CPT® purpose & mission

The language of medicine today

The CPT® coding system offers doctors across the country a uniform process for coding medical services that streamlines reporting and increases accuracy and efficiency. For more than 5 decades, physicians and other health care professionals have relied on CPT to communicate with colleagues, patients, hospitals and insurers about the procedures they have performed.

CPT descriptive terms and identifying codes currently serve a wide variety of important functions. This system of terminology is the most widely accepted medical nomenclature used to report medical procedures and services under public and private health insurance programs. CPT is also used for administrative management purposes such as claims processing and developing guidelines for medical care review.

The uniform language is also applicable to medical education and research by providing a useful basis for local, regional and national utilization comparisons.

Role of the CPT® Editorial Panel

The CPT Editorial Panel is tasked with ensuring that CPT codes remain up to date and reflect the latest medical care provided to patients. In order to do this, the panel maintains an open process and convenes meetings 3 times per year to solicit the direct input of practicing physicians, medical device manufacturers, developers of the latest diagnostic tests and advisors from over 100 societies representing physicians and other qualified health care professionals.

The group has the final authority to decide on assigning a code’s category, whether it is a Category I or Category III.

Development of the CPT code

URL: https://www.ama-assn.org/about/cpt-editorial-panel/cpt-purpose-mission
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The AMA first developed and published CPT in 1966. The 1st edition helped encourage the use of standard terms and descriptors to document procedures in the medical record, helped communicate accurate information on procedures and services to agencies concerned with insurance claims, provided the basis for a computer oriented system to evaluate operative procedures and contributed basic information for actuarial and statistical purposes.

The 1st edition of CPT contained primarily surgical procedures, with limited sections on medicine, radiology and laboratory procedures. The 2nd edition was published in 1970 and presented an expanded system of terms and codes to designate diagnostic and therapeutic procedures in surgery, medicine and the specialties. At that time, a 5-digit coding system was introduced, replacing the former 4-digit classification. Another significant change was a listing of procedures relating to internal medicine.

In the mid to late 1970s, the 3rd and 4th editions of CPT were introduced. The 4th edition, published in 1977, represented significant updates in medical technology, and a system of periodic updating was introduced to keep pace with the rapidly changing medical environment. In 1983 CPT was adopted as part of the Centers for Medicare & Medicaid Services (CMS), formerly Health Care Financing Administration’s (HCFA), Healthcare Common Procedure Coding System (HCPCS). With this adoption, CMS mandated the use of HCPCS to report services for Part B of the Medicare Program. In October 1986, CMS also required state Medicaid agencies to use HCPCS in the Medicaid Management Information System. In 2000, the CPT code set was designated by the Department of Health and Human Services as the national coding standard for physician and other health care professional services and procedures under the Health Insurance Portability and Accountability Act (HIPAA).

Today, in addition to use in federal programs (Medicare and Medicaid), CPT is used extensively throughout the United States as the preferred system of coding and describing health care services.

HIPAA and CPT

The Administrative Simplification Section of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires the Department of Health and Human Services to name national standards for electronic transaction of health care information. This includes transactions and code sets, national provider identifier, national employer identifier, security and privacy. The Final Rule for transactions and code sets was issued on Aug. 17, 2000. The rule names CPT (including codes and modifiers) and HCPCS as the procedure code set for:

- Physician services
- Physical and occupational therapy services
Radiological procedures
Clinical laboratory tests
Other medical diagnostic procedures
Hearing and vision services
Transportation services including ambulance

The Final Rule also named ICD-10 volumes 1 and 2 as the code set for diagnosis codes, ICD-10-CM volume 3 for inpatient hospital services, CDT for dental services and NDC codes for drugs.

All health care plans and providers who transmit information electronically were required to use established national standards by the end of the implementation period, Oct. 16, 2003. In addition, all local codes were eliminated and national standard code sets were required for use after Oct. 16, 2003.

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