



cpt[®] 2026

PROFESSIONAL EDITION

The only official CPT[®] codebook with rules and guidelines
from the AMA's CPT Editorial Panel.

AMA publications fund initiatives that drive improvements in
patient health, practice innovation and medical education.

Symbols

▲	Revised code
●	New code
↔	New or revised text
⇒	Reference to <i>CPT Assistant</i> , <i>Clinical Examples in Radiology</i> , and <i>CPT Changes</i>
+	Add-on code
⊖	Modifier 51 exempt
⚡	Product pending FDA approval
#	Resequenced code
★	Telemedicine
🎧	Audio-only
⌘	Duplicate PLA test

Modifiers (See [Appendix A](#) for definitions)

22	Increased Procedural Services
23	Unusual Anesthesia
24	Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period
25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service
26	Professional Component
32	Mandated Services
33	Preventive Services
47	Anesthesia by Surgeon
50	Bilateral Procedure
51	Multiple Procedures
52	Reduced Services
53	Discontinued Procedure
54	Surgical Care Only
55	Postoperative Management Only
56	Preoperative Management Only
57	Decision for Surgery
58	Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
59	Distinct Procedural Service
62	Two Surgeons
63	Procedure Performed on Infants less than 4 kg
66	Surgical Team
76	Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional
77	Repeat Procedure by Another Physician or Other Qualified Health Care Professional
78	Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period
79	Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
80	Assistant Surgeon
81	Minimum Assistant Surgeon
82	Assistant Surgeon (when qualified resident surgeon not available)
90	Reference (Outside) Laboratory
91	Repeat Clinical Diagnostic Laboratory Test
92	Alternative Laboratory Platform Testing
93	Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System
95	Synchronous Telemedicine Service Rendered via a Real-Time Interactive Audio and Video Telecommunications System
96	Habilitative Services
97	Rehabilitative Services
99	Multiple Modifiers

Category II Modifiers

1P	Performance Measure Exclusion Modifier due to Medical Reasons
2P	Performance Measure Exclusion Modifier due to Patient Reasons
3P	Performance Measure Exclusion Modifier due to System Reasons

8P Performance measure reporting modifier—action not performed, reason not otherwise specified

Anesthesia Physical Status Modifiers

- P1** A normal healthy patient
- P2** A patient with mild systemic disease
- P3** A patient with severe systemic disease
- P4** A patient with severe systemic disease that is a constant threat to life
- P5** A moribund patient who is not expected to survive without the operation
- P6** A declared brain-dead patient whose organs are being removed for donor purposes

Modifiers Approved for Hospital Outpatient Use

Level I (CPT)

- 25** Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service
- 27** Multiple Outpatient Hospital E/M Encounters on the Same Date
- 33** Preventive Services
- 50** Bilateral Procedure
- 52** Reduced Services
- 58** Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
- 59** Distinct Procedural Service
- 73** Discontinued Outpatient Procedure Prior to Anesthesia Administration
- 74** Discontinued Outpatient Procedure After Anesthesia Administration
- 76** Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional
- 77** Repeat Procedure by Another Physician or Other Qualified Health Care Professional
- 78** Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period
- 79** Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
- 91** Repeat Clinical Diagnostic Laboratory Test

Level II (HCPCS/National)

- E1** Upper left, eyelid
- E2** Lower left, eyelid
- E3** Upper right, eyelid
- E4** Lower right, eyelid
- FA** Left hand, thumb
- F1** Left hand, second digit
- F2** Left hand, third digit
- F3** Left hand, fourth digit
- F4** Left hand, fifth digit
- F5** Right hand, thumb
- F6** Right hand, second digit
- F7** Right hand, third digit
- F8** Right hand, fourth digit
- F9** Right hand, fifth digit
- GG** Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day
- GH** Diagnostic mammogram converted from screening mammogram on same day
- LC** Left circumflex coronary artery
- LD** Left anterior descending coronary artery
- LM** Left main coronary artery
- LT** Left side (used to identify procedures performed on the left side of the body)
- QM** Ambulance service provided under arrangement by a provider of services
- QN** Ambulance service furnished directly by a provider of services
- RC** Right coronary artery
- RI** Ramus intermedius coronary artery
- RT** Right side (used to identify procedures performed on the right side of the body)
- TA** Left foot, great toe
- T1** Left foot, second digit
- T2** Left foot, third digit
- T3** Left foot, fourth digit
- T4** Left foot, fifth digit
- T5** Right foot, great toe
- T6** Right foot, second digit
- T7** Right foot, third digit
- T8** Right foot, fourth digit
- T9** Right foot, fifth digit



Place-of-Service Codes for Professional Claims

Listed below are place-of-service codes and descriptions. These codes should be used on professional claims to specify the entity where service(s) were rendered. Check with individual payers (eg, Medicare, Medicaid, other private insurance) for reimbursement policies regarding these codes. If you would like to comment on a code(s) or description(s), please send your request to posrequest@cms.hhs.gov.

