Conventions Used in the CPT Code Set

CPT® Assistant.

August 2023; Volume 33: Issue 8

Conventions Used in the CPT Code Set

As medical technology and procedures progress, the Current Procedural Terminology (CPT®) Editorial Panel (the Panel) recognizes the need to adapt to the ever-evolving health care landscape. They accomplish this by continually updating and refining CPT codes, which serve as a standardized language for health care professionals, patients, hospitals, payers, and other stakeholders to communicate about the latest procedures and services. Through the CPT process, new codes are introduced, existing ones are replaced, and revisions are made to ensure accurate and up-to-date communication within the health care community. The CPT codes provide a uniform language that accurately describes medical, surgical, and diagnostic services that may facilitate reimbursement and analysis of health care data. One of the ways to ensure accuracy in the code set is by adhering to and maintaining the consistent structure of the CPT coding conventions. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the United States (US) Department of Health and Human Services (HHS) adopted specific code sets for medical diagnoses and procedures, including the CPT code set. This article provides an overview and update of the CPT coding conventions used for the CPT code set.

Code Symbols

It is important to review the various code symbols used in the CPT code set and their meanings, which are fundamental to understanding and using the CPT codes. For a summary of the CPT code symbols and their meanings, see Table 1.

Table 1. CPT Code Symbols and Their Meanings

	Indicates a new code, ie, new procedure, was added to the CPT nomenclature. Note that this symbol is used for only 1 year, ie, the new code symbol will be removed from the code in the following year.
	Indicates a code descriptor has been revised. If the code is unchanged in the following year, this symbol will be removed from the code.
	Indicates revised content in guidelines, instructions, and/or parenthetical notes. If the content is unchanged in the following year, this symbol will be removed from the guidelines, instructions, and/or parenthetical notes.
	Indicates an add-on code. Add-on codes are always performed in addition to the primary service or procedure and must never be reported as a stand-alone code. Consult Appendix D for a complete listing of these codes.
	Indicates a code that is exempt from the use of modifier 51 but is not designated as a CPT add-on procedure or service. Consult Appendix E for a complete listing of these codes.
	Indicates a code for a vaccine that is pending the Food and Drug Administration (FDA) approval. Once approval has been given by the FDA, the symbol will be removed from the code in the following year. In addition, the change in its FDA-approval status will be noted and provided via the American Medical Association (AMA) CPT "Category I Vaccine Codes" website listing at www.ama-assn.org/cpt-cat-i-vaccine-codes and in subsequent publications of the CPT code set.
#	**Indicates a resequenced code**. Note that rather than deleting and renumbering, resequencing allows existing codes to be relocated to an appropriate location for the code concept, regardless of the numeric sequence. Numerically placed references (ie, "Code is out of numerical sequence. See...") are used as navigational alerts in the CPT codebook to direct the user to the location of an out-of-sequence code. Consult Appendix N for a complete listing of these codes.
	Indicates a telemedicine code. It also indicates that these telemedicine services and procedures may be reported with modifier 95, *Synchronous Telemedicine Service Rendered via a Real-Time Interactive Audio and Video Telecommunications System*. These services and procedures, which are typically performed face-to-face, may be reported as synchronous (real-time) telemedicine services if they are performed using electronic communication with interactive telecommunications equipment that includes, at a minimum, audio and video. Consult Appendix P for a complete listing of these codes.

⊠	**Indicates an audio-only telemedicine service** when appended with modifier 93. Consult Appendix T for a complete listing of these codes.
⊠	**Indicates a duplicate PLA test code**, ie, when more than one proprietary laboratory analyses (PLA) test has an identical descriptor, the codes are annotated by the (i) symbol. PLA codes describe proprietary clinical laboratory analyses and can be provided by a single (sole-source) laboratory or licensed or marketed to multiple providing laboratories (eg, cleared or approved by the FDA). Consult Appendix O for a complete listing of these codes with the procedure's proprietary name.
⊠	**Indicates a Category I PLA code**. Unless specifically noted with this symbol, a PLA code does not fulfill Category I code criteria.
⊠	**Indicates articles in the AMA's monthly *CPT Assistant* newsletter**. This symbol indicates that the AMA has published reference material regarding that particular code in the *CPT Assistant* newsletter. The newsletter serves as the authoritative source of educational information regarding the appropriate intent, use, and technical aspects of CPT codes and guidelines for both physicians and other health care professionals and payers. It is available for subscription as an online-only newsletter.
⊠	**Indicates articles in the AMA and American of College of Radiology (ACR)** monthly *Clinical Examples in Radiology* newsletter. This symbol indicates that the AMA/ACR has published reference material regarding that particular code in the quarterly newsletter. This newsletter provides users with educational information specifically for radiology coding. It is available for subscription as an online-only newsletter.
⊠	Indicates the AMA's annual book *CPT Changes: An Insider's View,* which provides the rationales with clinical examples for new and revised codes for the specific year.

Common Conventions Used in CPT Codes

There are several commonly used conventions in the CPT code set, and these conventions and their meaning are used consistently throughout the entire code set. In essence, these conventions could be considered as universal codes or rules to help users decipher the code structures. Using a consistent set of conventions helps maintain consistent language and coding structures throughout the CPT code set. For a summary of the frequently used terms used in

CPT codes and their meanings, see Table 2.

