In this module, you will learn the main categories of Current Procedural Terminology (CPT®), the purpose of each category, and how to use the CPT code set.

*Instructions:* Click the *Start Course* above, or navigate to a section below to begin.

Questions or comments on this module? Contact us [here](#).

**LEARN**

- Introduction
- Purpose of Each Category
- Introduction to the CPT Parent-Child Relationship
- How to use Add-Ons and Code Modifiers
- How to Use Unlisted Procedures and Time
- Challenge
The CPT code set allows healthcare professionals to speak the same language, which is imperative to maintain high quality patient care. There are three main categories of CPT codes that each focus on specific areas.

**Learning Objectives**

After completing this course, you will be able to:
Categories of Current Procedural Terminology

Instructions: Click each card below to learn more.

1. Recognize the main categories of Current Procedural Terminology (CPT) codes
2. Define the purpose of each main category
3. Demonstrate how to use CPT codes

The CPT code set is divided into **four main categories**, followed by several appendices and an alphabetic index.

The main body of the Category I is composed of **six sections**.
The procedures and services with their identifying codes are presented in **numeric order** with one exception—the Evaluation and Management (E/M) Services section (99202-99499) appears at the **beginning** because these codes are used by most physicians to report a significant portion of their services.

*Instructions: Click each tab to learn more about each category.*

- Procedures/Services Consistent with Contemporary Practice
- Clinically recognized and generally accepted
- 5-digit identifier
- Most Stringent Evidence and Validation Criteria
- Codes Ordered Sequentially, except for Evaluation and Management
- Resource valuation is applied

- Supplemental Tracking Codes
- Performance Measurement, Quality of Care
- Alpha-Numeric Structure: 4 digits + F
- Use is Optional
- Example:
0012F Community-acquired bacterial pneumonia assessment (includes all of the following components) (CAP):¹

Co-morbid conditions assessed (1026F)¹

Vital signs recorded (2010F)¹

Mental status assessed (2014F)¹

Hydration status assessed (2018F)¹

🔗 CPT Changes: An Insider’s View 2007

- Identify Emerging Technology and Procedures
- Permit Data collection
- Alpha-Numeric Structure: 4 digits + T
- Temporary Codes
- Example:
For Labs / Manufacturers to uniquely identify their laboratory test

- Alpha-Numeric: 4 digits + U
- Example:

**0071T**  
Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume less than 200 cc of tissue

Sunset January 2025

» CPT Changes: An Insider’s View 2005
» CPT Assistant Mar 05:1, 5, Dec 05:3

**0002U**  
Oncology (colorectal), quantitative assessment of three urine metabolites (ascorbic acid, succinic acid and carnitine) by liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring acquisition, algorithm reported as likelihood of adenomatous polyps

» CPT Changes: An Insider’s View 2018
» CPT Assistant Aug 18:4
Instructions: Fill in the blank by typing your answer on the line provided and click Submit.

Each section is further divided into subsections with anatomic, procedural, condition, or ________ subheadings.

Type your answer here
Category I: Recognized and generally accepted procedures

Category I CPT® codes describe clinically recognized and generally accepted procedures or services identified with five-digit numeric CPT codes and descriptors. Each procedure or service is identified by a five-digit code. Two-digit numeric modifiers are also used. The inclusion of a code number and descriptor in this category of CPT codes is based on the procedure being consistent with contemporary medical practice and widely performed by many clinical professionals.

Category II: Report performance measures

Category II CPT codes are supplemental tracking codes designed specifically to report performance measures. These codes are used for claims-based reporting and data collection of specific services that support nationally established performance measures directly affecting quality patient care. This alpha-numeric code set consists of four numeric digits and an alphabetical character as the fifth character (eg, 4 digits followed by the letter F).
Category II Modifiers

1P  Performance Measure Exclusion Modifier due to Medical Reasons
2P  Performance Measure Exclusion Modifier due to Patient Reasons
3P  Performance Measure Exclusion Modifier due to System Reasons
8P  Performance measure reporting modifier—action not performed, reason not otherwise specified

Use of these codes is not required for correct coding and may not apply for all clinical settings. Performance measurement exclusion modifiers (1P, 2P, 3P, 8P) may be used to indicate that a service specified by a performance measure was considered, but, due to medical, patient, or systems reason(s) documented in the medical record, the service was not provided. Other modifiers may not be used with Category II codes.