Place of Service Code(s)	Place of Service Name	Place of Service Description
01	Pharmacy	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients. (Effective 10/1/03)
02	Telehealth Provided Other than in Patient's Home	The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health-related services through telecommunication technology. (Effective 1/1/17)
03	School	A facility whose primary purpose is education. (Effective 1/1/03)
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (eg, emergency shelters, individual or family shelters). (Effective 1/1/03)
05	Indian Health Service Free-Standing Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization. (Effective 1/1/03)
06	Indian Health Service Provider-Based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients. (Effective 1/1/03)
07	Tribal 638 Free-Standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization. (Effective 1/1/03)
08	Tribal 638 Provider-Based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients. (Effective 1/1/03)
09	Prison/Correctional Facility	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State, or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders. (Effective 7/1/06)
10	Telehealth Provided in Patient's Home	The location where health services and health related services are provided or received, through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient

		receives care in a private residence) when receiving health services or health related services through telecommunication technology. (Effective 1/1/22)
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services. (Effective 10/1/03)
14	Group Home	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (eg, medication administration). (Effective 10/1/03)
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services. (Effective 1/1/03)
16	Temporary Lodging	A short term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code. (Effective 1/1/08)
17	Walk-in Retail Health Clinic	A walk-in health clinic, other than an office, urgent care facility, pharmacy, or independent clinic, and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services. (Effective 5/1/10)
18	Place of Employment/Worksite	A location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic or rehabilitative services to the individual. (This code is available for use effective January 1, 2013 but no later than May 1, 2013.)
19	Off Campus— Outpatient Hospital	A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Effective January 1, 2016)
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention. (Effective 1/1/03)
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	On Campus— Outpatient Hospital	A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Description change effective January 1, 2016)
23	Emergency Room— Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A free-standing facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of newborn infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service

		(USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
27	Outreach Site/Street	A non-permanent location on the street or found environment, not described by any other POS code, where health professionals provide preventive, screening, diagnostic, and/or treatment services to unsheltered homeless individuals. (Effective October 1, 2023)
28-30	Unassigned	N/A
31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than individuals with intellectual disabilities.
33	Custodial Care Facility	A facility that provides room, board, and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35-40	Unassigned	N/A
41	Ambulance—Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance— Air or Water	An air or water vehicle specifically designed, equipped, and staffed for lifesaving and transporting the sick or injured.
43-48	Unassigned	N/A
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only. (Effective 10/1/03)
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility— Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community Mental Health Center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate Care Facility/Individuals with Intellectual Disabilities	A facility which primarily provides health-related care and services above the level of custodial care to individuals with intellectual disabilities but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric	A facility or distinct part of a facility for psychiatric care which provides a total

	Residential Treatment Center	24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing. (Effective 10/1/03)
58	Non-residential Opioid Treatment Facility	A location that provides treatment for opioid use disorder on an ambulatory basis. Services include methadone and other forms of Medication Assisted Treatment (MAT). (Effective January 1, 2020)
59	Unassigned	N/A
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63-64	Unassigned	N/A
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66	Programs of All-Inclusive Care for the Elderly (PACE) Center	A facility or location providing comprehensive medical and social services as part of the Programs of All-Inclusive Care for the Elderly (PACE). This includes, but is not limited to, primary care; social work services; restorative therapies, including physical and occupational therapy; personal care and supportive services; nutritional counseling; recreational therapy; and meals when the individual is enrolled in PACE. (Effective August 1, 2024)
67-70	Unassigned	N/A
71	Public Health Clinic	A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
73-80	Unassigned	N/A
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82-98	Unassigned	N/A
99	Other Place of Service	Other place of service not identified above.

current procedural terminology

cpt[®] 2026

Professional Edition

Current CPT Editorial Panel

Christopher L. Jagmin, MD, FAAFP*, *Chair*
Barbara S. Levy, MD, FACOG*, *Vice Chair*
Samantha L. Ashley, MS, Secretary
Sarah M. Abshier, DPM
J. Mark Bailey, DO, PhD, FACN
Aaron D. Bossler, MD, PhD
Leo J. Bronston, DC, MAppSc
Joseph S. Cheng, MD
Samuel L. Church, MD, MPH, CPC-I, FAAFP*
Scott A.B. Collins, MD, FAAD, FACMS
Richard A. Frank, MD, PhD
Padma Gulur, MD
Daniel A. Halevy, MD, FASN, CPC
Steven C. Hao, MD, FACC, FHRS
Michael O. Idowu, MD, MPH

Kathy Y. Jones, MD
David M. Kanter, MD, MBA, CPC, FAAP
Janet L. McCauley, MD, MHA, CPC, FACOG
Daniel J. Nagle, MD, FACS, FAAOS
Daniel Picus, MD, FACR, RCC*[†]
Rahul Seth, DO
Lawrence M. Simon, MD, MBA, FACS*
Timothy L. Swan, MD, FACR, FSIR*



*Member of the CPT Executive Committee

[†]Former CPT Editorial Panel Member, who was active during 2026 content creation

About CPT

Current Procedural Terminology (CPT[®]), Fourth Edition, is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and other qualified health care professionals. 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 and other qualified health care professionals, patients, and third parties. CPT 2026 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. The CPT code set is useful for administrative management purposes such as claims processing and for the development of guidelines for medical care review. The uniform language is also applicable to medical education and outcomes, health services, and quality research by providing a useful basis for local, regional, and national utilization comparisons. The CPT code set is the most widely accepted nomenclature for the reporting of physician and other qualified health care professional procedures and services under government and private health insurance programs. 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). This means that for all financial and administrative health care transactions sent electronically, the CPT code set will need to be used.

