Current Procedural Terminology (CPT): How It Works and What It Means

Current Procedural Terminology, perhaps better known by its abbreviation “CPT,” is the coding system the medical field uses to document healthcare services during a procedure.

This system is extensive and can be confusing for those unfamiliar, but it’s essential to understand the basics, whether you’re a full-time medical professional or a patient.

Below, you’ll learn the meaning of CPT, how it works, and the different categories to be aware of. You’ll also find tips for navigating this complex system.

What is current Procedural Terminology (CPT)? FAQs answered

CPT sometimes stands for curricular practical training, cognitive processing therapy, or carriage paid-to.

However, below will discuss Current Procedural Terminology (CPT) as the acronym used to report medical procedures and healthcare services.

This medical coding is developed and maintained by the American Medical Association (AMA) and used by health insurance companies, hospitals, and other healthcare providers to process claims and reimbursements.

CPT codes are divided into three sections: evaluation and management, surgery, and radiology. Each section has its own

set of codes for performance measurement for specific procedures.

Healthcare providers and billers should be familiar with the CPT code system to ensure accurate billing.

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How does CPT work?

CPT officially launched in 1966 and is now in its fifth edition. AMA evaluates the coding annually to gauge whether a new CPT code is necessary. The CPT system has three levels of codes: Category I, Category II, and Category III.

Category I codes, the most common, are used to report general medical procedures and services.

Category II codes report more specific procedures and services, including those requiring special training or equipment.

Category III codes are used for emerging technologies and procedures that are still being evaluated.

Codes from all three categories can be used to bill for physician services. The AMA developed the CPT Editorial Panel to ensure that codes are accurately assigned to procedures. The panel comprises doctors from various specialties who regularly review and revise the CPT code set.

There is also an annual review process during which new codes can be proposed and existing codes revised. The CPT system is constantly evolving to keep up with medical technology and practice changes.

How Is the CPT code set categorized?

Remember that evaluation and management (E/M), surgical, and radiology services comprise the three primary CPT categories.

E/M codes are for office visits, hospital visits, and other outpatient services. These codes account for the level of care provided and the time spent with the patient.

Surgical codes are for procedures performed in an operating room or another setting; they include information on the type of procedure, the body area involved, and the anesthesia used.

Radiology codes are for diagnostic tests and procedures such as X-rays, MRIs, and CT scans. They describe the type of test or procedure performed and any special circumstances that may be involved.

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How can you find the right CPT code(s) for the procedure or service you're billing for?

When billing for a healthcare procedure or service, providers must use the correct CPT code (or codes) so that insurers can reimburse them for the cost. Billers can find the right CPT code(s) by searching AMA's online CPT code database.

To search, simply enter key terms related to the procedure or service. For example, if you're billing for a skin biopsy, you might enter "skin biopsy" or "Biopsy, skin."

The results typically include a list of codes that match your search terms and a description of each code.

Once you've identified the appropriate code (or codes), you can include them on your insurance claim form. Billers can typically ask a supervisor or another experienced medical billing professional for help if they don't know which codes to use/

How can you understand CPT codes on a bill?

If you're reading a medical bill for yourself, a family member, or someone else, you may see CPT codes listed for the services rendered. It's helpful to understand what each code means to ensure everything is accurate and no mistakes have been made.

For example, a bill with the five-digit code "99213" indicates a type of office visit. The number of the code reveals the level of service provided: a 99213 is for an established patient with a visit between 20-29 minutes, while a 99214 indicates an established patient with a visit of 30-39 minutes.

Understanding CPT codes on your medical bill can help you identify errors or inconsistencies that may have occurred. If you're ever unsure about what a code means, you can refer to the CPT codebook or get in touch with your provider's billing staff for further clarification.

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How do modifiers work?

CPTmodifiers are two-digit codes that provide additional information about a medical service or procedure. They are used to indicate a modified procedure or to report a change in the usual circumstances of service.

When submitting claims to insurance companies, it’s crucial to use the correct modifier code for accurate reimbursement. Failure to use a modifier can result in claim denial in some cases.

There are many different types of CPTmodifiers, each with a specific meaning.

Some of the most common modifiers include:

Modifier 25: Indicates a separate and distinct procedure performed on the same day as another procedure

Modifier 50: Indicates a procedure performed bilaterally (on both sides)

Modifier 51: Indicates a procedure performed with multiple units

CPTmodifiers are only sometimes required but are often essential to receive full reimbursement. When in doubt, check with the patient’s insurance company to see if a modifier is needed.

Other important facts about using CPT codes in healthcare billing and reimbursement transactions

By now, you likely understand CPT codes and their role in healthcare billing and reimbursement transactions. But as with anything related to healthcare billing, CPT is complex and requires you to learn continually.

Here are a few other things to remember:

- CPT codes can describe the services provided, not the diagnosis. The diagnosis is reported using ICD-10 codes.
- CPTmodifiers may be needed to describe the service

provided more accurately.

- Always use the most specific CPT code possible. If there is doubt about which code to use, it's generally better to err on the side of caution and choose the more specific code.
- Bundling edits are in place for many CPT codes. This means specific codes cannot be billed together because they're considered part of the same service.
- Remember that CPT coding is just one part of the healthcare billing and reimbursement process. Other important considerations include documentation, billing software, and payer policies.

Along with deepening your understanding of CPT, it's best practice to keep your patients' medical records organized. Many offices now use digital technology like EMR for its efficiency and convenience, and many of these electronic systems have built-in features to make billing with these codes easier and more intuitive.

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Are there any limitations to CPTfunctionality?

There are certain limitations to CPT codes to be aware of as a healthcare professional. Here are some of the most prevalent ones:

Specificity

The first limitation is that the code must be specific to the service provided and accurately describe the procedure or service performed.

For example, a diagnosis code cannot be used for a procedure code, nor can a procedure code be used for a diagnosis code. A

minor coding mistake can cause issues for the healthcare provider, especially regarding reimbursement.

Necessity

CPT codes can only be used for medically appropriate and necessary services. You can’t use CPT codes for experimental or investigational treatments, procedures, or services.

Accuracy

You must choose the correct code level when reporting a procedure, meaning that you select the code that best describes the service provided. Choosing an inaccurate code level might lead to an improper payment or even an investigation by Medicare.

Submitting claims

It’s essential to consider the limitations of any coding system when billing for services or submitting claims.

For example, CPT codes are only meant for medical procedures – not non-medical services such as administrative tasks.

Also, selecting the correct code that accurately describes the service provided can be daunting due to the sheer number of codes available. You’ll want to carefully consider and research when selecting CPT codes for billing purposes.

Moreover, CPT codes must adhere to certain limitations to accurately describe the service. It’s up to the provider or biller to select the correct code and ensure that all services are medically necessary.

Remember to take the time to familiarize yourself with CPT codes and become aware of their limitations before submitting any claims for reimbursement.

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Now that you know about CPT codes

CPT codes are an important part of healthcare billing and reimbursement. It’s essential to use the correct code when submitting a claim to ensure that you’re being appropriately reimbursed for the services you’ve provided.

By understanding how CPT codes work and using the search tips above, you should be able to find the correct code(s) for your procedure or service quickly and easily.

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