codes

0500F-0575F Patient Management

1000F-1505F Patient History

2000F-2060F Physical Examination

3006F-3776F Diagnostic/Screening Processes or Results

4000F-4563F Therapeutic, Preventive or Other Interventions

5005F-5250F Follow-up or Other Outcomes

6005F-6150F Patient Safety

7010F-7025F Structural Measures

9001F-9007F Nonmeasure Code Listing

Category III Codes

Category III codes are used to report new technology, procedure and services rendered to patients and should be used in lieu of a Category I unlisted procedure code when a Category III code adequately describes the service.

Category III codes are five digit alpha-numeric codes beginning with four numbers and ending with the letter T.

In addition to the Category I, II and III codes discussed above, other sections of CPT contain important information regarding instructional use of CPT and other elements within the publication.

CPT Instructional Guidelines

CPT instructional guidelines assist the coder in understanding the overall structure, formatting and rules for reporting CPT codes. Additional instructions can be found in each CPT section and subsection area. Instructional guidelines include an introduction to CPT, format of terms, guidelines, add-on codes, modifiers and other CPT coding guidance.

The **introduction** of CPT gives guidance as to the proper use of the CPT coding system. The **instructions for use of CPT** direct the coder to select the appropriate procedure or service performed by name in the index. Services and procedures chosen should be documented in the medical record documentation.

CPT is broken down into specialty areas; however, it is important to note that CPT clearly states that there is no restriction for any specialty group to utilize any certain section of the CPT book. Any procedure or service in any section of the CPT book may be utilized to report any service rendered by any physician qualified to perform such services.

The **format of the terminology** is also described in the introduction section of CPT. This section describes how the procedure numbers are indented under main component codes to save space within the CPT numeric sections. The following example shows the main component code and the indented codes listed as inclusive of that component code:

Example:

38500 Biopsy or excision of lymph node(s); superficial (separate procedure)
38505   by needle, superficial (e.g., cervical, inguinal, axillary)

The **common portion** of 38500 is considered part of 38505. The full procedure for which code 38505 represents is as follows:

38505 Biopsy or excision of lymph node(s); by needle, superficial (eg, cervical, inguinal, axillary)
Guidelines are provided for each section of Category I codes. The guidelines are provided so that a coder is able to understand how to report the specific section of codes being used.

Add-on codes can be found in all CPT Category I sections. Add-on codes are codes that are coded in addition to a primary code to further define services rendered. Add-on codes cannot be coded independent from their primary code. Add-on codes are marked with a **+** symbol.

An example of an add-on code is 17000: Destruction of premalignant lesion; first lesion. The add-on code would be coded using 17003: second through fourteenth lesion, each.

Modifiers are two digit numeric codes and are used to modify or enhance the meaning of the procedure or service reported by the CPT code. Modifiers may be section specific or may be used within multiple sections throughout the CPT book.

Unlisted procedure codes are listed at the end of each section of CPT. These codes are utilized to report services and procedures for which there is no listing in CPT. These codes end with the digits 99. A common use of these codes is for immunizations which are new to the market and do not have specified codes in place to report such immunizations. Medical record documentation should accompany the claim being billed when unlisted procedure codes are used as carriers monitor closely the use of these codes.

There are a variety of **symbols** utilized in CPT to recognize new procedure code listings, code description revisions, new and revised text, add on codes, codes exempt from −51 modifier and starred procedures.

Symbols within the CPT Section Guidelines

▲ Revised Code

● New Code

✚ Add-on Code

►◄ Contains New or Revised Text

🚫 Modifier 51 Exempt

○ Recycled/Reinstated Code

Resequenced Code

⚡ FDA Approval Pending

★ Telemedicine

CPT Appendices

Appendix A: Modifiers

Appendix B: Summary of additions, deletions and revisions

Appendix C: Clinical examples supplement

Appendix D: Summary of CPT add-on codes

Appendix E: Summary of CPT codes exempt from modifier -51

Appendix F: Summary of CPT codes exempt from modifier -63

Appendix G: Summary of CPT codes that include moderate sedation **(DELETED)**

Appendix H: Alphabetical clinical topics listing (AKA – alphabetical listing)

