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Current Procedural Terminology

cpt™ 1999

Standard Edition

The Official American Medical Association cpt 1999

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Current Procedural Terminology

cpt™ 1999

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Foreword

Current Procedural Terminology, Fourth Edition (*CPT*™) is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. The purpose of the terminology is to provide a uniform language that will accurately describe medical, surgical, and diagnostic services, and will thereby provide an effective means for reliable nationwide communication among physicians, patients, and third parties. *CPT 1999* is the most recent revision of a work that first appeared in 1966.

CPT descriptive terms and identifying codes currently serve a wide variety of important functions in the field of medical nomenclature. CPT is the most widely accepted nomenclature for the reporting of physician procedures and services under government and private health insurance programs. *CPT* is also useful for administrative management purposes such as claims processing and for the development of guidelines for medical care review. The uniform language is likewise applicable to medical education and research by providing a useful basis for local, regional, and national utilization comparisons.

The changes that appear in this revision have been prepared by the CPT Editorial Panel with the assistance of physicians representing all specialties of medicine, and with important contributions from many third party payors and governmental agencies.

The American Medical Association trusts that this revision will continue the usefulness of its predecessors in identifying, describing, and coding medical, surgical, and diagnostic services.

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October 1, 1998

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Introduction

Current Procedural Terminology, Fourth Edition (*CPT*) is a systematic listing and coding of procedures and services performed by physicians. Each procedure or service is identified with a five-digit code. The use of CPT codes simplifies the reporting of services. With this coding and recording system, the procedure or service rendered by the physician is accurately identified.

Inclusion of a descriptor and its associated specific five-digit identifying code number in *CPT* is generally based upon the procedure being consistent with contemporary medical practice and being performed by many physicians in clinical practice in multiple locations. Inclusion in *CPT* does not represent endorsement by the American Medical Association of any particular diagnostic or therapeutic procedure. Inclusion or exclusion of a procedure does not imply any health insurance coverage or reimbursement policy.

The main body of the material is listed in six sections. Within each section are subsections with anatomic, procedural, condition, or descriptor subheadings. The procedures and services with their identifying codes are presented in numeric order with one exception—the entire **Evaluation and Management** section (99201-99499) has been placed at the beginning of the listed procedures. These items are used by most physicians in reporting a significant portion of their services. The **Medicine** (procedures) section now follows **Pathology and Laboratory**.

Section Numbers and Their Sequences

Evaluation and Management . .99201 to 99499

Anesthesiology . . . . . .00100 to 01999, 99100 to 99140

Surgery . . . . . .10040 to 69990

Radiology (Including Nuclear Medicine and Diagnostic Ultrasound) . . .70010 to 79999

Pathology and Laboratory . . . .80049 to 89399

Medicine (except Anesthesiology) . . . . . .90281 to 99199

The first and last code numbers and the subsection name of the items appear at the top of each page (eg, "11043–11313 Surgery/Integumentary System"). The continuous pagination of *CPT* is found on the lower, outer margin of each page along with the section name.

Instructions for Use of CPT

Select the name of the procedure or service that most accurately identifies the service performed. In surgery, it may be an operation; in medicine, a diagnostic or therapeutic procedure; in radiology, a radiograph. Other additional procedures performed or pertinent special services are also listed. When necessary, any modifying or extenuating circumstances are added. Any service or procedure should be adequately documented in the medical record.

It is important to recognize that the listing of a service or procedure and its code number in a specific section of this book does not restrict its use to a specific specialty group. Any procedure or service in any section of this book may be used to designate the services rendered by any qualified physician.

Format of the Terminology

CPT procedure terminology has been developed as stand-alone descriptions of medical procedures. However, some of the procedures in *CPT* are not printed in their entirety but refer back to a common portion of the procedure listed in a preceding entry. This is evident when an entry is followed by one or more indentations. This is done in an effort to conserve space.

