All About CPT Codes:
Who, What, Where, When, How

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What is a CPT code?

- CPT codes are the numerical codes used to identify medical services and procedures furnished by qualified healthcare professionals (QHPs). The American Medical Association (AMA) is responsible for all decisions for additions, deletions, or revisions of the CPT codes. CPT codes are updated annually.
- *CPT does not include codes regularly billed by medical suppliers other than QHPs to report medical items or services.*

Medical Coding Sets

There are three sets of codes that are used to describe medical conditions, procedures, services and equipment for billing purposes:

1. **ICD-10** or international classification of diseases is a set of medical diagnostic codes used to report diseases and injury. The code set is maintained by the World Health Organization.
2. **CPT Codes** or current procedural terminology codes are used to identify procedures or services performed and are maintained by the AMA.
3. **HCPCS codes** or the Healthcare Common Procedure Coding System (HCPCS) is used to identify equipment, medication and out-patient services not include in CPT. This code set is maintained by the Centers for Medicare and Medicaid Services.

CPT Codes by Category

- **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).

Category III CPT Codes

- New Category III CPT codes are released biannually (January and July) with a six-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.

Category III CPT Codes

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.

Who assigns CPT codes?

- 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 is comprised 17 members (11 physicians nominated by the national medical specialty societies; four 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.

Who may request a CPT revision or new code?

- 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. 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.

The Process: Steps 1 and 2

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 three months for the AMA staff to prepare all the submitted materials and dispense 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.

The Process: Step 3

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.
- 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.

The Process: Step 4

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.

The Process: Steps 5 and 6

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.

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. The RUC committee schedule can be accessed at the AMA website

The Process: Step 7

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 three 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*

Applying for a new or revised CPT code

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.

Information needed to apply for a CPT code

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.

Information needed to apply for a CPT code (cont.)

- 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?

Links to CPT resources

- AMA Criteria for CPT Category I and Category III codes: https://www.ama-assn.org/practice-management/cpt/criteria-cpt-category-i-and-category-iii-codes
- CPT Codes: What Are They, Why Are They Necessary, and How Are They Developed? https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3865623/
- AMA CPT Editorial Panel & RUC meetings & calendar: https://www.ama-assn.org/about/cpt-editorial-panel/cpt-editorial-panel-ruc-meetings-calendar

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