CPT® Codes: What Are They, Why Are They Necessary, and How Are They Developed?

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Qualified healthcare professionals (QHPs) need to identify the professional services they provide and to report those services in a way that can be universally understood by institutions, private and government payers, researchers, and others interested parties. The QHPs' data are used to track healthcare utilization, identify services for payment, and to gather statistical healthcare information about populations. Each year, in the United States, healthcare insurers process over 5 billion claims for payment.¹ To ensure that healthcare data are captured accurately and consistently and that health claims are processed properly for Medicare, Medicaid, and other health programs, a standardized coding system for medical services and procedures is essential. The Current Procedural Terminology (CPT®) system, developed by the American Medical Association (AMA), is used for just these purposes. The AMA system provides a standard language and numerical coding methodology to accurately communicate across many stakeholders, including patients, the medical, surgical, diagnostic, and therapeutic services provided by QHPs. The CPT descriptive terminology and associated code numbers provide the most widely accepted medical nomenclature used to report medical procedures and services for processing claims, conducting research, evaluating healthcare utilization, and developing medical guidelines and other forms of healthcare documentation.

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BACKGROUND

History of Current Procedural Terminology coding development

THE FIRST PUBLICATION, in 1966, of the American Medical Association (AMA) Current Procedural Terminology (CPT®) edition of standardized codes and terms was a means to code procedures (mainly surgical) for medical records, insurance claims, and information for statistical purposes.

By 1970, the AMA had broadened the system of terms and classification codes to include diagnostic and therapeutic procedures in surgery, medicine, and the specialties as well as procedures relating to internal medicine. This timeframe also coincided with the introduction of the five-digit numeric coding system. With the release of the fourth edition of CPT in 1977, the AMA introduced a system for periodic

Information regarding coding, coverage, and payment is provided as a service to our readers. Every effort has been made to ensure the accuracy of the information. Providers, suppliers, and manufacturers are responsible for case-by-case assessment, documentation, and justification of medical necessity. However, Mary Ann Liebert, Inc., and the author do not represent, guarantee, or warranty that the coding, coverage, and payment information is error-free and/or that payment will be received. The ultimate responsibility for verifying coding, coverage, and payment information accuracy lies with the reader.

updating of the codes to keep up with the ever-changing medical environment.

In 1983, CPT was adopted as part of the Centers for Medicare & Medicaid Services (CMS), Healthcare Common Procedure Coding System (HCPCS). This HCPCS code set is divided into two principal subsystems: (1) Level I of the HCPCS, which comprised the CPT and (2) Level II of the HCPCS (see Marcia Nussgart's article).^{1,2}

Level I CPT codes are the numerical codes used primarily to identify medical services and procedures furnished by qualified healthcare professionals (QHPs). CPT does not include codes regularly billed by medical suppliers other than QHPs to report medical items or services. The AMA is responsible for all decisions for additions, deletions, or revisions of the CPT codes [Level I HCPCS code set]. CPT codes are updated annually.

In 1983, CMS mandated that CPT codes be used to report services for Part B of the Medicare Program and in 1986 required state Medicaid programs to also use the CPT codes. As part of the Omnibus Budget Reconciliation Act in 1987, CMS mandated use of CPT for reporting outpatient hospital surgical procedures. As part of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the Department of Health and Human Services designated CPT and HCPCS as the national standards for electronic transaction of healthcare information.

Today, the CPT coding system is the preferred system for coding and describing healthcare services and procedures in federal programs (Medicare and Medicaid) and throughout the United States by private insurers and providers of healthcare services.

Types of CPT codes

The CPT code can be identified by one of the following three categories.

Category I CPT codes describe distinct medical procedures or services furnished by QHPs and are identified by a 5-digit numeric code [e.g., 29580: Unna boot]. New Category I CPT codes are released annually.

Category II CPT codes are supplemental tracking codes, also referred to as performance measurement codes. These numeric alpha codes [e.g., 2029F: complete physical skin exam performed] are used to collect data related to quality of care. Category II codes are released three times a year in March, July, and November by the CPT Editorial Panel.

Category III CPT codes are temporary tracking codes for new and emerging technologies to allow data collection and assessment of new services and

procedures. They are used to collect data in the FDA approval process or to substantiate widespread usage of the new and emerging technology to justify establishment of a permanent Category I CPT code. Category III CPT codes are issued in a numeric alpha format [e.g., 0307T: near-infrared spectroscopy study for lower extremity wounds].