Appendix I: Genetic testing code modifiers

Appendix J: Electrodiagnostic medicine listing of sensory, motor and mixed nerves

Appendix K: Product pending FDA approval

Appendix L: Vascular families

Appendix M: Renumbered CPT codes- citations crosswalk

Appendix N: Summary of resequenced CPT codes

Appendix O: Multianalyte assays with algorithmic analyses

Appendix P: CPT codes that may be used for synchronous telemedicine services **(NEW)**

The ***Alphabetic Index*** is listed in the back of the book and is the first area that the coder utilizes to reference the narrative that points to the correct numeric equivalent of the procedure or service provided.

Example: A female patient presents to the office complaining of soreness and a lump in her right breast. Upon evaluation of the patient, the physician decides to perform a **breast biopsy** to make sure the lump (which is confirmed on exam) is not a malignancy. The physician schedules the patient for a right breast biopsy.

The coder would reference the Index of CPT first to determine the series of numeric codes that they will be utilizing to accurately assign the proper CPT procedure code for the breast biopsy. The coder may reference biopsy or excision (referencing the type of procedure you are performing will generally lead you to the correct series of numeric codes) or even the location from where the biopsy is being taken.
These reference terms are called **main terms**. Main terms fall generally into one of four categories. These categories are as follows:

1)   Procedure or service performed (biopsy)
2)   The organ or anatomical site (breast)
3)   The condition (lump, mass, cyst)
4)   Key synonyms, eponyms, and abbreviations (Swanz Gantz catheter)

In all cases the indented codes under the main category (***modifying terms***) will reference you either to a single listed code or to a ***code range*** (19100-19101). **Never code directly from the index**. Codes in the index may not be specific and/or the coder may be directed to a more specific code and additional instructions documented in section or subsection guidelines.

There are two types of **cross-references** found in the Index of CPT. These cross-references are **"see"** and **"see also".** The cross-references direct the coder to see another reference main term listed after the see and see also terms.

Example:

See: Accessory, Toe, *see* Polydactyly, Toe
See Also: Lesion, *see also* Tumor

Section and Subsection Guidelines

At the beginning of each of the six main sections of CPT, there are detailed guidelines as to how to report the services contained within the specific service or procedural section. These **section guidelines** are critical to understanding how to use the specific section from which the procedure or service is being reported. The E/M section guidelines, for instance, describe the elements required for appropriate documentation of a particular level of service. The surgery section describes starred procedures and add-on procedures and how they are utilized in the surgery section. Modifiers are also referenced within the section and subsection guidelines.

Subsection guidelines provide even more detail on a certain series of codes. An example is the series of codes that describe laceration repairs. The definitions of simple, intermediate, and complex repairs and how to code them are found in the subsection guidelines for repair codes.

More detail on section and subsection guidelines is provided in each of the six   sections of CPT and will be discussed in more detail in each CPT category of codes discussed in the next few chapters.

RBRVS, RVU's, and Fee Schedules

Accurate CPT coding not only has an effect on tracking of morbidity and mortality rates, disease processes, and quality of care issues, but also on payment rates and fee schedules set by carriers for reimbursement for services provided. All procedures contain a value (or a weight) called a RVU (Relative Value Unit). The RVU indicates the level of difficulty of the procedure being performed.

Each element has a numeric weight that is attached to it. Conversion factors (CF) are used to convert these RVU's into charge (physicians) and payment rates (third-party payers). The conversion factor is the dollar amount utilized by the physician or payer using the California Relative Value Study (the creator of the RVU). The RVS has not updated its system since 1974, as the Federal Trade Commission made a determination that the California RVS was "price fixing".

Medicare payments, prior to 1992, were based on claims data reported for services performed by geographical area. In 1992, the Health Care Financing Committee (now Center for Medicare & Medicaid) created the Medicare Fee Schedule.