Example

25100 Arthrotomy, wrist joint; for biopsy

25105 for synovectomy

Note that the common part of code 25100 (that part before the semicolon) should be considered part of code 25105. Therefore the full procedure represented by code 25105 should read:

25105 Arthrotomy, wrist joint; for synovectomy

Requests to Update CPT

The effectiveness of *Current Procedural Terminology (CPT)*™ is dependent upon constant updating to reflect changes in medical practice. This can only be accomplished through the interest and timely suggestions of practicing physicians, medical specialty societies, state medical associations, and other organizations and agencies. Accordingly, the American Medical Association welcomes correspondence, inquiries, and suggestions concerning old and new procedures, as well as other matters such as codes and indices.

For suggestions concerning the introduction of new procedures, or the coding, deleting, or revising of procedures contained in *CPT 1999*, correspondence requesting an application for coding change should be directed to:

CPT Editorial Research & Development
American Medical Association
515 North State Street
Chicago, Illinois 60610

All proposed additions to, or modifications of, *CPT 1999* will be by decision of the CPT Editorial Panel after consultation with appropriate medical specialty societies.

Guidelines

Specific "Guidelines" are presented at the beginning of each of the six sections. These guidelines define items that are necessary to appropriately interpret and report the procedures and services contained in that section. For example, in the **Medicine** section, specific instructions are provided for handling unlisted services or procedures, special reports, and supplies and materials provided. Guidelines also provide explanations regarding terms that apply only to a particular section. For instance, **Surgery Guidelines** provides an explanation of the use of the star, while in **Radiology**, the unique term, "radiological supervision and interpretation" is defined.

Starred Procedures

The star "*" is used to identify certain surgical procedures. A description of this reporting mechanism will be found in the **Surgery Guidelines**.

Modifiers

A modifier provides the means by which the reporting physician can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. The judicious application of modifiers obviates the necessity for separate procedure listings that may describe the modifying circumstance. Modifiers may be used to indicate to the recipient of a report that:

- A service or procedure has both a professional and technical component.
- A service or procedure was performed by more than one physician and/or in more than one location.
- A service or procedure has been increased or reduced.
- Only part of a service was performed.
- An adjunctive service was performed.
- A bilateral procedure was performed.
- A service or procedure was provided more than once.
- Unusual events occurred.

Example

A physician providing diagnostic or therapeutic radiology services, ultrasound or nuclear medicine services in a hospital would use either modifier '-26' or 09926 to report the professional component.

73090-26 = Professional component only for an x-ray of the forearm

or

73090 AND 09926 = Professional component only for an x-ray of the forearm

Example

Two surgeons may be required to manage a specific surgical problem. ►When two surgeons work together as primary surgeons performing distinct part(s) of a single reportable procedure, each surgeon should report his/her distinct operative work by adding the modifier '-62' to the single definitive procedure code. Each surgeon should report the co-surgery once using the same procedure code.◄ The modifier '-62' or the alternative modifier five-digit code 09962 would be applicable. For instance, a neurological surgeon and an otolaryngologist are working as co-surgeons in performing transsphenoidal excision of a pituitary neoplasm.

61548-62 = Hypophysectomy or excision of pituitary tumor, transnasal or transseptal approach, nonstereotactic + two surgeons modifier

or

61548 AND 09962 = Hypophysectomy or excision of pitiutary tumor, transnasal or transseptal approach, nonstereotactic + two surgeons modifier

AND the second surgeon would report:

61548-62 = Hypophysectomy or excision of pitiutary tumor, transnasal or transseptal approach, nonstereotactic + two surgeons modifier

or

61548 AND 09962 = Hypophysectomy or excision of pitiutary tumor, transnasal or transseptal approach, nonstereotactic + two surgeons modifier

If additional procedure(s) (including add-on procedure(s)) are performed during the same surgical session, separate code(s) may be reported without the modifier '-62' added. **Note:** If a cosurgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s) with the modifier '-80' or modifier '-81' added, as appropriate. A complete listing of modifiers is found in Appendix A.

Unlisted Procedure or Service

It is recognized that there may be services or procedures performed by physicians that are not found in *CPT*. Therefore, a number of specific code numbers have been designated for reporting unlisted procedures. When an unlisted procedure number is used, the service or procedure should be described. Each of these unlisted procedural code numbers (with the appropriate accompanying topical entry) relates to a specific section of the book and is presented in the Guidelines of that section.