New Category III CPT codes are released biannually (January and July) with a 6-month delay before activation for implementation in the Medicare system. Codes released on January 1st are effective July 1st, and codes released on July 1st are effective January 1st. The codes usually remain active for five years from the date of implementation, if the code has not been accepted for placement in the Category I section of CPT.

Obtaining a CPT Level III code requires less clinical data and has a shorter review timeframe. It allows billing and tracking through the local and regional contractors for Medicare and other payers. There are no assigned fees to these codes, but payment is available at the discretion of the Insurance Carriers or Medicare contractors. When considering payment, the Medicare contractors and insurers consider evidence of effectiveness, improved outcomes, and potential cost savings.

Criteria used by the CPT Advisory Committee and the CPT Editorial Panel for evaluating Category III code for emerging technology include any one of the following for consideration:

1. A protocol for a study of procedures being performed.
2. Support from the specialties that would use the procedure.
3. Availability of U.S. peer-reviewed literature.
4. Descriptions of current U.S. trials outlining the efficacy of the procedure.

DISCUSSION

Who manages the CPT process?

The responsibility to update or modify code descriptors, coding rules, and guidelines for the CPT code set lies with the AMA CPT Editorial Panel, authorized by the AMA Board of Trustees. The panel comprised 17 members [11 physicians nominated by the national medical specialty societies; 4 physicians nominated from the Blue Cross and Blue Shield Association, America's Health Insurance Plans, the American Hospital Association, and the CMS; and two seats reserved for members of the CPT Health Care Professionals Advisory Committee (HCPAC)]. Five of these members serve as the

panel's Executive Committee. In addition, the CPT Advisory Committee supports the panel. Members of CPT Advisory committee are primarily physicians nominated by the national medical specialty societies represented in the AMA House of Delegates as well as the AMA HCPAC, organizations representing limited license practitioners and other allied health professionals. The Performance Measures Advisory Group, which represents various organizations concerned with performance measures, also provides expertise.

How is a new code developed?

Any individual QHP, medical specialty society, hospital, third-party payer, and other interested party may submit an application for changes to CPT for new or revised codes to the CPT Editorial Panel. This ongoing process has a schedule for submission deadlines and meetings of the CPT Panel, which can be found on the AMA site.³ It is important to understand that an applicant needs to carefully plan to submit their request in the appropriate timeframe to coincide with the scheduled meetings for the CPT Editorial Panel reviews.

Step 1: AMA staff determines if the request is new. If the Editorial Panel has already reviewed the request, the staff will notify the requestor of the panel's coding recommendation. If the request is a new issue or includes significant new information on an item that the panel reviewed previously, the application moves to step 2.

Step 2: Refer application to the CPT Advisory Committee for evaluation and commentary. The process allows at least 3 months for the AMA staff to prepare all the submitted materials and disperse them to the Editorial Panel reviewers. Steps 1 and 2 are complete when all appropriate CPT Advisors have responded and all information requested of an applicant has been provided to AMA.

Step 3: Refer application to the CPT Editorial Panel. The 17 member CPT Editorial Panel meets three times each year and addresses nearly 350 major topics per year, usually involving more than 3,000 votes on individual items.⁴

- AMA staff prepare an agenda item that includes the application, compiled CPT Advisor comments, and a ballot for decision by the CPT Editorial Panel.
- Thirty days before a scheduled meeting, the panel members receive the agenda documents and the CPT Advisor comments. The panel members can confer with experts as appropriate.

- If an applicant does not receive the CPT Advisor support, then the applicant is notified 14 days before each CPT Editorial Panel meeting. Applicants can withdraw their applications up until the agenda item is called at the meeting.
- Applications that have not received any CPT Advisor support will be presented to the CPT Editorial Panel for discussion and possible decision.

Step 4: CPT Editorial Panel takes an action and preliminary approvals. If applying for a Category I or Category III code, the CPT Editorial Panel votes and determines into which category the code(s) should be assigned. A decision can result in one of the following four outcomes:

1. Add a new code or revise the existing nomenclature; this change would appear in a forthcoming volume of the CPT Book.
2. Refer to a workgroup for further study.
3. Postpone to a future meeting [to allow submittal of additional information in a new application].
4. Reject the request.