The **Resource Based Relative Value System** is measured by three elements:

1)   Work Value – the amount of actual work it takes to perform the procedure

2)   Overhead Value – the overhead expense required to perform the procedure

3)   Malpractice Value – the risk expense for performing the procedure

Medicare allowables under the RBRVS system are based on the total RVU, a geographic adjustment factor, and a national conversion factor. Under the RBRVS system, accurate and complete reporting of services is a must. If services are incorrectly coded, this can greatly affect the reimbursement amounts paid by not only Medicare but all other third-party payers as well. Under-coding of E/M, inaccurate reporting of procedures and services or inaccurately coding non-specific diagnosis codes, for instance, may give the appearance that the physician is seeing patients for conditions that are not serious. The lower amounts paid may encourage the carriers to lower reimbursement rates for higher level services or eliminate payment for some procedures altogether that are not coded frequently due to inaccuracy.

Place of Service Indicators

Place of service indicators are utilized for reimbursement purposes to compare the place of service to the Evaluation and Management procedure code to ensure that the site of service is compatible. Incorrect assignment of the site of service code can cause payment denials. Many computer systems provide a mneumonic link to the appropriate place of service code. For example, the pneumonic ASC may link to the place of service code of 24 (Ambulatory Surgery Center). The representative entering charges may never see the actual numeric equivalent of the ASC place of service indicator, but it will print on the claim form to its linked numeric equivalent.

Place of Service codes are generally not visible to healthcare staff as they are "linked" to the appropriate location within various systems used within the healthcare environment. It is important to ensure that the links are accurate each year. Inaccurate POS code assignment can affect reimbursement and can also skew data analytics and quality of care reporting. The complete list of Place of Service codes can be found in the first pages of the CPT book.

Most Common Place of Service Codes for Providers

POS Code	POS Location	POS Description
11	Office	Non-hospital location where patient is diagnosed and treated by healthcare provider
12	Home	Care provided in private residence.
20	Urgent Care Facility	Outpatient facility where treatment is provided without appointment. Not designated as ER.
21	Inpatient Hospital	Location where patients are admitted to inpatient setting for diagnosis and treatment.
POS Code	POS Location	POS Description
22	Outpatient Hospital	Location within hospital setting where patients are diagnosed and treated on

			an outpatient basis.
23		Emergency Room	Location within hospital setting where patients are treated and diagnosed for emergent conditions.
24		Ambulatory Surgery Center	Location, other than a physician's office, where surgical and diagnostic services are provided.
31		Skilled Nursing Facility	Location, not inpatient hospital, where patients are provided skilled nursing care, rehab and medical services.
32		Nursing Facility	Location where residents are provided medical and skilled nursing care in addition to rehab services.
34		Hospice	Facility other than patient's residence that provides care for terminally ill patients.
49		Independent Clinic	Location providing outpatient services. Use when no other POS code is available.
71		Public Health Clinic	Facility maintained by State or local health department to provide diagnosis and treatment in outpatient setting.
72		Rural Health Clinic	Certified facility providing diagnosis and treatment to patients in outpatient setting that are located in rural areas.

CPT Coding for Professional and Outpatient Hospital Facility Services

CPT codes are reported by physicians and practitioners regardless of where they diagnose and treat patients. These services are called ***professional services***.

CPT codes are also reported in the outpatient hospital and ambulatory facility settings. These services are called ***technical services***. Outpatient and ambulatory settings do not use CPT codes for all charges. If a CPT code does not adequately describe a particular procedure or diagnostic service provided in the ambulatory setting, the charge-master produces a charge for the service without a CPT code.

The rules for reporting CPT codes for professional services versus technical services are unique. Some CPT codes are reported using the same code regardless of the site of service

or if the service is professional or technical in nature. Other times, a code may be reported using a modifier to distinguish between professional (26) and technical (TC) components. Still, other procedures require a completely different CPT code that defines what type of service is being performed, technical or professional, as described within the CPT code description narrative. To ensure accuracy, it is recommended that a coder familiarize themselves with the rules that govern CPT coding within the setting and for which provider type they are coding.