Table 2. CPT Coding Convention and Their Meanings	
Convention	**Summary**
Inclusionary Parenthetical Notes	The inclusionary parenthetical notes following the add-on codes are designed to include the typical base code(s) and *not* every possible reportable code combination. **Example:** **15854** Removal of sutures **and** staples not requiring anesthesia (List separately in addition to E/M code) (Use 15854 in conjunction with 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350) The inclusionary parenthetical note indicates the typical base codes that may be reported with the add-on code.
Exclusionary Parenthetical Notes	The exclusionary parenthetical notes throughout the CPT code set indicate when it is inappropriate to report specific codes in conjunction with other codes.
Parenthetical Information within a Code Descriptor	There are code descriptors throughout the CPT code set that include parenthetical information. Parenthetical information is considered part of the complete descriptor. **Example:** 57282 Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus) This code describes a vaginal extra-peritoneal colpopexy with sacrospinous or iliococcygeus ligament fixation. This is the entire procedure descriptor, and the parenthetical information should not be dropped.

ie	Abbreviation for *id est* (ie) means “that is.” When “ie” is used in a code descriptor, ie, usually within parentheses, it means only the terms listed in parentheses are included. **Example:** 43112 Total or near total esophagectomy, with thoracotomy; with pharyngogastrostomy or cervical esophagogastrostomy, with or without pyloroplasty (ie, McKeown esophagectomy or tri-incisional esophagectomy) **The parenthetical** “(ie, McKeown esophagectomy or tri-incisional esophagectomy)” represents commonly used or known terminology when performing this procedure and represents the complete code descriptor.
eg	Abbreviation for *exempli gratia* (eg) means “for example.” When “eg” is used in a code descriptor, ie, usually within parentheses, the items listed in parentheses are examples only and are not restricted to just those listed. **Example:** 24136 Sequestrectomy (eg, for osteomyelitis or bone abscess), radial head or neck The parenthetical “(eg, for osteomyelitis or bone abscess)” offers typical examples of conditions when the procedure may be performed and is part of the complete code descriptor.
Semicolon	Used to demarcate the common portion of the parent and child code descriptors. To save space in the codebook, the complete code descriptor of child codes is not listed in its entirety, ie, the shared or common portion of the child code descriptors, which is the portion before the semicolon, is left out. Therefore, the complete code descriptor for a child code includes the common portion of the parent code descriptor that precedes the semicolon. **Example:** 25100 Arthrotomy, wrist joint; with biopsy 25105with synovectomy Note that the common portion of code 25100 (ie, portion before the semicolon) is part of the code descriptor for child code 25105. Therefore, the complete code descriptor for code 25105 is as follows: 25105 Arthrotomy, wrist joint; with synovectomy

Unlisted Services or Procedures	Each section of the CPT code set contains codes to report procedures or services that do not have a specific CPT code (ie, “Unlisted Services or Procedures”). A complete list of unlisted procedures is located at the beginning of each section. When reporting an unlisted code for a procedure or service, it is necessary to submit supporting documentation (eg, a procedure report) along with the claim to provide an adequate description of the nature, extent, and need for the procedure and the time, effort, and equipment necessary to provide the service.
Time	The CPT code set contains many codes that use time for code selection. Time is usually face-to-face time with the patient, unless it is specifically noted otherwise in the guidelines or code descriptor, such as time for reviewing tests, documenting clinical information, etc. A unit of time is attained when the midpoint is passed. The Evaluation and Management service times are thresholds and represent total time on the date of the encounter. **Example:** The physician saw a patient who was admitted as an inpatient and spent 25 minutes of face-to-face total time. Code 99221 may be reported because the midpoint of 21 minutes or more (of 40 minutes) has been reached.
Results, Testing, Interpretation, and Report	Certain procedures or services described in the CPT code set involve a technical component (eg, tests) that produces results (eg, data, images, slides). Producing the results is the technical component of a service. Testing leads to results; results lead to interpretation. Reports are the work product of the interpretation of test results.
Special Report	When reporting a service or procedure that is rarely provided, unusual, variable, or new (eg, unlisted procedure), the inclusion of a special report is required. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure and the time, effort, and equipment necessary to provide the service.
Multiple Procedures	When multiple procedures or services are performed at the same session by the same health care professional, the primary procedure should be reported as listed in the CPT code set. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s).

Surgical Package	The global surgical package concept in CPT coding includes the preoperative, intraoperative, and postoperative surgical services. Certain preoperative services, performance of the surgical procedure (including procedures that are integral components of a procedure), and all uncomplicated follow-up care are included in the CPT surgical package. Note that surgical package as defined in the CPT code set is different from the Centers for Medicare & Medicaid Services' global period.
Foreign Body/Implant Definition	The definitions of "foreign body" and "implant" were added to the Surgery Guidelines in the CPT 2022 code set to provide clarity between these two terms. An implant is an object placed by a physician or other qualified health care professional for any purpose, whether diagnostic or therapeutic. Examples include artificial joints or an internal pacemaker. A foreign body is any object that is unintentionally placed. Examples include swallowing a penny or glass lodged in the soft tissue after a motor vehicle accident.