Instructions: Click each card below to learn more.

Category II codes are ______ and, as such, do not have a relative value associated with them or their reporting.

Category II codes are optional and, as such, do not have a relative value associated with them or their reporting.
Category III: Denote emerging technology, services, and procedures

Category III CPT codes are released as temporary codes for emerging technology, services, and procedures. These codes allow for data collection and specific identification of services and procedures to substantiate widespread use in the Food and Drug Administration (FDA) approval process for a given time. Category III codes have an alpha-numeric structure, comprised of 4 digits followed by the letter T (e.g., 1234T).

If a procedure or service is specifically described by a Category III code, the Category III code should be used instead of a non-specific Category I code. Importantly, some Category III codes may be converted into Category I codes if the procedure satisfies criteria for inclusion as a Category I code at a future date. Category III codes become archived, or sunset, five years after publication or revision unless there is demonstrated need that the temporary status is still needed. If a Category III code is archived after five years, and it has not been converted to Category I status, the appropriate non-specific, or unlisted, Category I code would then be reported.

Proprietary Laboratory Analysis (PLA) subsection: Pathology and Laboratory
The Proprietary Laboratory Analysis (PLA) subsection is found within the Pathology and Laboratory section of the CPT code set. Codes in this subsection are the result of clinical laboratories or manufacturers that wish to specifically identify their test(s) and submit an application to be considered for a code, which is subsequently approved. The tests included in the PLA subsection must be commercially available in the United States for use on human specimens. Whereas Category I codes are released annually, PLA codes are released on a quarterly basis and are published on the CPT public website. New codes are effective in the quarter following their approval and publication. They have been included in the annual update of the CPT codebook since 2018.

Instructions: Click each card below to learn more.

Summary Table
Knowledge Check

Instructions: Select the best answer option and click Submit.

The PLA codes are released:

- [ ] Annually
- [ ] Monthly
- [ ] Quarterly
- [ ] Semi-Annually
However, to save space, many of the procedures and services in the CPT codebook are not printed in their entirety but refer to a common portion of the procedure listed in a prior entry. Within the CPT code set, this is known as the Parent-Child relationship. Understanding this relationship is critical to reading CPT code descriptions and the appropriate selection of codes.

The parent-child code relationship is evident whenever an entry is followed by one or more indentations. The codes' shared or common description is not listed repeatedly in the child
code’s descriptor, rather the child code’s descriptor is physically indented under the parent code’s descriptor to show this relationship.

*Instructions*: Click each plus sign to learn more.

25100  Arthrotomy, wrist joint; with biopsy

25101  with joint exploration, with or without biopsy, with or without removal of loose or foreign body
25100  Arthrotomy, wrist joint; with biopsy

25101  with joint exploration, with or without biopsy, with or without removal of loose or foreign body

Shared portion

25100  Arthrotomy, wrist joint; with biopsy

25101  with joint exploration, with or without biopsy, with or without removal of loose or foreign body

The placement of the semicolon defines the shared portion of the codes.
25100  Arthrotomy, wrist joint; with biopsy
25101  with joint exploration, with or without biopsy, with or without removal of loose or foreign body

Common portion

25100  Arthrotomy, wrist joint; with biopsy
25101  with joint exploration, with or without biopsy, with or without removal of loose or foreign body

The common portion of the code descriptor precedes the semicolon.
In this example, the common part of parent code 25100 (the part before the semicolon) is also an integral component of codes 25101.

**The full procedure described by the indented code reads as:**

25101, Arthrotomy, wrist joint; with joint exploration, with or without biopsy, with or without removal of loose or foreign body.
**Guidelines**

Guidelines are available to direct the use of the codes in the CPT code set and provide **critical information** for correctly **interpreting and reporting** the listed procedures and services.

