

## CPT Coding

### Chapter 9 Introduction to CPT Coding

#### Introduction

- Introduces the CPT coding system or HCPCS Level I, a proprietary coding system published annually by the AMA.
- CPT is a listing of descriptive terms and identifying codes for reporting medical services and procedures.
- It provides a uniform language that describes medical, surgical, and diagnostic services to facilitate communication among providers, patients, and 3<sup>rd</sup> party payers.

#### History of CPT

- The AMA first published CPT in 1966, and subsequent editions expanded its descriptive terms and codes for diagnostic and therapeutic procedures.
- Five-digit codes were introduced in 1970, replacing the four-digit classification.
- Its use was mandated for reporting Medicare Part B physician services.
- In 1986, HCPCS was required for reporting to Medicaid agencies, and the Omnibus Budget Reconciliation Act (OBRA) of 1986 mandated that CPT codes be reported for outpatient hospital surgical procedures.
- HIPAA of 1996 named CPT and HCPCS Level II as the procedure code sets for physician services, physical and occupational therapy services, radiological procedures, clinical laboratory tests, other medical diagnostic procedures, hearing and vision services, and transportation services including ambulance.
- CMS required that new, revised and deleted CPT codes be implemented each January 1.
  - If outdated codes are submitted on claims, providers and health care facilities will incur administrative costs associated with resubmitting corrected claims and delayed reimbursement for services provided.

#### Overview of CPT

- CPT codes are used to report services and procedures performed on patients by the the following types of providers:
  - Home health care and hospice agencies
  - Outpatient hospital departments
  - Physicians who are employees of a health care facility
  - Physicians who see patients in their offices or clinics and in other health care settings.
- CPT codes and descriptions are based on consistency with contemporary medical practice and are performed by clinical providers throughout the country.
- Assignment of CPT codes simplifies reporting and assists in the accurate identification of procedures and services for 3<sup>rd</sup> party payer consideration
- Procedures and services reported on a claim must be linked to ICD-10-CM code that justifies the need for the service or procedure. This demonstrates medical necessity for the service or procedure provided so the payer can judge whether the claim should be paid
- When reporting Cpt does, some services are considered integral to the standard of practice, which means that certain medical and surgical srvcies are not assigned CPT codes. Such services including the following:

# Cpt Chapter Wise Notes

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Lovaasen, Deborah L. Neville**

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