The changes that appear in this revision have been prepared by the CPT Editorial Panel with the assistance of physicians and representatives of other health care professions representing all specialties of medicine, and with important contributions from many third-party payers 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.

Maintenance and Authorship of the CPT Code Set

The CPT Editorial Panel (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 at a minimum three times per year.

The Panel wishes to sincerely thank the many national medical specialty societies, health insurance organizations and agencies, and individual physicians and other health professionals who have made contributions. In particular, the Panel acknowledges the efforts of the following Panel Organizational and Coding Liaison Participants:

Sue Bowman, RHIA, *American Health Information Management Association*

Edith Hambrick, MD, JD, MPH, *Centers for Medicare & Medicaid Services*

Raemarie Jimenez, CPC, *American Academy of Professional Coders*

Douglas Kelly, MD, *Food and Drug Administration*

Mary E. Little, RN, CPC, *Blue Cross and Blue Shield Association*

Tammy R. Love, RHIA, CCS, CDIP, CMA, *American Hospital Association*

Lori Moore, PharmD, *Centers for Disease Control and Prevention*

The AMA CPT staff is also key to authorship of the code set and resulting CPT Professional Edition codebook. This experienced team prepares agenda materials for each panel meeting, facilitates the application process, compiles, and reviews advisor comments, reconciles differences in opinions, and ultimately compiles all resulting information into a codebook filled with informative guidelines, practical tips, and procedural illustrations.

AMA CPT Staff

Shawn Agyeman
Samantha L. Ashley, MS
Thilani Attale, MS
Jennifer Bell, BS, RHIT, CPC, CPMA, CPC-I, CEMC, CPEDC
Barbara Benstead
Andrei Besleaga, BS, RHIT
Kemi Borokini, MSHI, RHIA, CCS
Kyle Dahl
Becky Dolan, MPH
Martha Espronceda
Desiree D. Evans, BS
Kerri Fei, MSN, RN
DeHandro Hayden, BS
Jennifer Hernandez, MBA, CCS-P, CRC, CRC-I
Tamesia M. Hill, MPA, CPC, CPB, CPC-I
Zach Hochstetler, MPP, MBA, CPC
Mark Levine
Charniece J. Martin, MBA, RHIA, CCS, CCS-P
Caitlin Mora
Sara F. Nakira, BS
Karen E. O'Hara, BS
Leslie W. Prellwitz, MBA, CCS, CCS-P
Diane J. Regets, BS, RHIA
Desiree Rozell, MPA
Miroslava Rudneva, MS, RHIT, CCS, CRC, COBGC
Lianne Stancik, BA, RHIT
Keisha A. Sutton-Asaya, MHA, CPC
Okwara Uzoh
Ada Walker, CCA
Arletrice Watkins, MHA, RHIA
Chad Whitney
Rejina L. Young