*Instructions: Click each plus sign to learn more.*

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Codes</td>
<td>Shared or common description is not listed repeatedly, it precedes a semicolon; indented below parent code</td>
</tr>
<tr>
<td>Add-on Codes</td>
<td>Some of the listed procedures are commonly carried out in addition to the primary procedure or service</td>
</tr>
<tr>
<td>Code Modifiers</td>
<td>Modifiers are two-character code suffixes (alpha and/or numeric) that are appended to a procedure code and indicates when a service or procedure performed was altered but its basic definition was not changed</td>
</tr>
<tr>
<td>Unlisted Procedure Codes</td>
<td>If no specific code exists, the service is to be reported using the appropriate unlisted procedure or service code from that section</td>
</tr>
<tr>
<td>Time</td>
<td>Many codes can use time as the main criteria for code selection</td>
</tr>
</tbody>
</table>
Operating Microscope

The surgical microscope is employed when the surgical services are performed using the techniques of microsurgery. Code 69990 should be reported (without modifier 51 appended) in addition to the code for the primary procedure performed. Do not use 69990 for visualization with magnifying lenses or corrected vision.

Do not report 69990 in addition to procedures where use of the operating microscope is an inclusive component (15756-15758, 15842, 19364, 19368, 20955-20962, 20969-20973, 22551, 22592, 22856-22861, 26654-26656, 31526, 31531, 31536, 31541, 31545, 31546, 31561, 31571, 43116, 43180, 43456, 46601, 46607, 49906, 61548, 63075-63078, 64727, 64820-64823, 64912, 64913, 65091-68850, 68854, 0184T, 0308T, 0402T, 0583T).

69990

Microsurgical techniques, requiring use of operating microscope (I at separately in addition to code for primary procedure)

CPT Changes: An Insider’s View

In the above example, add-on code 69990 describes the use of operating microscope for microsurgical techniques. The operating microscope is utilized during many surgical procedures, including vascular surgery, spinal and nervous system procedures and others as appropriate.
The guidelines preceding the code instruct users on the appropriate reporting of this code. For example, code 69990 should not be reported when using magnifying glasses or for corrected vision. In addition, the guidelines list many procedures for which the operating microscope is an inclusive component.

Specific guidelines are included at the beginning of each of the CPT code set sections and may also be found throughout individual subsections. These guidelines define items that are necessary to appropriately interpret and report the procedures and services contained in that section. For example, in the Medicine section, specific instructions are provided for handling unlisted services or procedures, special reports, and supplies and materials provided. Guidelines also provide explanations regarding terms that apply only to a particular section.
Parenthetical notes may be found either before or after a single code or family of codes and provide instruction on appropriate use of the codes. These instructions are intended to help reduce coding errors and to ensure the accuracy and the quality of coding by adding clarity to the intent of the codes.

The content of parenthetical instruction varies, but essentially includes information related to:

- Deletion of a code or codes
- Cross referencing a deleted code to another code or codes (cross-reference); direction regarding the intended use of a code or codes (instructional parenthetical);
Listing which standalone codes are applicable for reporting with an add-on code; and listing those codes not to be reported in conjunction with a code or codes (exclusionary parenthetical).

CPT parenthetical notes include instructions on the use of add-on codes. These notes are placed after the add-on codes to indicate whether it is appropriate to report a particular add-on code in conjunction with the primary procedure(s). In addition, these parenthetical notes may also list the code(s) that should not be reported in conjunction with the add-on code listed.

The following are a few examples of parenthetical instructions that are critical to appropriate code selection:

Instructions: Click each tab to learn more about each category.

<table>
<thead>
<tr>
<th>EXAMPLE 1</th>
</tr>
</thead>
</table>

| EXAMPLE 2 |

| EXAMPLE 3 |

In this example, the:

- Parenthetical note instructs users to see codes 67961, 67966 for excision and repair of eyelid by reconstructive surgery.
In this example, the:

• Parent code 93286 is followed by parenthetical notes that instruct the user how to appropriately report this procedure along with what codes should not be reported in conjunction with this procedure.

• Child code 93287 is indented and its descriptor differentiates this procedure as implantable defibrillator system as opposed to a pacemaker system.

• The parenthetical notes following 93287 also offer guidance on the appropriate reporting of this procedure, along with a list of codes that may not be reported in conjunction with this code.
In this example, the:

- Code 69210 describes the unilateral (single ear) removal of impacted cerumen (ear wax) that requires instrumentation.

