In this module, you will learn a brief history of the Current Procedural Terminology (CPT®) code set, its purpose, and key components.

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

Questions or comments on this module? Contact us here.
Introduction

What is the Current Procedural Terminology (CPT®) code set and why is it used throughout the entire health care ecosystem?

The CPT code set allows health care professionals to speak the same language, which is imperative to maintain high quality patient care.

Learning Objectives

After completing this course, you will be able to:
The Current Procedural Terminology (CPT) code set is a listing of descriptive terms and identifying codes for reporting medical, surgical and diagnostic services and
procedures performed by physicians and other qualified health care professionals (QHPs). The code set standardizes medical procedure nomenclature and improves specificity for services typically performed by physicians and other QHPs.

Prior to the introduction of the CPT code set, there was no national standardized coding methodology to account for and describe the work that physicians and QHPs performed, and no such system was in use for reporting and reimbursement of medical insurance claims. Since 1966, the code set has been continuously developed and maintained by the American Medical Association (AMA).

The CPT code structure supports efficiency and accuracy by applying the intended use of the code(s) in practice and removing unnecessary redundancy.

Important Definitions

The CPT code set addresses the following pillars of health care delivery:

Instructions: Click each card below to learn more about these pillars.

- Quality of Care: Driving standardization, interoperability and transparency to improve outcomes and quality
History of CPT Coding: 50+ Years of CPT Evolution

Instructions: Click each plus sign below to learn more.

Cost of Care

Standardizing physician services reporting and measurement to unlock efficiencies that improve outcomes and drive cost effectiveness

Access to Care

Driving standardized, modernized, digital health solutions that enable coordinated care, improved outcomes and increased access across the entire health care system
<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1966</td>
<td><strong>AMA introduces CPT coding system</strong> consisting of two- to four-digit codes</td>
</tr>
<tr>
<td>1970</td>
<td>Introduction of <strong>5-digit codes</strong> due to the expansion of procedural terminology</td>
</tr>
<tr>
<td>1990</td>
<td>Introduction of <strong>CPT data files</strong></td>
</tr>
<tr>
<td>2002</td>
<td>Introduction of <strong>Category II and III codes</strong> for quality performance tracking and emerging technologies</td>
</tr>
<tr>
<td>2005</td>
<td>CPT Editorial Panel changed to an open, transparent and inclusive process</td>
</tr>
<tr>
<td>2012</td>
<td>—</td>
</tr>
</tbody>
</table>
Molecular Pathology code set established to describe different diagnostic laboratory tests

2015

Release of public Panel actions

2016

Launch of new Proprietary Laboratory Analyses (PLA) codes

2019

The CPT code set is launched internationally to expand the reach and availability for users worldwide

2020

The CPT Editorial Panel began establishing new COVID-19 laboratory testing and vaccine administration codes in response to the global pandemic
Primary Objectives of the CPT Editorial Panel to Revise the CPT Evaluation and Management Office Visits:

- To decrease administrative burden of documentation and coding
- To decrease the need for audits, through the addition and expansion of key definitions and guidelines
- To decrease unnecessary documentation in the medical record that may not be pertinent to the patient’s care
- To ensure that payment for E/M is resource-based and that there is no direct goal for payment redistribution between specialties

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

The CPT code set addresses 3 pillars of health care delivery: ________, Cost, and Access.

Type your answer here
The CPT Editorial Panel is instrumental in reviewing and deliberating all coding change proposals.

The CPT Editorial Panel is the governing body that is tasked with maintaining the CPT code set and has the sole authority to:

- Create, Revise and Delete codes
- Update descriptions
- Update applicable guidelines for appropriate CPT coding
Instructions: Click each hot spot below to learn more.