Special Report

A service that is rarely provided, unusual, variable, or new may require a special report in determining medical appropriateness of the service. 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. Additional items which may be included are:

Complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care.

Code Changes

A summary listing of additions, deletions, and revisions applicable to *CPT 1999* is found in Appendix B. New procedure numbers added to *CPT* are identified throughout the text with the symbol "●" placed before the code number. In instances where a code revision has resulted in a substantially altered procedure descriptor, the symbol "▲" is placed before the code number. The symbols "►◄" are used to indicate new and revised text other than the procedure descriptors. CPT add-on codes are annotated by a "✚" symbol and are listed in **Appendix E**. The "⊘" symbol is used to identify codes that are exempt from the use of modifier '-51', but have not been designated as CPT add-on procedures/services. A list of codes exempt from modifier '-51' usage is included in **Appendix F**.

Short Procedure Tape Revision

Appendix C has been included for those users who have purchased a *CPT 1998* short procedure description tape or diskette or have a tape/disk current through *CPT 1998*. The listing includes changes and/or corrections necessary to update the *CPT 1999* data file. For additional information regarding the availability of *CPT* magnetic computer tapes and diskettes, see below.

Alphabetical Reference Index

A new, expanded alphabetical index is found in the back of the book. It includes listings by procedure and anatomic site. Procedures and services commonly known by their eponyms or other designations are also included.

CPT in Electronic Formats

CPT 1999 procedure codes and descriptors are also available on magnetic computer tapes, diskettes, and CD-ROM in the formats listed below.

CPT *Full Procedure Tape* contains the complete procedural text of the *CPT* manual. The sequential file is constructed of 80-byte records.

CPT *Short Description Tape* also contains the complete listing of procedural codes found in the *CPT* manual; however, each has an abbreviated narrative written in non-technical or layman's terms. Each code and description is limited to a single record.

Technical Description of Tapes

Both *CPT* computer tapes are identical technically, each having the following line specifications:

record format . . . . . .fixed
logical record length . . . . . .80 bytes
block size . . . . . .80 bytes
label . . . . . .no label
tracks 9
tape density . . . . . .1600 or 6250 BPI
content . . . . . .EBCDIC or ASCII

CPT *Diskette* The short description diskette is identical in content to the short description tape. That is, each code and description is limited to a single line. The long description text of *CPT* is also available on diskette and is identical in content to the long description tape.

Technical Description of Diskettes

- Standard PC format
- Content: ASCII
- 3½" double side/double density (720K) disk

The short and long description diskettes are in fixed-width text format with a maximum length of 80 characters. In the long description diskette, where the code description may exceed 80 characters, a sequence number immediately follows the CPT code number. This sequence number indicates how many lines a description occupies. The short description diskette contains one line of code description.

Please bear in mind that the disks and tapes contain *only* a *CPT* data file. They are *not* programs or other operations software. We have deliberately not included programs with this data file, as each user has different needs.

CodeManager '99 uses Windows®-based FOLIO Infobase™ to combine five essential coding references in one easy-to-use software package. The entire *CPT '99* text appears as it does in the printed book, as well as ICD-9-CM, HCPCS, Medicare Payment Rules, and Relative Value Units. The program allows you to search the database by words or code numbers, and to color code, highlight, and create bookmarks. CodeManager is available as a CD-ROM or diskette, in single user or network versions. System requirements include an IBM PC 486 or better, minimum 60MB available disk space for diskette version, 7MB for CD-ROM, Windows 3.1 or higher, 2X CD-ROM drive or faster.

In addition, the AMA offers CPT coding clarification and consultation with its CPT Information Services (CPT-IS). A subscription-based service, CPT-IS provides answers to your coding questions by phone, fax, or mail. AMA Health Information Specialists answer calls from 9AM-1PM CST. For more information or to subscribe, call 800 634-6922.

Contents

Evaluation and Management (E/M) Services Guidelines

In addition to the information presented in the **Introduction,** several other items unique to this section are defined or identified here.

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories such as office visits, hospital visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes. This classification is important because the nature of physician work varies by type of service, place of service, and the patient's status.