- The parenthetical notes add guidance that clarifies when this procedure is performed bilaterally, modifier 50 (Bilateral procedure), should be appended to the code.

- Additional notes instruct users to report 69209 when impacted cerumen is removed with irrigation and/or lavage but without instrumentation.

- A final note directs users to more appropriate codes in other sections of the CPT book for cerumen removal that is not impacted, which is often performed as part of typical visits described in the note (eg, outpatient visit, hospital, emergency department, nursing facility, etc.)
Parenthetical notes may be found where in the CPT codebook?

*Instructions*: Select the best answer option and click Submit.

- Modifiers section
- Before or after a single code or family of codes
- Index section
Add-on Codes

Some of the listed procedures are commonly carried out in addition to the primary procedure or service performed in the same setting.

These additional or supplemental procedures are designated as add-on codes with the + symbol. They are also listed in Appendix D of the CPT® codebook. Add-on codes in the CPT code set can be identified by specific descriptor wording that includes phrases such as:

- Each additional

- (List separately in addition to primary procedure)
Add-on codes are always performed in addition to the primary service or procedure and should **never be reported as a standalone code**. Add-on codes describe additional intra-service work associated with the primary procedure (such as additional digits, lesions, tendons, or joints). All add-on codes in the CPT code set are **exempt from the multiple procedure concept**, in which certain modifiers (51, 59, etc.) would need to be appended if those procedures were stand-alone codes.

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### Code Modifiers

The CPT code set uses **modifiers** as an **integral** component of its structure. Modifiers are two-character code suffixes (alpha and/or numeric) that are appended to a procedure code and indicates when a **service or procedure performed was altered** but its basic definition was not changed.

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**For example a modifier may be used to indicate that:**

- A procedure was performed bilaterally (modifier 50)

- Multiple procedures performed during the same operative session (modifier 51)

- Two surgeons were required to perform the procedure (modifier 62)

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CPT modifiers are developed by the AMA and there are many modifiers within the CPT code set to provide further information on the circumstances of a particular patient encounter.
More than one modifier may be appended to a procedure code when applicable, however, not all modifiers may be used with all procedure codes. The use of modifiers requires a good understanding of the purpose for each modifier.

Modifiers may be used for information only and may affect payment, therefore their correct use is important for compliance and revenue.

Instructions on using the modifiers are available within the CPT code set, and payer policy and/or manuals. CPT modifiers are found in Appendix A of the CPT codebook.

Knowledge Check

CPT Modifiers are:
Instructions: Select the best answer option and click Submit.

- One-character code suffixes (numeric)
- Three-character code suffixes (alpha)
- Two-character code suffixes (alpha and/or numeric)
However, there may be times when the specific services or procedures performed by physicians or other qualified health care professionals (QHPs) are not found in the CPT code set.

To address this, a number of codes have been designated for reporting unlisted procedures:

- In surgery, it may be an operation
• In medicine, a diagnostic or therapeutic procedure

• In radiology, a radiograph

Each of these unlisted procedures relates to a specific section of the book and is presented in the guidelines of that section.

**Other Procedures**

64999  
Unlisted procedure, nervous system

енно CPT Assistant Apr 96:11, Sep 96:16, Oct 96:10, Jan 00:10,
Aug 00:7, Sep 00:10, Feb 02:10, Nov 03:5, Oct 04:11, Apr 05:13,
Aug 05:13, Sep 05:9, Sep 07:10, Nov 07:4, Dec 07:3, Jul 08:9,
Sep 08:11, Aug 09:8, Dec 09:11, Jun 10:8, Sep 10:10, Nov 10:4,
Apr 11:12, Jul 11:12, 16:17, Sep 11:12, Jan 12:14, Feb 12:11,
May 12:14, Sep 12:16, Oct 12:14, Dec 12:13, Apr 13:5, 10,
Jun 13:13, Nov 13:14, Dec 13:14, Jan 14:9, 9, Feb 14:11,
Jul 14:8, Feb 15:9, Apr 15:10, Jul 15:11, Aug 15:8, Oct 15:8,
Feb 16:13, Oct 16:11, Nov 16:6, May 17:10, Dec 17:13, Jan 18:7,
Mar 18:9, Aug 18:10, Oct 18:8, Dec 18:8, Apr 19:9, May 19:10,
Jul 19:11, Dec 19:12, Jan 20:12, Feb 20:13