AMA CPT Advisory Committee

American Academy of Child & Adolescent Psychiatry

Benjamin N. Shain, MD, PhD

Morgan Fallor, MD

American Academy of Dermatology

Alexander Miller, MD

Ann F. Haas, MD

American Academy of Family Physicians

Mary Krebs, MD

Michael Hanak, MD

American Academy of Neurology

Neil A. Busis, MD

Raissa Villanueva, MD

American Academy of Ophthalmology

Michael X. Repka, MD, MBA

John M. Haley, MD

American Academy of Orthopaedic Surgeons

Frank R. Voss, MD

Julie Y. Bishop, MD

American Academy of Otolaryngology Head and Neck Surgery

James Lin, MD, FACS

Jay R. Shah, MD

American Academy of Pain Medicine

Joseph Maxwell Hendrix, MD

Eduardo M. Fraifeld, MD

American Academy of Pediatrics

Renee F. Slade, MD

Kathryn Lalor, MD

American Academy of Physical Medicine and Rehabilitation

Joseph P. Shivers, MD

Antigone Argyiou, MD

American Academy of Sleep Medicine

Lawrence J. Epstein, MD

Vikas Jain, MD, FAASM

American Association for Thoracic Surgery

Scott C. Silvestry, MD

Charles C. Canver, MD

American Association of Clinical Endocrinologists

William C. Biggs, MD, FACE, ECNU

Pavan Chava, DO, FACE

American Association of Clinical Urologists

Jeffery Glaser, MD, FACS

American Association of Neurological Surgeons

Cheerga Upadhyaya, MD

Joshua M. Rosenow, MD, FAANS, FACS

American Association of Neuromuscular and Electrodiagnostic Medicine

Earl J. Craig, MD

John C. Kincaid, MD

American Clinical Neurophysiology Society

Marc R. Nuwer, MD, PhD, FAAN, FACP

Eva Ritzl, MD

American College of Allergy, Asthma and Immunology

James L. Sublett, MD

Gary N. Gross, MD

American College of Cardiology

Randall C. Thompson, MD

Barbara Pisani, DO, FAHA, FACC

American College of Chest Physicians

Steve G. Peters, MD

Michael E. Nelson, MD, FCCP

American College of Emergency Physicians

J. Mark Meredith, III, MD, MMM, FACEP

Michael J. Lemanski, MD, FACEP, FAAFP

American College of Lifestyle Medicine

Vinita Magoon, DO, JD, MBA, MPH[‡]

American College of Gastroenterology

Christopher Y. Kim, MD, MBA, FACG, FASGE, AGAF, FACP

American College of Medical Genetics and Genomics
David B. Flannery, MD

American College of Mohs Surgery
David B. Pharis, MD, PC
Kishwer S. Nehal, MD

American College of Nuclear Medicine
Gary L. Dillehay, MD, FACNP, FACR
Alan K. Klitzke, MD, FACNM

American College of Obstetricians and Gynecologists
Judith Volkar, MD, MBA
Lisa Hofler, MD

American College of Physicians
Jeannine Z. Engel, MD, FACP
Shreya P. Chandra, MD[‡]

American College of Radiation Oncology
Tarita Thomas, MD, PhD[‡]
Salah Dajani, MD

American College of Radiology
Eric M. Rubin, MD[‡]
Timothy A. Crummy, MD, RCC

American College of Rheumatology
Joseph E. Huffstutter, MD

American College of Surgeons
Megan E. McNally, MD, FACS
Jayme Lieberman, MD, FACS

American Dental Association
Joshua E. Everts, DDS, MD
Adam S. Pitts, DDS, MD

American Gastroenterological Association
Braden Kuo, MD
Joseph Losurdo, MD

American Geriatrics Society
Robert A. Zorowitz, MD, MBA, FACP, AGSF, CMD

American Orthopaedic Association
M. Bradford Henley, MD
Adam Levin, MD

American Orthopaedic Foot and Ankle Society

John A. DiPreta, MD

Andrew Hsu, MD

American Osteopathic Association

Philip Eskew, DO, JD[‡]

Auguste Niyibizi, DO[‡]

American Psychiatric Association

Carlene MacMillan, MD[‡]

Sarah E. Parsons, MD

American Rhinologic Society

Bradford Woodworth, MD

Stacey T. Gray, MD

American Roentgen Ray Society

Mark D. Alson, MD, FACR, RCC[‡]

Benjamin E. Northrup, MD[‡]

American Society for Clinical Pathology

Lee H. Hilborne, MD, MPH, FASCP

American Society for Dermatologic Surgery

Murad Alam, MD, MBA

Ian A. Maher, MD

American Society for Gastrointestinal Endoscopy

Glenn D. Littenberg, MD, MACP

Edward Sun, MD

American Society for Metabolic and Bariatric Surgery

Joseph Northup, MD

American Society for Radiation Oncology

Catheryn M. Yashar, MD

Anita Mahajan, MD

American Society for Surgery of the Hand

Steven H Goldberg, MD

Thomas D. Kaplan, MD

American Society of Addiction Medicine

Joel V. Brill, MD, FACP, AGAF

American Society of Anesthesiologists

Edward R. Mariano, MD

Rene Przkora, MD

American Society of Breast Surgeons

Richard E. Fine, MD, FACS

Walton Taylor, MD

American Society of Clinical Oncology

Joseph J. Merchant, MD

American Society of Colon and Rectal Surgeons

Eric Weiss, MD

Joshua M. Eberhardt, MD, MBA, FACS, FASCRS

American Society of Cytopathology

Renu K. Virk, MD[‡]

American Society of Dermatopathology

Jonathan S. Ralston, MD

Aleodor A. Andea, MD, MBA

American Society of Echocardiography

Michael L. Main, MD

Vera M. Rigolin, MD[‡]

American Society of General Surgeons

George K. Gillian, MD, FACS

American Society of Hematology

Chancellor E. Donald, MD

American Society of Interventional Pain Physicians

Mahendra Sanapati, MD

Sheri Albers, DO

American Society of Neuroimaging

Ryan Hakimi, DO, MS

American Society of Neuroradiology

Colin M. Segovis, MD, PhD

Gaurang V. Shah, MD

American Society of Nuclear Cardiology

Friederike Keating, MD

American Society of Ophthalmic Plastic and Reconstructive Surgery

L. Neal Freeman, MD, MBA, CCS-P, FACS

American Society of Plastic Surgeons

Jeffrey H. Kozlow, MD, MS

David Schnur, MD

American Society of Regional Anesthesia and Pain Medicine

Houman Danesh, MD

Kevin King, DO, MBA[‡]