The basic format of the levels of E/M services is the same for most categories. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office consultation. Third, the content of the service is defined, eg, comprehensive history and comprehensive examination. (See "Levels of E/M Services," page 2, for details on the content of E/M services.) Fourth, the nature of the presenting problem(s) usually associated with a given level is described. Fifth, the time typically required to provide the service is specified. (A detailed discussion of time is provided on page 4.)

Definitions of Commonly Used Terms

Certain key words and phrases are used throughout the E/M section. The following definitions are intended to reduce the potential for differing interpretations and to increase the consistency of reporting by physicians in differing specialties.

New and Established Patient

A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

In the instance where a physician is on call for or covering for another physician, the patient's encounter will be classified as it would have been by the physician who is not available.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

Chief Complaint

A concise statement describing the symptom, problem, condition, diagnosis or other factor that is the reason for the encounter, usually stated in the patient's words.

Concurrent Care

Concurrent care is the provision of similar services, eg, hospital visits, to the same patient by more than one physician on the same day. When concurrent care is provided, no special reporting is required. Modifier '-75' has been deleted.

Counseling

Counseling is a discussion with a patient and/or family concerning one or more of the following areas:

- diagnostic results, impressions, and/or recommended diagnostic studies;
- prognosis;
- risks and benefits of management (treatment) options;
- instructions for management (treatment) and/or follow-up;
- importance of compliance with chosen management (treatment) options;
- risk factor reduction; and
- patient and family education.

(For psychotherapy, see 90804-90857)

Family History

A review of medical events in the patient's family that includes significant information about:

- the health status or cause of death of parents, siblings, and children;
- specific diseases related to problems identified in the Chief Complaint or History of the Present Illness, and/or System Review;
- diseases of family members which may be hereditary or place the patient at risk.

History of Present Illness

A chronological description of the development of the patient's present illness from the first sign and/or symptom to the present. This includes a description of location, quality, severity, timing, context, modifying factors and associated signs and symptoms significantly related to the presenting problem(s).

Levels of E/M Services

Within each category or subcategory of E/M service, there are three to five levels of E/M services available for reporting purposes. Levels of E/M services are *not* interchangeable among the different categories or subcategories of service. For example, the first level of E/M services in the subcategory of office visit, new patient, does not have the same definition as the first level of E/M services in the subcategory of office visit, established patient.

The levels of E/M services include examinations, evaluations, treatments, conferences with or concerning patients, preventive pediatric and adult health supervision, and similar medical services, such as the determination of the need and/or location for appropriate care. Medical screening includes the history, examination, and medical decision-making required to determine the need and/or location for approriate care and treatment of the patient (eg, office and other outpatient setting, emergency department, nursing facility, etc.). The levels of E/M services encompass the wide variations in skill, effort, time, responsibility and medical knowledge required for the prevention or diagnosis and treatment of illness or injury and the promotion of optimal health. Each level of E/M services may be used by all physicians.

The descriptors for the levels of E/M services recognize seven components, six of which are used in defining the levels of E/M services. These components are:

- history;
- examination;
- medical decision making;
- counseling;
- coordination of care;
- nature of presenting problem; and
- time.

The first three of these components (history, examination, and medical decision making) are considered the **key** components in selecting a level of E/M services. (See "Determine the Extent of History Obtained," page 6.)

The next three components (counseling, coordination of care, and the nature of the presenting problem) are considered **contributory** factors in the majority of encounters. Although the first two of these contributory factors are important E/M services, it is not required that these services be provided at every patient encounter.

Coordination of care with other providers or agencies without a patient encounter on that day is reported using the case management codes.

The final component, time, is discussed in detail (see page 4).

►Any specifically identifiable procedure (ie, identified with a specific *CPT* code) performed on or subsequent to the date of initial or subsequent Evaluation and Management Services should be reported separately.◄

The actual performance and/or interpretation of diagnostic tests/studies ordered during a patient encounter are not included in the levels of E/M services. Physician performance of diagnostic tests/studies for which specific *CPT* codes are available may be reported separately, in addition to the appropriate E/M code. The physician's interpretation of the results of diagnostic tests/studies (ie, professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate *CPT* code with the modifier -26 appended.