CPT Modifiers

Modifiers are two digit numeric or alphanumeric codes that are appended to a CPT code in an effort to modify the code without changing its core meaning. An example would be modifier -52 (Reduced Service). This modifier appended to a CPT code describes a service in which a portion of the *surgical* procedure was not done. While the CPT code description remains the same, the modifier indicates that the entire procedure was not completed without the need for a whole new CPT code number to be developed.

CPT modifiers are specific to CPT code category. While the CPT code book lists many modifiers (generally found inside front cover of the CPT book), they do not list the modifiers by code category. The below table provides coders with a modifier list by code category so that the modifiers are not appended to the wrong code category.

We will discuss both CPT and HCPCS modifiers in more detail within each CPT code category chapter and in the HCPCS chapter of this book.

2017 Most Commonly Used CPT HCPCS Level I Modifiers Table

CPT Modifier Code	HCPCS Modifier Description	HCPCS Modifier Category
22	Increased Procedural Services	Surgery
23	Unusual Anesthesia	Surgery
24	Unrelated E/M Service by Same Physician or Other Qualified Health Care Professional During Postop Period	Evaluation & Management
25	Significant, Separately Identifiable E/M Service by Same Physician or Other Qualified Health Care Professional on Same Day of Procedure or Other Service	Evaluation & Management
26	Professional Component	Surgery/Radiology/Medicine
CPT Modifier Code	HCPCS Modifier Description	HCPCS Modifier Category
32	Mandated Service	E&M/Anesthesia/Surgery/Radiology/Lab/Medicine
33	Preventative Services	Evaluation and Management

CPT Modifier Code	Description	Category
47	Anesthesia by Surgeon	Surgery
50	Bilateral Procedures	Surgery
51	Multiple Procedures	Surgery
52	Reduced Services	Surgery
54	Surgical Care Only	Surgery
55	Postoperative Management Only	Surgery
56	Preoperative Management Only	Surgery
57	Decision for Surgery	Evaluation and Management
58	Staged or Related Procedure or Service by Same Physician or Other Qualified Health Care Professional During Postop Period	Surgery
59	Distinct Procedural Service	Surgery
62	Two Surgeons	Surgery
63	Procedures Performed on Infants Less Than 4kg	Surgery
66	Surgical Team	Surgery
76	Repeat Procedure by Same Physician or Other Qualified Health Care Professional	Surgery/Lab/Radiology/Medicine
77	Repeat Procedure by Another Physician or Other Qualified Health Care Professional	Surgery/Lab/Radiology/Medicine
78	Unplanned Return to the Operating or Procedure Room by Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure- Postop Period	Surgery
CPT Modifier Code	**HCPCS Modifier Description**	**HCPCS Modifier Category**
79	Unrelated Procedure or Service or Service by Same Physician or Other Qualified Health Care Professional During the Postop Period	Surgery/Lab/Radiology/Medicine

80	Assistant Surgeon	Surgery
81	Minimum Assistant Surgeon	Surgery
82	Assistant Surgeon When Qualified Resident Surgeon Not Available	Surgery
90	Reference Outside Laboratory	Laboratory
91	Repeat Clinical Diagnostic Laboratory	Laboratory
92	Alternative Laboratory Platform Testing	Laboratory
95	Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system	Medicine **(NEW MODIFIER IN 2017)**

2017 Most Commonly Used HCPCS Level II Modifiers Table

HCPCS Modifier Code	HCPCS Modifier Description	HCPCS Modifier Category
F1-F10	Fingers, each digit	Surgery
P1	Anesthesia Physical Status Modifier Level I	Anesthesia
P2	Anesthesia Physical Status Modifier Level II	Anesthesia
P3	Anesthesia Physical Status Modifier Level III	Anesthesia
P4	Anesthesia Physical Status Modifier Level IV	Anesthesia
P5	Anesthesia Physical Status Modifier Level V	Anesthesia
P6	Anesthesia Physical Status Modifier Level VI	Anesthesia
T1-T10	Toes, each digit	Surgery
GA	Waiver on File	Radiology, Laboratory, Medicine