American Society of Retina Specialists

Gayatri S. Reilly, MD

Christopher R. Henry, MD

American Thoracic Society

Stephen P. Hoffmann, MD

Michael E. Nelson, MD, FCCP

American Urological Association

Jonathan N. Rubenstein, MD

Jay A. Motola, MD, FACS

American Vein & Lymphatic Society

Satish Vayuvegula, MD, MS

Michael S. Graves, MD

Association for Molecular Pathology

Samuel K. Caughron, MD, FCAP

Association of University Radiologists

Shiva Gupta, MD

Christina Marks, MD

College of American Pathologists

Ronald W. McLawhon, MD, PhD

Mark Synovec, MD

Congress of Neurological Surgeons

Henry H. Woo, MD, FACS, FAANS

Heart Rhythm Society

Christopher F. Liu, MD, FACC, FHRS

Sumeet Mainigi, MD

Infectious Diseases Society of America

Ronald E. Devine, MD

Jo-Anne S. Klein, MD[‡]

International Pain and Spine Intervention Society

Scott I. Horn, DO

Yusef Sayeed, MD[‡]

International Society for the Advancement of Spine Surgery

James J. Yue, MD

Morgan L. Lorio, MD, FACS

North American Neuromodulation Society

Corey W. Hunter, MD

Dawood Sayed, MD

North American Spine Society

David Cohen, MD

William J. Sullivan, MD[‡]

Outpatient Endovascular and Interventional Society

Eric J. Dippel, MD

Radiological Society of North America

Timothy A. Crummy, MD

Cindy Yuan, MD

Renal Physicians Association

Timothy A. Pflederer, MD

Jeffrey Perlmutter, MD

Society for Cardiovascular Angiography and Interventions

Andrew M. Goldsweig, MD

Osama A. Ibrahim, MD[‡]

Society for Investigative Dermatology

Yvonne E. Chiu, MD[‡]

Society for Vascular Surgery

Sean P. Roddy, MD, FACS

Sunita D. Srivastava, MD

Society of American Gastrointestinal Endoscopic Surgeons

John S. Roth, MD, FACS

Kevin E. Wasco, MD, FACS

Society of Cardiovascular Computed Tomography

Ahmad M. Slim, MD

Society of Critical Care Medicine

Piyush Mathur, MD

Society of Interventional Radiology

Ashok Bhanushali, MD

Julie C. Bulman, MD[‡]

Society of Nuclear Medicine and Molecular Imaging

Scott C. Bartley, MD

Gary L. Dillehay, MD, FACNP, FACR

Society of Thoracic Surgeons

Francis C. Nichols, III, MD

Jeffrey P. Jacobs, MD, FACS, FACC, FCCP

The Endocrine Society

Ricardo Correa Marquez, MD

Sandhya Chhabra, MD

The Society for Pediatric Dermatology

Jeffrey L. Sugarman, MD, PhD[‡]

The Triological Society

Brian J. McKinnon, MD, MBA

Wayne E. Berryhill, MD[‡]

United States and Canadian Academy of Pathology

Ericka Olgaard, DO

[‡]New Advisors

AMA Health Care Professionals Advisory Committee (HCPAC)

Christopher L. Jagmin, MD, FAAFP*, Co-Chair
AMA CPT Editorial Panel

Leo J. Bronston, DC, MAppSc, Co-Chair
AMA CPT Editorial Panel

Academy of Nutrition and Dietetics
Keith-Thomas Ayoob, EdD, RD, FADA, CSP
Jessie M. Pavlinac, MS, RD, CSR, LD

American Academy of Audiology
Brad A. Stach, PhD
Annette A. Burton, AuD

American Academy of Physician Assistants
Lorie L. Weber, MS, PA-C[‡]

American Association of Naturopathic Physicians
Eva Miller, ND
Amy E. Hobson, ND

American Association for Respiratory Care
Susan Rinaldo-Gallo, Med, RRT, FAARC, CTTS

American Chiropractic Association
Kris Anderson, DC, MS

American Massage Therapy Association
Nancy M. Porambo, BA, MS, LMT, NCTMB

American Nurses Association
Jill Olmstead, MSN, NP-C, ANP-BC, FAANP
Julia Rogers, DNP, RN, CNS, FNP-BC

American Occupational Therapy Association
Leslie F. Davidson, PhD, OTR/L, FAOTA
Rebecca Finni, DHS, OTR/L, FAOTA[‡]

