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2020

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Contents

Using CPT® Codes

The codes of the *Physicians' Current Procedural Terminology* (CPT®) book constitute procedural and medical service components. The CPT book is in its fourth edition with revisions occurring every year.

The CPT coding system was selected as one of the National Code Sets mandatory for use to facilitate electronic transactions, including health claims, enrollments, eligibility, payment/remittance, and referral authorization. CPT codes are divided into three categories to enhance the use of the CPT system by practicing physicians, managed care and other payer organizations, and researchers. Category I codes refer to the accustomed five-digit numerical system. Category II codes are a set of optional tracking codes, developed principally for performance measurement. The CPT Category III codes are temporary codes to identify new and emerging technologies.

History of CPT

The CPT book is a standardized system of five-digit codes and descriptive terms used to report medical services and procedures performed by physicians. The system was developed and is updated and published annually by the AMA. CPT codes communicate to payers, and in some instances other providers and even patients, the procedures and services performed during a medical encounter.

The AMA published the first edition of the CPT book in 1966 as a companion piece to its Current Medical Terminology (CMT), a manual of preferred medical nomenclature, then in its third edition. The first edition of CPT (5 x 7 inches, 163 pages) contained a listing of four-digit codes and brief descriptions to report a full range of medical procedures and services. Each code was cross-referenced to then-available diagnostic codes: the *Standard Nomenclature of Diseases and Operations* (SNDO) and the *International Classification of Diseases, Adapted* (ICDA).

Editors of the first edition cited a variety of sources in developing the work, including the Social Security Administration, the Blue Shield Manual of Statistical Requirements, and the Relative Value Studies of the California Medical Society. The four-digit codes do not approximate those of today's CPT. The task of modifying them to the present format was reserved for the editors of the second edition, published in 1970.

The 1970 edition of the CPT book marks the genesis of the coding manual familiar to today's medical office workers. Many of the 1970 edition's five-digit codes and expanded descriptions in this work remain unchanged. The number of coded procedures far exceeds those available to users of the first edition and guidelines to the various sections appeared for the first time. The second edition was developed with assistance from a handful of members of medical professional societies, a practice that would evolve into the near 150-member CPT Advisory Committee, and representatives from 18 organizations comprising the Health Care Professionals Advisory Committee (HCPAC) currently listed in CPT 2018.

The third edition of the CPT book published in 1973 offered new features, such as alphabetic modifiers and starred procedures marked by an asterisk. Deleted codes (but not new codes) could be found in an appendix. This edition also saw the medical codes moved to the front of the code listings, a benchmark that would stand for almost 20 years until the introduction of the evaluation and management (E/M) codes in 1992.

The fourth edition of the CPT book was originally published in 1977. This edition began the custom of significant yearly revisions, usually concentrated on a limited number of sections. Since then, medical office coders have made an annual ritual of anticipating the code changes and the related effects on coding and billing habits for their practices.

The CPT Book Conventions

The CPT book is self-referencing. Its introductory material provides information about its rules, format, and guidelines. The introduction to the CPT book should be carefully studied at least once by medical coders and reviewed annually for changes. Classes and correspondence courses teach medical coding and several introductory coding books convey the CPT book fundamentals. Additionally, the AMA and private consultants sponsor coding seminars to discuss changes and methods to implement these changes into regular coding practice.

The heart of this chapter is a glossary of the CPT book terminology. Consult these listings as needed to solve procedural coding problems. However, a brief primer to conventions, rules, and anomalies is presented below.

The six major sections of Category 1 codes in the CPT book are:

- Evaluation and Management (E/M)
- Anesthesiology
- Surgery

Gonin's operation
67107 Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), including, when performed, implant, cryotherapy, photocoagulation, and drainage of subretinal fluid

Thermocautery of the fissure of a detached retina is performed through an incision in the sclera.

Graefe's operation
66830 Removal of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid) with corneo-scleral section, with or without iridectomy (iridocapsulotomy, iridocapsulectomy)

Cataracts are corrected by removing the lens, lacerating the capsule, and performing an iridectomy via the sclera.

Grice arthrodesis
28725 Arthrodesis; subtalar

Bone graft is planted in the lateral part of the subtalar joint.

Gritti-stokes amputation
27590 Amputation, thigh, through femur, any level;

Supracondylar amputation of the femur is performed with the patella placed as a cap on the amputated end.

Guthrie test
84030 Phenylalanine (PKU), blood

Bacterial inhibition assay measures serum phenylalanine. It is in widespread use for detection of phenylketonuria in newborns.

Halsted mastectomy
19305 Mastectomy, radical, including pectoral muscles, axillary lymph nodes

Radical mastectomy, which includes removal of the breast along with the pectoral minor muscle.

Ham test
85475 Hemolysin, acid

Laboratory test that checks for acidified serum.

Harii procedure
25430 Insertion of vascular pedicle into carpal bone (eg, Hori procedure)

Procedure involves complex repair of an injury that affects the dorsal skin, subcutaneous fat, including the nerves and blood vessels, and the covering immediately adjacent to the tendon.

Hartley-Krause operatoin
61450 Craniectomy, subtemporal, for section, compression, or decompression of sensory root of gasserian ganglion

Gasserian ganglion is removed to relieve trigeminal neuralgia.