<table>
<thead>
<tr>
<th>Evidence-based</th>
<th>Clinically valid</th>
<th>Criteria-based</th>
<th>Deliberation-driven</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 meetings/year</td>
<td>Public</td>
<td>Thousands of volunteers</td>
<td>Hundreds of participants</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Clinical expertise from the full House of Medicine</td>
</tr>
</tbody>
</table>

CPT Editorial Panel
17 Members appointed by AMA Board

- Medical Specialties
- Clinical Expertise
- Industry, Manufacturers, Labs
- Technology/Market Expertise
- Payers
- CMS, AMIA, Blue Cross
- CPT Advisory Committee
- CPT Health Care Professionals Advisory Committee (HCPAC)
- Molecular Pathology
  Advisory Group (MPAG)
- The Pathology Coding Caucus (PCC)
- The Vaccine Coding Caucus (VCC)
- The Proprietary Laboratory Analysis Technical Advisory Group (PLA-TAB)
Orange Icons

As code change applications are guided through the process, various committees and workgroups participate to review the application(s) and the associated medical literature, evidence-based rationales and the proposed uses of each new potential code.
Blue Icons

These various workgroups connect telephonically and/or in person throughout the year, leading up to the coding cycle meetings, and review each code application as appropriate. They then make recommendations that find their way to the applicants via the designated AMA staff that is assigned to each application as well as to the Panel reviewers.
Purple Icons

Depending on the applicable field of medicine that applies to the code change, the Panel may receive input from the Molecular Pathology Advisory Group (MPAG), the Pathology Coding Caucus (PCC), the Vaccine Coding Caucus (VCC), and from the Proprietary Laboratory Analysis Technical Advisory Group (PLA-TAG).

The Panel ensures that all applicants who meet the criteria and complete timely applications receive fair, transparent sessions to advocate their proposals with medical literature using a question-and-answer format, with additional opportunities for other participants to ask questions during the review process.

CPT Editorial Panel Composition

The Panel consists of 17 members from the:

- National medical specialty societies in the AMA's House of Delegates
- Health Care Professionals Advisory Committee (HCPAC)
The 11 AMA seats on the Panel have a maximum tenure of two four-year terms. CPT Panel members do not advocate for their specialty or organization once named to the Panel. The Panel typically holds three face-to-face meetings per
year, involving thousands of volunteers and hundreds of participants bringing together clinical expertise from all areas of medicine.

Knowledge Check

The CPT Editorial Panel meets to:

- discuss previous years medical issues
- discuss and review code change applications
- determine third party payer policy
- plan next year's budget

SUBMIT

CONTINUE
Support for Interoperability

The CPT® code set compliments HCPCS Level II, works well with International Classification of Diseases (ICD) version 10 and others, and maps to Systematized Nomenclature of Medicine (SNOMED).

The demand for increased interoperability – or the ability of coding systems or nomenclatures to exchange and make use of information – is an area of focus for CPT code development and usability, and will lead to health care data evolution for improving, organizing and sharing information.
The CPT code set consists of 5-digit codes in Category I, and alphanumeric codes in Categories II, III; and Proprietary Laboratory Analyses (PLA).

Category I is most extensive section, with resource valuation applied to represent physician workload, practice expense, and professional liability insurance. They are released annually.
<table>
<thead>
<tr>
<th>Main Code</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>11102</td>
<td>Tangential biopsy of skin (e.g., shave, scoop, saucerize, curette); single lesion</td>
</tr>
</tbody>
</table>

- [CPT Changes: An Insider's View 2019](#)
- [CPT Assistant Jan 19.9, Dec 19.9](#)

Category II relates to Quality of Care, with tracking codes to measure key outcomes.

<table>
<thead>
<tr>
<th>0012F</th>
<th>Community-acquired bacterial pneumonia assessment (includes all of the following components) (CAP)¹</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Co-morbid conditions assessed (1026F)¹</td>
</tr>
<tr>
<td></td>
<td>Vital signs recorded (2010F)¹</td>
</tr>
<tr>
<td></td>
<td>Mental status assessed (2014F)¹</td>
</tr>
<tr>
<td></td>
<td>Hydration status assessed (2018F)¹</td>
</tr>
</tbody>
</table>

- [CPT Changes: An Insider's View 2007](#)
Category III increases Access to Care through identifying emerging technology and procedures. These codes are approved and released quarterly.