American Optometric Association

Rebecca H. Wartman, OD

Harvey B. Richman, OD, FAAO, FCOVD

American Physical Therapy Association

Kathleen M. Picard, PT, DPT

Jonathan Morren, PT, DPT

American Podiatric Medical Association

Ira H. Kraus, DPM

R. Alexander Dellinger, DPM[‡]

American Psychological Association

Neil H. Pliskin, PhD, ABPP-CN

Stephen Gillaspay, PhD

American Society of Acupuncturists

Jessica Gregory, MSAOM

American Speech-Language-Hearing Association

Renee Kinder, MS, CCC-SLP

National Association of Social Workers

Mirean F. Coleman, LICSW

Nelda Spyres

National Athletic Trainers' Association

Karen D. Fennell, MS, ATC, LAT

Joseph J. Greene, MS, ATC

National Society of Genetic Counselors

Brian Reys, MS, CGC

Pharmacy Health Information Technology Collaborative

Brian J. Isetts, PhD, BCPS, FAPhA

Laura J. Hanson, PharmD, MBA, BCPS

*Member of the CPT Executive Committee

‡New Advisors

Contents

Disclaimer and Notices

About CPT

Maintenance and Authorship of the CPT Code Set

AMA CPT Staff

Introduction

Release of CPT Codes

Section Numbers and Their Sequences

Instructions for Use of the CPT Codebook

Format of the Terminology

Requests to Update the CPT Nomenclature

Application Submission Requirements

►General CPT Code Criteria◀

Category-Specific Requirements

Audio-Video (Appendix P) and Audio-Only (Appendix T) Telemedicine Services
Criteria

Guidelines

Add-on Codes

Modifiers

Place of Service and Facility Reporting

Unlisted Procedure or Service

Results, Testing, Interpretation, and Report

Special Report

Time

Code Symbols

Alphabetical Reference Index

CPT 2026 in Electronic Formats

References to AMA Resources

Illustrated Anatomical and Procedural Review

Prefixes, Suffixes, and Roots

Numbers
Surgical Procedures
Conditions
Directions and Positions
Additional References
Medical Dictionaries
Anatomy References
Lists of Illustrations
Anatomical Illustrations
Procedural Illustrations
Evaluation and Management Tables

Evaluation and Management (E/M) Services Guidelines

E/M Guidelines Overview
Classification of Evaluation and Management (E/M) Services
Levels of E/M Services
Unlisted Service
Special Report

Evaluation and Management

Office or Other Outpatient Services
Telemedicine Services
Hospital Inpatient and Observation Care Services
Consultations
Emergency Department Services
Critical Care Services
Nursing Facility Services
Home or Residence Services
Prolonged Services
Case Management Services
Care Plan Oversight Services
Preventive Medicine Services
Non-Face-to-Face Services
Special Evaluation and Management Services
Newborn Care Services
Delivery/Birthing Room Attendance and Resuscitation Services

Inpatient Neonatal Intensive Care Services and Pediatric and Neonatal Critical Care Services

Cognitive Assessment and Care Plan Services

Care Management Services

Psychiatric Collaborative Care Management Services

Transitional Care Management Services

Advance Care Planning

General Behavioral Health Integration Care Management

Other Evaluation and Management Services

Anesthesia Guidelines

Time Reporting

Anesthesia Services

Supplied Materials

Separate or Multiple Procedures

Unlisted Service or Procedure

Special Report

Anesthesia Modifiers

Qualifying Circumstances

Anesthesia

Head

Neck

Thorax (Chest Wall and Shoulder Girdle)

Intrathoracic

Spine and Spinal Cord

Upper Abdomen

Lower Abdomen

Perineum

Pelvis (Except Hip)

Upper Leg (Except Knee)

Knee and Popliteal Area

Lower Leg (Below Knee, Includes Ankle and Foot)

Shoulder and Axilla

Upper Arm and Elbow

Forearm, Wrist, and Hand

Radiological Procedures
Burn Excisions or Debridement
Obstetric
Other Procedures

Surgery Guidelines

Services
CPT Surgical Package Definition
Follow-Up Care for Diagnostic Procedures
Follow-Up Care for Therapeutic Surgical Procedures
Supplied Materials
Reporting More Than One Procedure/Service
Separate Procedure
Unlisted Service or Procedure
Special Report
Imaging Guidance
Surgical Destruction
Foreign Body/Implant Definition
▶Graft Procurement◀

Surgery

General
Integumentary System
Musculoskeletal System
Respiratory System
Cardiovascular System
Hemic and Lymphatic Systems
Mediastinum and Diaphragm
Digestive System
Urinary System
Male Genital System
Reproductive System Procedures
Intersex Surgery
Female Genital System
Maternity Care and Delivery
Endocrine System

Nervous System
Eye and Ocular Adnexa
Auditory System
Operating Microscope

Radiology Guidelines (Including Nuclear Medicine and Diagnostic Ultrasound)

Subject Listings
Separate Procedures
Unlisted Service or Procedure
Special Report
Supervision and Interpretation, Imaging Guidance
Administration of Contrast Material(s)
Written Report(s)
Foreign Body/Implant Definition

