American Medical Association

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CPT

1992

Physicians' Current Procedural Terminology

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Celeste G. Kirschner, MHSA
Judy A. Coy, RN, MGS
Nancy K. Edwards, MA
Gina Leoni, RRA
Mary R. McNamara O'Heron, RRA
Ann Pollack, MBA
Carrie L. Ryan, RRA
Dianne M. Willard, RRA, MBA

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Department of Coding & Nomenclature
American Medical Association
515 North State Street
Chicago, IL 60610

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PO Box 10950
Chicago, IL 60610

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Foreword

Physicians' *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 1992 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. This system of terminology 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.

This volume of CPT is particularly significant in that it presents a new set of codes for evaluation and management services. This new set of codes is necessary to accommodate a number of important changes in the medical practice environment. Experience with the use of these new codes provides strong evidence that this new system will provide greater uniformity, will be easier for physicians to use, and will be flexible enough to accommodate additional medical practice changes for many years.

As with any new system, it is expected that there will be a period of adjustment and continued refinement. This period will require efforts by both physicians and by third party payors to learn and adapt to the concepts inherent in the new system.

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 performed by practicing physicians.

James S. Todd, M.D.
Executive Vice President

November 1, 1991

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Acknowledgements

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Introduction

Physicians' *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 (not on an investigational basis) 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 (99200-99499) 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**.

The section numbers and their sequence are as follows:

EVALUATION AND MANAGEMENT	99200 to 99499
ANESTHESIOLOGY	00100 to 01999, 99100 to 99140
SURGERY	10000 to 69999
RADIOLOGY (INCLUDING NUCLEAR MEDICINE AND DIAGNOSTIC ULTRASOUND)	70000 to 79999
PATHOLOGY AND LABORATORY	80000 to 89999
MEDICINE (except Anesthesiology)	90701 to 99199

The first and last code numbers and the subsection name of the items appear at the top of each page (eg, "20000-20250 Musculoskeletal"). 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

A physician using CPT terminology and coding selects 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. The physician then may list other additional procedures performed or pertinent special services. When necessary, he lists any modifying or extenuating circumstance. **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.

For 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 Physicians' Current Procedural Terminology 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 1992, correspondence should be directed to:

Department of Coding and Nomenclature
American Medical Association
515 North State Street
Chicago, Illinois 60610

All proposed additions to, or modifications of, CPT 1992 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 by the physician. Guidelines also provide explanations regarding terms that apply only to a particular section. For instance, **SURGERY** guidelines provide an explanation of the use of the star, while in **RADIOLOGY,** the unique term, "radiologicial 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.

For 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.

For example:

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

Two surgeons, usually with different skills, may be required to manage a specific surgical problem. The modifier-62 or the alternative modifier five digit code 09962 would be applicable. For instance the first surgeon would report:

21340-62 = Treatment of nasoethmoid complex fracture + two surgeons modifier

OR

21340 AND 09962 = Treatment of nasoethmoid complex fracture + two surgeons modifier

AND the second surgeon would report:

32110-62 = Thoracotomy with traumatic hemorrhage + two surgeons modifier

OR

32110 AND 09962 = Thoracotomy with traumatic hemorrhage + two surgeons modifier

A listing of modifiers pertinent to **EVALUATION AND MANAGEMENT, ANESTHESIA, SURGERY, RADIOLOGY, PATHOLOGY,** and **MEDICINE** are located in the Guidelines of each section. 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 1992 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.

Short Procedure Tape Revision

Appendix C has been included for those users who have purchased a CPT 1991 short procedure description tape or floppy disk or have a tape/disk current through CPT 1991. The listing includes changes and/or corrections necessary to update the CPT 1991 data file. For additional information regarding the availability of CPT magnetic computer tapes and floppy disks, see page xvi of the **INTRODUCTION.**

Alphabetical Reference Index

A complete 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.

Magnetic Computer Tapes and Floppy Disk

CPT 1992 procedure codes and descriptors are also available on magnetic computer tapes in the three formats listed below.

CPT Full Procedure Tape contains the complete procedural text of the CPT manual. The procedures in this tape are constructed of 80-byte line records. In cases where the procedural narrative exceeds the 80-byte line limit, the header record is followed by several trailing line records. The start of each procedure is indicated by a change in "procedure number" or the presence of 01, 02 etc. in the sequence fields.

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 28 characters or less on a single line.

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	800, 1600 or 6250 BPI
content	EBCDIC or ASCII

CPT Floppy Disk is identical in content to the short description tape. That is, each code and description is limited to 28 characters or less on a single line.

Technical Description of Disk

- Standard PC format with a maximum length of 36 characters per record
- Content: ASCII
- PC requirements: IBM PC, XT, AT or compatible
- 5¼″ double side/double density (360K) disk

Using Compatible Software

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.

Order information for the CPT magnetic computer tapes/disk may be found at the back of this book. Questions or suggestions concerning the CPT magnetic computer tapes/disk may be directed to:

Department of Coding and Nomenclature
CPT Magnetic Computer Tapes
American Medical Association
515 N. State Street
Chicago, Illinois 60610

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:

1. **CLASSIFICATION OF EVALUATION AND MANAGEMENT (E/M) SERVICES:** CPT 1992 includes for the first time, a major section devoted entirely to E/M services. The new codes are more than a clarification of the old definitions; they represent a new way of classifying the work of physicians. In particular, they involve far more clinical detail than the old visit codes. For this reason, it is important to treat the new codes as a new system and not make a one-for-one substitution of a new code number for a code number previously used to report a level of service defined as "brief", "limited", "intermediate", etc.

   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 following 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 following.)

2. **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 within the past three years.

An established patient is one who has received professional services from the physician 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.

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 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.

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