Step 5: AMA staff inform the applicant of the CPT Editorial Panel's decision. Applicants or other interested parties can seek reconsideration of the panel's decision. Information of this process is available on the AMA/CPT website.⁵

Step 6: Refer code to AMA/Specialty Society Relative Value Update Committee (RUC). Once the new/revised CPT codes are approved by the CPT Editorial Panel, the code is then referred to the RUC, which will conduct a survey of QHPs from relevant medical specialties that provide the service or procedure. This survey will measure the QHP work involved in performing the service/procedure to determine an accurate relative value recommendation for the service.⁶ The RUC committee schedule can be accessed at the AMA website.³

Step 7: Implementation of the new/revised CPT code.

- Category I service and procedure CPT codes are updated annually and effective for use on January 1 of each year, except for Category I vaccine product codes, Molecular Pathology, which are released January 1st or July 1st. The new CPT book, with the newly released

codes, is released in the fall to allow for implementation on January 1.

- Category II codes are released for reporting three times yearly (March 15th, July 15th, and November 15th) to become effective three months subsequent to the date of release, allowing 3 months for implementation.
- Category III codes are released for reporting either January 1st or July 1st of a given CPT cycle and become effective six months subsequent to the date of release.

NOTE: This entire new CPT Code application process can take from 18 to 24 months.

What do the CPT Advisory Committee and CPT Editorial Panel need?

Success in obtaining a new or revised CPT code is dependent on understanding the process and preparing an application with the complete information required. Obtaining support from the appropriate medical community, society, or provider group that requires or endorses the need for the code is essential for the CPT approval process.

The major information requirements for a new or revised CPT code application include the following.

- A complete description of the procedure or service (*e.g.*, describe in detail the skill and time involved. If a surgical procedure, include an operative report that describes the procedure in detail).
- A clinical vignette, which describes the typical patient and work provided by the physician/practitioner.
- The diagnosis of patients for whom this procedure/service would be performed.
- A copy(s) of peer reviewed articles published in the U.S. journals indicating the safety and effectiveness of the procedure.
- Frequency with which the procedure is performed and/or estimation of its projected performance.
- A copy(s) of additional published literature, which further explains the request (*e.g.*, practice parameters/guidelines or policy statements on a particular procedure/service).
- Evidence of FDA approval of the drug or device used in the procedure/service if required.
- Rationale why the existing codes are not adequate and can any existing codes be changed to include these new procedures without significantly affecting the extent of the service?

Where can I find more information?

The AMA website has all the information available concerning the CPT process, access to the application forms, the schedule for the CPT Editorial Panel, and the reconsideration process forms.⁷

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AUTHOR DISCLOSURE AND GHOSTWRITING

No competing financial interests exist. No ghostwriters were used to write this article.

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Peggy Dotson, RN, BS, earned her nursing diploma in 1971 at Our Lady of Lourdes School of Nursing (Camden, NJ), and graduated from Philadelphia University (Philadelphia, PA) in 1993 with a Bachelor's of Science degree. She has 9 years of experience in clinical practice working in surgical, coronary care, intensive care, and as a field trainer for the Mercer County Paramedic Project in New Jersey. She worked for 23 years in Bristol-Myers Squibb's ConvaTec Division in varying roles, including clinical trial monitor for ostomy, wound care, and incontinence devices; medical sales representative; sales management; international marketing; worldwide business development; and Director of Reimbursement & Payer Alliances, analyzing the U.S. healthcare market and developing strategic approaches for the company. Since 2003, she is the owner and President of Healthcare Reimbursement Strategy Consulting, which evaluates healthcare policy, coverage, coding, and payment issues, and the impact of reimbursement on the healthcare market. She serves the Association for the Advancement of Wound Care (AAWC) as the Chair of the Regulatory Committee (2008 onward) and a member of the AAWC Quality Measure Task Force and Finance Committees. Since 2012, she serves on the Board of the Alliance for Wound Care Stakeholders.

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Abbreviations and Acronyms

AMA = American Medical Association
CMS = Centers for Medicare & Medicaid Services
CPT = Current Procedural Terminology
HCPCS = Healthcare Common Procedure Coding System
HIPAA = Health Insurance Portability and Accountability Act
QHP = qualified healthcare professional