Radiology

Diagnostic Radiology (Diagnostic Imaging)
Diagnostic Ultrasound
Radiologic Guidance
Breast, Mammography
Bone/Joint Studies
Radiation Oncology
Nuclear Medicine

Pathology and Laboratory Guidelines

Services in Pathology and Laboratory
Separate or Multiple Procedures
Unlisted Service or Procedure
Special Report

Pathology and Laboratory

Organ or Disease-Oriented Panels
Drug Assay
Therapeutic Drug Assays
Evocative/Suppression Testing
Pathology Clinical Consultations
Urinalysis
Molecular Pathology

Genomic Sequencing Procedures and Other Molecular Multianalyte Assays

Multianalyte Assays with Algorithmic Analyses

Chemistry

Hematology and Coagulation

Immunology

Transfusion Medicine

Microbiology

Anatomic Pathology

Cytopathology

Cytogenetic Studies

Surgical Pathology

In Vivo (eg, Transcutaneous) Laboratory Procedures

Other Procedures

Reproductive Medicine Procedures

Proprietary Laboratory Analyses

Medicine Guidelines

Add-on Codes

Separate Procedures

Unlisted Service or Procedure

Special Report

Imaging Guidance

Supplied Materials

Foreign Body/Implant Definition

Medicine

Immune Globulins, Serum or Recombinant Products

Immunization Administration for Vaccines/Toxoids

Vaccines, Toxoids

Psychiatry

Biofeedback

Dialysis

Gastroenterology

Ophthalmology

Special Otorhinolaryngologic Services

Cardiovascular

Noninvasive Vascular Diagnostic Studies
Pulmonary
Allergy and Clinical Immunology
Endocrinology
Neurology and Neuromuscular Procedures
Medical Genetics and Genetic Counseling Services
Adaptive Behavior Services
Central Nervous System Assessments/Tests (eg, Neuro-Cognitive, Mental Status, Speech Testing)
Health Behavior Assessment and Intervention
Behavior Management Services
Hydration, Therapeutic, Prophylactic, Diagnostic Injections and Infusions, and Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration
Photodynamic Therapy
Special Dermatological Procedures
►Mechanical Scalp-Cooling Services◄
Physical Medicine and Rehabilitation
Medical Nutrition Therapy
Acupuncture
Osteopathic Manipulative Treatment
Chiropractic Manipulative Treatment
Education and Training for Patient Self-Management
Non-Face-to-Face Nonphysician Qualified Health Care Professional Services
Special Services, Procedures and Reports
Qualifying Circumstances for Anesthesia
Moderate (Conscious) Sedation
Other Services and Procedures
Home Health Procedures/Services
Medication Therapy Management Services

Category II Codes

Modifiers
Composite Codes
Patient Management
Patient History

Physical Examination
Diagnostic/Screening Processes or Results
Therapeutic, Preventive, or Other Interventions
Follow-up or Other Outcomes
Patient Safety
Structural Measures
Nonmeasure Code Listing

Category III Codes

Appendix A—Modifiers

Appendix B—Summary of Additions, Deletions, and Revisions

Appendix C—Clinical Examples

Appendix D—Summary of CPT Add-on Codes

Appendix E—Summary of CPT Codes Exempt from Modifier 51

Appendix F—Summary of CPT Codes Exempt from Modifier 63

Appendix G—Summary of CPT Codes That Include Moderate (Conscious) Sedation

Appendix H—Alphabetical Clinical Topics Listing (AKA – Alphabetical Listing)

Appendix I—Genetic Testing Code Modifiers

Appendix J—Electrodiagnostic Medicine Listing of Sensory, Motor, and Mixed Nerves

Appendix K—Product Pending FDA Approval

Appendix L—Vascular Families

Appendix M—Renumbered CPT Codes—Citations Crosswalk

Appendix N—Summary of Resequenced CPT Codes

Appendix O—Multianalyte Assays with Algorithmic Analyses and Proprietary Laboratory Analyses

Appendix P—CPT Codes That May Be Used for Synchronous Real-Time Interactive Audio-Video Telemedicine Services

Appendix Q—Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) Vaccines

Appendix R—Digital Medicine—Services Taxonomy

Appendix S—Artificial Intelligence Taxonomy for Medical Services and Procedures

Appendix T—CPT Codes That May Be Used for Synchronous Real-Time Interactive Audio-Only Telemedicine Services

Index

Introduction

Current Procedural Terminology (CPT[®]), Fourth Edition, is a set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other qualified health care professionals, or entities. Each procedure or service is identified with a five-digit code. The use of CPT codes simplifies the reporting of procedures and services. In the CPT code set, the term “procedure” is used to describe services, including diagnostic tests.

Inclusion of a descriptor and its associated five-digit code number in the CPT Category I code set is based on whether the procedure or service is consistent with contemporary medical practice and is performed by many practitioners in clinical practice in multiple locations. Inclusion in the CPT code set of a procedure or service, or proprietary name, does not represent endorsement by the American Medical Association (AMA) of any particular diagnostic or therapeutic procedure or service or proprietary test or manufacturer. Inclusion or exclusion of a procedure or service, or proprietary name, does not imply any health insurance coverage or reimbursement policy.