**0543T** Transapical mitral valve repair, including transthoracic echocardiography, when performed, with placement of artificial chordae tendineae
Sunset January 2025

🔗 CPT Changes: An Insider’s View 2020

(For transesophageal echocardiography image guidance, use 93355)

PLA codes also increase Access to Care, specifically in the rapidly growing area of laboratory tests. These are released quarterly.

| ScoliScore™ Transgenomic | 0004M | Scoliosis, DNA analysis of 53 single nucleotide polymorphisms (SNPs), using saliva, prognostic algorithm reported as a risk score |

**Code Descriptors**
Code descriptors facilitate the use of the CPT code set in many settings, including use by physicians at the point of care (Clinician), in electronic health records systems (Short, Medium and Long) and in patient-facing materials (Consumer).

**Short Descriptor**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>28260</td>
<td>Release of Midfoot Joint</td>
</tr>
</tbody>
</table>

**Long Descriptor**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>28260</td>
<td>Capsulotomy, midfoot; medial release only (separate procedure)</td>
</tr>
</tbody>
</table>

**Guidelines and Instructions**

Guidelines tell the user how the codes should be reported. Instructions, typically included as parenthetical notes with selected codes, indicate that a code should not be reported with another code or codes.

**Destruction**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>45190</td>
<td>Destruction of rectal tumor (eg, electrosiccation, electrosurgery, laser ablation, laser resection, cryosurgery) transanal approach</td>
</tr>
<tr>
<td></td>
<td><em>CPT Changes: An Insider's View 2002</em></td>
</tr>
<tr>
<td></td>
<td><em>CPT Assistant Jun 10:3</em></td>
</tr>
<tr>
<td></td>
<td><em>(For excision of rectal tumor, transanal approach, see 45171, 45172)</em></td>
</tr>
<tr>
<td></td>
<td><em>(For transanal endoscopic microsurgical [ie, TEMS] excision of rectal tumor, including muscularis propria [ie, full thickness], use 0184T)</em></td>
</tr>
</tbody>
</table>
Modifiers

Modifiers indicate when a special condition applies to care (sample listing below):
22 – Increased Procedural Services
50 – Bilateral Procedure
51 – Multiple Services
52 – Reduced Services
62 – Two Surgeons
95 – Synchronous Telemedicine

11426  excised diameter over 4.0 cm

CPT Changes: An Insider’s View 2003
CPT Assistant Summer 92:22, Fall 95:3, May 96:11,
Jul 10:10, May 12:13, Jan 13:15, Mar 14:4, 12, Apr 16:3,
Feb 18:10, Sep 18:7, Nov 19:3

(For unusual or complicated excision, add modifier 22)

Symbols

Symbols next to a code denote key changes as well as special uses, such as new, revised, add-on codes, resequenced, and codes that can be used with telemedicine capabilities.
The AMA organizes an **independent, expert panel** of physicians called the **Relative Value Scale Update Committee (RUC)**, dedicated to making recommendations on the resources required to provide a medical service. The RUC is comprised of 31 members. Individuals exercise their **independent judgment** and are not advocates for their specialty.

The physician work component accounts for an average of **51% of the total relative value** for each service.

**The factors used to determine physician work include the:**

1. Time it takes to perform the service
2. Technical skill and physical effort
3. Required mental effort, judgment and stress due to the potential risk to the patient

The physician work relative values are updated each year to account for changes in medical practice.

*Instructions: Click each card to reveal the answer.*

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The practice expense component accounts for what percentage of the total relative value for each service?

The practice expense component accounts for an average of **45%** of the total relative value for each service.
With this implementation and the final transition of the resource-based practice expense relative units on Jan. 1, 2002, all components of the RBRVS are resource-based.