Hartmann procedure
44143 Colectomy, partial; with end colostomy and closure of distal segment (Hartmann type procedure)

44206 Laparoscopy, surgical; colectomy, partial, with end colostomy and closure of distal segment (Hartmann type procedure)

The lower part of the sigmoid colon and/or the upper part of the rectum is excised. The descending colon is manipulated and sutured to the skin to create a colostomy. The proximal end of the descending colon is oversewn and a pouch is formed.

Heaf test
86580 Skin test; tuberculosis, intradermal

Laboratory test that checks for tuberculin antibodies.

Heine's operation
66700 Ciliary body destruction; diathermy

Procedure in which the ciliary body is destroyed to relieve glaucoma.

Hibbs' fusion
22610 Arthrodesis, posterior or posterolateral technique, single level; thoracic (with lateral transverse technique, when performed)

22612 Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)

22614 Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)

Intentional fracture of the spinous processes and pressing each tip downward to rest in the fractured area of the process below it.

Hicks-Pitney test
85730 Thromboplastin time, partial (PTT); plasma or whole blood

Thromboplastin generation test that measures the efficiency of plasma in forming thromboplastin.

Holten test
82575 Creatinine; clearance

Creatines are used to test renal efficiency.

CPT® Lay Descriptions

CPT® descriptions are written for people with medical training but may not offer the details needed to choose a code based on a patient's chart or an operative report. The following overview of the procedures listed in CPT describes the most common methods of each in general terms. Where possible, descriptions are in lay terms for coders' use. Key words used in the operative report are included to facilitate coding.

Unlisted procedures are excluded from this chapter. Be aware insurance payers usually review unlisted procedure codes manually, increasing processing time and the need for documentation.

Because some consecutive codes describe similar procedures, their descriptions have been combined under one heading, which indicates the range of codes described. If a satisfactory code description cannot be matched with the patient's chart, consult the physician.

Integumentary

10021-10022

Fine needle aspiration (FNA) is a percutaneous procedure that uses a fine gauge needle (often 22 or 25 gauge) and a syringe to sample fluid from a cyst or remove clusters of cells from a solid mass. First, the skin is cleansed. If a lump can be felt, the radiologist or surgeon guides a needle into the area by palpating the lump. If the lump is non-palpable, the FNA procedure is performed under image guidance using fluoroscopy, ultrasound, or computed tomography (CT), with the patient positioned according to the area of concern. In fluoroscopic guidance, intermittent fluoroscopy guides the advancement of the needle.
Ultrasonography-guided aspiration biopsy involves inserting an aspiration catheter needle device through the accessory channel port of the echoendoscope; the needle is placed into the area to be sampled under endoscopic ultrasonographic guidance. After the needle is placed into the region of the lesion, a vacuum is created and multiple in and out needle motions are performed. Several needle insertions are usually required to ensure that an adequate tissue sample is taken. CT image guidance allows computer-assisted targeting of the area to be sampled. At the completion of the procedure, the needle is withdrawn and a small bandage is placed over the area. Report 10021 if fine needle aspiration is performed without imaging guidance. Report 10022 if imaging guidance is used to assist in locating the lump.

10030

A fluid collection in the soft tissue, such as a hematoma, seroma, abscess, lymphocele, or cyst, is drained using a catheter. The area over the abnormal tissue is cleansed and local anesthesia is administered. Imaging is performed to assist in the insertion of a needle or guidewire into the fluid collection. Small tissue samples may be collected from the site for pathological examination. A catheter is inserted to drain and collect the fluid for analysis. More imaging may be performed to ensure hemostasis. In some cases, the catheter may be attached to a drainage system to allow for further drainage over the course of days. Once the fluid has completely drained, the catheter is removed. A bandage is applied. Report 10030 for each fluid collection drained using a separate catheter.

10035-10036

The physician places a soft tissue localization device prior to a biopsy. Using image guidance, the physician places a metallic clip, pellet, wire, needle, or radioactive seed adjacent to a soft tissue lesion to mark the site for an open soft tissue procedure or a percutaneous soft tissue biopsy to be performed during the same or a different encounter. Report 10035 for the first lesion and 10036 for each additional lesion marked using imaging guidance.

10040

The physician makes a small incision through the skin overlying a lesion, or multiple lesions, such as comedones (blackheads), cysts, or pustules for acne surgery. The skin over the lesion is removed. The lesion is opened with a surgical instrument and the fluid is drained for secondary healing. The lesion may be removed or marsupialized by exteriorizing the cyst and making a pouch where it used to be enclosed. No sutures are needed. Do not bill a benign lesion excision code (11400-11446) and chemical exfoliation for acne (17360) on same date of service with 10040.

10060-10061

The physician makes a small incision through the skin overlying an abscess for incision and drainage (e.g., carbuncle, cyst, furuncle, paronychia, hidradenitis). The abscess or cyst is opened with a surgical instrument, allowing the contents to drain. The lesion may be curetted and irrigated. The physician leaves the surgical wound open to allow for continued drainage or the physician may place a Penrose latex drain or gauze strip packing to allow continued drainage. Report 10060 for incision and drainage of a simple or single abscess. Report 10061 for complex or multiple cysts. Complex or multiple cysts may require surgical closure at a later date.

10080-10081

The physician incises and drains a pilonidal cyst. A pilonidal cyst is an abnormal pocket in the skin and subcutaneous tissue that may contain hair follicles,