енно Clinical Examples in Radiology Winter 17:3

If **no specific code exists**, the service is to be reported using the appropriate **unlisted procedure or service code** from that section. When an unlisted code is used, it will likely be necessary to **submit supporting documentation** (eg, procedure report) along with the claim in order to adequately describe the nature, extent of, and need for the procedure, as well as the time, effort, and equipment necessary to provide the service or procedure.

**Time**

GLenum::Oftentimes a comparable code may be listed as a reference to the payer in the hopes of obtaining appropriate reimbursement.
The CPT code set contains many codes which use time as the main criteria for code selection. Therefore, documentation of time is necessary to justify reporting time-based codes.

Time is typically defined as **direct face-to-face time with the patient**. A unit of time is attained when the midpoint is passed or achieved.

**For example:**

- An hour is attained when 31 minutes have elapsed (more than midway between zero and sixty minutes).

- A second hour is attained when a total of 91 minutes have elapsed (60 minutes plus 31 minutes).

When codes are ranked in sequential typical times and the actual time is between two typical times, the code with the **typical time closest to the actual time is used**.

When another service is performed concurrently with a **time-based service**, the time associated with the concurrent service should not be included in the time used for reporting the time-based service. Some services measured in units extend across calendar dates. For continuous services that last beyond midnight, use the date of service in which services began and report the total units of time provided **continuously**.

**Instructions:** Click each plus sign to learn more.
★ 90832  Psychotherapy, 30 minutes with patient

 repercussions CPT Changes: An Insider's View 2013, 2017
 repercussions CPT Assistant Jan 13:3, May 13:12, Jun 13:3, Aug 13:14, 
 repercussions Feb 14:3, Aug 14:5, Oct 15:9, Dec 16:11, Sep 17:12, Nov 18:3

★☆ 90833  Psychotherapy, 30 minutes with patient when performed 
 repercussions with an evaluation and management service (List 
 repercussions separately in addition to the code for primary procedure)
 repercussions repercussions CPT Changes: An Insider's View 2013, 2017
 repercussions repercussions CPT Assistant Jan 13:3, May 13:12, Jun 13:3, Aug 13:14, 
 repercussions repercussions Aug 14:5, Oct 15:9, Dec 16:11, Nov 18:3
 repercussions repercussions (Use 90833 in conjunction with 99202-99255, 99304- 
 repercussions repercussions 99337, 99341-99350)

★ 90834  Psychotherapy, 45 minutes with patient

 repercussions CPT Changes: An Insider's View 2013, 2017
 repercussions CPT Assistant Jan 13:3, May 13:12, Jun 13:3, Aug 13:14, 
 repercussions Jun 14:3, Oct 15:9, Dec 16:11, Nov 18:3
In this example, three code options are available to select the appropriate service being provided based on time.
Code 90833 is designated as an add-on code which should be used in conjunction with the codes listed in the parenthetical notes below the code descriptor.
Note that all three options qualify for use as Telemedicine (star symbol)

Knowledge Check

Instructions: Match the terms with their definitions.

- Unlisted procedures
- Procedures that do not have specific codes
- A unit of time
- Attained when the midpoint is passed or achieved
Lesson 6 of 8

Challenge

Test your knowledge

Question 1 of 3

__________ contains many codes which use time as the main criteria for code selection.

Instructions: Fill in the blank by typing your answer on the line provided and click Submit.

Type your answer here

Question 2 of 3

What is the purpose of CPT® guidelines?

Instructions: Select the best option and click Submit.
Two-character code ___________ (alpha and/or numeric) that are appended to a procedure code and indicates when a service or procedure performed was altered but its basic definition was not changed.

Instructions: Fill in the blank by typing your answer on the line provided and click Submit.
Type your answer here
Lesson 7 of 8

CEU Credit

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Return to the AMA Ed Hub activity and click the Take Quiz tab to proceed.

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