RUC’s cycle for developing recommendations is closely coordinated with the CPT schedule for annual code revisions. The CPT Editorial Panel meets three times a year to consider coding changes for the next year’s edition. These codes and relative values go into effect annually on January 1.

Knowledge Check

What does RUC evaluate?

- Physician work component of a medical service/procedure.

The professional liability insurance (PLI) component of the RBRVS accounts for an average of 4% of the total relative value for each service.
How much third-party insurers should reimburse physicians.

How much payment a hospital receives.

How many surgeons are required to complete a service/procedure.
The CPT® Ecosystem

The CPT code set is a versatile coding nomenclature.

In addition to describing and reporting physician work in medical procedures and services, it is also used for claims processing and other administrative management purposes. It is useful for defining medical care guidelines and can be used as a research tool to study outcomes, performance markers, and the quality of health services. The CPT code set can also be leveraged to analyze and improve resource utilization.

Instructions: Click each hot spot below to learn more.
Governments

Governments can leverage the CPT code set to measure physician services utilization, determine resource needs and track quality outcomes concerning public health across their population.
Hospitals

Hospitals rely on the CPT code set for physician work descriptors and reimbursement.
Electronic Health Records (EHRs)

EHRs are built with the CPT code set embedded to capture and output visits and procedures coding and to submit claims for payment.
Regulators rely on the standardized nature of the CPT code set to review and measure patient outcomes following medical procedures and to assign various accreditations to those facilities that meet established criteria, such as those set by the National Committee for Quality Assurance (NCQA) and others.
Physicians

Physicians and other Qualified Health Care Professionals (QHPs) directly report CPT codes on medical claim forms for reimbursement.
Outpatient Facilities

Outpatient facilities report CPT codes for the services their physicians and other Qualified Health Care Professionals (QHPs) perform.
Insurance Companies

Insurance companies use CPT codes to process claims and assign payment for services and procedures.
Coders review and analyze patient medical information and procedural reports to find and assign CPT codes used to identify patient visits and/or procedures.

The CPT code set provides a uniform language for the groups below, allowing them to advance patient outcomes, medical documentation, revenue cycle management, and to gauge and improve public health.
**Instructions:** Flip each card to learn more.

**Physicians**

Physicians and other QHPs use the CPT code set for reporting medical procedures, reimbursement, and documentation.

**Coders**

Coders use the CPT code set for coding operative/procedure reports, correct coding initiative/QA, and analytics.
In this introductory course, we reviewed the **history and purpose** of the Current Procedural Terminology (CPT) code set, from its inception in **1966** and tracking its evolution over the subsequent 50+ years, leading to the current **5-digit format**.
Next we discussed the objective and structure of the CPT Editorial Panel and supporting committees, such as the various workgroups consisting of subject matter experts (SMEs) that provide review and feedback to the applicants as well as the Panel, and the RUC who is tasked with reviewing and recommending relative values for procedures within the CPT code set, taking into account the physician’s work as well as practice expense and professional liability insurance components that are part of health care.
We noted that the Panel meets **three times annually** and that the process is open to all interested parties.

We then identified some key components of the CPT code set which are the **Category I, II, III, and PLA codes**, **the guidelines, parentheticals** that provide additional instructions, and some of the modifiers that may be used to denote special circumstances that occur or apply to a given procedure.

We also looked at **how and where the CPT code set is used** across the health care landscape so that we have a solid foundation from which to further explore the CPT code set more closely in future courses.
Test your knowledge

Question 1 of 4

What year did AMA introduce the CPT data files?

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

1. 1959
2. 1967
3. 1966
4. 1990
What is a major activity of the CPT Editorial Panel?

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

- Enacting third-party payer policies.
- Establishing, updating, and revising CPT codes, descriptors, and guidelines.
- Writing coding educational articles.
- Advocating for their respective specialty.

Question 3 of 4

Category III CPT codes relate to______.
The CPT code set allows healthcare professionals to report services using:

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

- Different coding systems
- A uniform code set
- Shorthand script
- Written progress notes
CONTINUE
CEU Credit

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