

CPT Coding

Chapter 9 Introduction to CPT Coding

Introduction

- Introduces the CPT coding system or HCPCS Level I, a proprietary coding system published annually by the AMA.
- CPT is a listing of descriptive terms and identifying codes for reporting medical services and procedures.
- It provides a uniform language that describes medical, surgical, and diagnostic services to facilitate communication among providers, patients, and 3rd party payers.

History of CPT

- The AMA first published CPT in 1966, and subsequent editions expanded its descriptive terms and codes for diagnostic and therapeutic procedures.
- Five-digit codes were introduced in 1970, replacing the four-digit classification.
- Its use was mandated for reporting Medicare Part B physician services.
- In 1986, HCPCS was required for reporting to Medicaid agencies, and the Omnibus Budget Reconciliation Act (OBRA) of 1986 mandated that CPT codes be reported for outpatient hospital surgical procedures.
- HIPAA of 1996 named CPT and HCPCS Level II as the procedure code sets for physician services, physical and occupational therapy services, radiological procedures, clinical laboratory tests, other medical diagnostic procedures, hearing and vision services, and transportation services including ambulance.
- CMS required that new, revised and deleted CPT codes be implemented each January 1.
 - If outdated codes are submitted on claims, providers and health care facilities will incur administrative costs associated with resubmitting corrected claims and delayed reimbursement for services provided.

Overview of CPT

- CPT codes are used to report services and procedures performed on patients by the the following types of providers:
 - Home health care and hospice agencies
 - Outpatient hospital departments
 - Physicians who are employees of a health care facility
 - Physicians who see patients in their offices or clinics and in other health care settings.
- CPT codes and descriptions are based on consistency with contemporary medical practice and are performed by clinical providers throughout the country.
- Assignment of CPT codes simplifies reporting and assists in the accurate identification of procedures and services for 3rd party payer consideration
- Procedures and services reported on a claim must be linked to ICD-10-CM code that justifies the need for the service or procedure. This demonstrates medical necessity for the service or procedure provided so the payer can judge whether the claim should be paid
- When reporting Cpt does, some services are considered integral to the standard of practice, which means that certain medical and surgical services are not assigned CPT codes. Such services including the following:

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Table of Contents Cpt Chapter Wise Notes

1. Understanding the eBook Cpt Chapter Wise Notes
 - The Rise of Digital Reading Cpt Chapter Wise Notes
 - Advantages of eBooks Over Traditional Books
2. Identifying Cpt Chapter Wise Notes
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Cpt Chapter Wise Notes
 - User-Friendly Interface
4. Exploring eBook Recommendations from Cpt Chapter Wise Notes
 - Personalized Recommendations

- Cpt Chapter Wise Notes User Reviews and Ratings
- Cpt Chapter Wise Notes and Bestseller Lists
- 5. Accessing Cpt Chapter Wise Notes Free and Paid eBooks
 - Cpt Chapter Wise Notes Public Domain eBooks
 - Cpt Chapter Wise Notes eBook Subscription Services
 - Cpt Chapter Wise Notes Budget-Friendly Options
- 6. Navigating Cpt Chapter Wise Notes eBook Formats
 - ePub, PDF, MOBI, and More
 - Cpt Chapter Wise Notes Compatibility with Devices
 - Cpt Chapter Wise Notes Enhanced eBook Features
- 7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Cpt Chapter Wise Notes
 - Highlighting and Note-Taking Cpt Chapter Wise Notes
 - Interactive Elements Cpt Chapter Wise Notes
- 8. Staying Engaged with Cpt Chapter Wise Notes
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Cpt Chapter Wise Notes
- 9. Balancing eBooks and Physical Books Cpt Chapter Wise Notes
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Cpt Chapter Wise Notes
- 10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
- 11. Cultivating a Reading Routine Cpt Chapter Wise Notes
 - Setting Reading Goals Cpt Chapter Wise Notes
 - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Cpt Chapter Wise Notes
 - Fact-Checking eBook Content of Cpt Chapter Wise Notes

- Distinguishing Credible Sources
- 13. Promoting Lifelong Learning
 - Utilizing eBooks for Skill Development
 - Exploring Educational eBooks
- 14. Embracing eBook Trends
 - Integration of Multimedia Elements
 - Interactive and Gamified eBooks

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