►The physician may need to indicate that on the day a procedure or service identified by a *CPT* code was performed, the patient's condition required a significant separately identifiable E/M service above and beyond other services provided or beyond the usual preservice and postservice care associated with the procedure that was performed. The E/M service may be caused or prompted by the symptoms or condition for which the procedure and/or service was provided. This circumstance may be reported by adding the modifier -25 to the appropriate level of E/M service. As such, different diagnoses are not required for reporting of the procedure and the E/M services on the same date.◄

Nature of Presenting Problem

A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for encounter, with or without a diagnosis being established at the time of the encounter. The E/M codes recognize five types of presenting problems that are defined as follows:

Minimal: A problem that may not require the presence of the physician, but service is provided under the physician's supervision.

Self-limited or minor: A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status OR has a good prognosis with management/compliance.

Low severity: A problem where the risk of morbidity without treatment is low; there is little to no risk of mortality without treatment; full recovery without functional impairment is expected.

Moderate severity: A problem where the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis OR increased probability of prolonged functional impairment.

High severity: A problem where the risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment OR high probability of severe, prolonged functional impairment.

Past History

A review of the patient's past experiences with illnesses, injuries, and treatments that includes significant information about:

- prior major illnesses and injuries;
- prior operations;
- prior hospitalizations;
- current medications;
- allergies (eg, drug, food);
- age appropriate immunization status;
- age appropriate feeding/dietary status.

Social History

An age appropriate review of past and current activities that includes significant information about:

- marital status and/or living arrangements;
- current employment;
- occupational history;
- use of drugs, alcohol, and tobacco;
- level of education;
- sexual history;
- other relevant social factors.

System Review (Review of Systems)

An inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced. For the purposes of CPT the following elements of a system review have been identified:

- Constitutional symptoms (fever, weight loss, etc.)
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

The review of systems helps define the problem, clarify the differential diagnosis, identify needed testing, or serves as baseline data on other systems that might be affected by any possible management options.

Time

The inclusion of time in the definitions of levels of E/M services has been implicit in prior editions of *CPT.* The inclusion of time as an explicit factor beginning in *CPT 1992* is done to assist physicians in selecting the most appropriate level of E/M services. It should be recognized that the specific times expressed in the visit code descriptors are averages, and therefore represent a range of times which may be higher or lower depending on actual clinical circumstances.

Time is *not* a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult for physicians to provide accurate estimates of the time spent face-to-face with the patient.

Studies to establish levels of E/M services employed surveys of practicing physicians to obtain data on the amount of time and work associated with typical E/M services. Since "work" is not easily quantifiable, the codes must rely on other objective, verifiable measures that correlate with physicians' estimates of their "work". It has been demonstrated that physicians' estimations of **intraservice time** (as explained below), both within and across specialties, is a variable that is predictive of the "work" of E/M services. This same research has shown there is a strong relationship between intra-service time and total time for E/M services. Intra-service time, rather than total time, was chosen for inclusion with the codes because of its relative ease of measurement and because of its direct correlation with measurements of the total amount of time and work associated with typical E/M services.

Intra-service times are defined as **face-to-face** time for office and other outpatient visits and as **unit/floor** time for hospital and other inpatient visits. This distinction is necessary because most of the work of typical office visits takes place during the face-to-face time with the patient, while most of the work of typical hospital visits takes place during the time spent on the patient's floor or unit.

Face-to-face time (office and other outpatient visits and office consultations): For coding purposes, face-to-face time for these services is defined as only that time that the physician spends face-to-face with the patient and/or family. This includes the time in which the physician performs such tasks as obtaining a history, performing an examination, and counseling the patient.

Physicians also spend time doing work before or after the face-to-face time with the patient, performing such tasks as reviewing records and tests, arranging for further services, and communicating further with other professionals and the patient through written reports and telephone contact.

This *non*-face-to-face time for office services—also called pre- and post-encounter time—is not included in the time component described in the E/M codes. However, the pre- and post-face-to-face work associated with an encounter was included in calculating the total work of typical services in physician surveys.

Thus, the face-to-face time associated with the services described by any E/M code is a valid proxy for the total work done before, during, and after the visit.