The main body of the Category I section is listed in six sections. Each section is divided into subsections with anatomic, procedural, condition, or descriptor subheadings. The procedures and services with their identifying codes are presented in numeric order with the exception of the resequenced codes and the entire **Evaluation and Management** section (98000-98016, 99202-99499), which appears at the beginning of the listed procedures. The evaluation and management codes are used by most physicians in reporting a significant portion of their services.

Release of CPT Codes

The CPT code set is published annually in late summer or early fall as both electronic data files and books. The release of CPT data files occurs annually between August 31 and early September. The release of the CPT Professional publication comes several weeks later. However, to meet the needs of a rapidly changing health care environment, the CPT code set is periodically updated throughout the year on a set schedule. Each update has both a release date and an effective date. The interval between the release of the update and the effective date is considered an implementation period and is intended to allow physicians and other providers, payers, and vendors to incorporate CPT changes into their systems. Changes to the CPT code set are meant to be applied prospectively from the effective date. The following table outlines the complete CPT code set update calendar.

New CPT codes have been created to streamline services related to the novel coronavirus. It is imperative to check the AMA CPT public website at <https://www.ama-assn.org/practice-management/cpt/covid-19-cpt-vaccine-and-immunization-codes> throughout the year to obtain the necessary frequent updates to the CPT code set.

CPT Code Set Update Calendar

CPT Category/Section	Release Timeline	Effective Timeline
Category I	August 31	January 1
Category II		
Category III	January 1	July 1
	July 1	January 1
Immune Globulins, Serum, or Recombinant Products Vaccines, Toxoids	April 1	July 1
	July 1	October 1
	October 1*	January 1
Molecular Pathology Tier 2 Administrative MAAA	April 1	July 1
	July 1	October 1
	October 1*	January 1
PLA	January 1	April 1
	April 1	July 1
	July 1	October 1
	October 1	January 1

* Note that the release date may be delayed by several days due to the timing of the CPT Panel fall meeting.

It is imperative to check the AMA CPT public website throughout the year to obtain the necessary updates to the CPT code set. The following are several links on the AMA CPT website where these updates can be found:

- Category III codes: [ama-assn.org/cpt-cat-iii-codes](https://www.ama-assn.org/cpt-cat-iii-codes)
- Immune globulins, serum, or recombinant products and vaccines, toxoids: [ama-assn.org/cpt-cat-i-immunization-codes](https://www.ama-assn.org/cpt-cat-i-immunization-codes)
- Proprietary Laboratory Analyses (PLA) codes: [ama-assn.org/cpt-pla-codes](https://www.ama-assn.org/cpt-pla-codes)

- Administrative MAAA codes: ama-assn.org/practice-management/cpt/multianalyte-assays-algorithmic-analyses-codes
- Molecular pathology tier 2 codes: ama-assn.org/mo-path-tier-2-codes
- General errata and technical correction updates: ama-assn.org/practice-management/cpt/errata-technical-corrections

Section Numbers and Their Sequences

Evaluation and Management	8000-98016, 99202-99499
Anesthesiology	00100-01999, 99100-99140
Surgery	0004-69990
Radiology (Including Nuclear Medicine and Diagnostic Ultrasound)	0010-79999
Pathology and Laboratory	80047-89398, 0001U-0599U
Medicine (except Anesthesiology)	90281-99199, 99500-99607

The first and last code numbers and the subsection name of the items appear at the top margin of most pages (eg, “10009-10036 Surgery/Integumentary System”). The continuous pagination of the CPT codebook is found on the lower margin of each page along with explanation of any code symbols that are found on that page.

Instructions for Use of the CPT Codebook

Select the CPT code of the procedure or service that accurately identifies the procedure or service performed. Do not select a CPT code that merely approximates the procedure or service provided. If no such specific code exists, then report the procedure or service using the appropriate unlisted procedure or service code. When using an unlisted code, any modifying or extenuating circumstances should be adequately and accurately documented in the medical record. Furthermore, all the language within a code descriptor should be assessed when selecting the appropriate procedure or service. This includes information directly in the descriptor that may be enclosed in parentheses.

It is equally important to recognize that as techniques in medicine and surgery have evolved, new types of services, including minimally invasive surgery, as well as endovascular, percutaneous, and endoscopic interventions have challenged the traditional distinction of Surgery vs Medicine. Thus, the listing of a service or procedure in a specific section of this book should not be interpreted as strictly classifying the service or procedure as “surgery” or “not surgery” for insurance or other purposes. The placement of a given service in a specific section of the book may reflect historical or other considerations (eg, placement of the percutaneous peripheral vascular endovascular interventions in the Surgery/Cardiovascular System section, while the percutaneous coronary interventions appear in the Medicine/Cardiovascular section).

When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician. A “physician or other qualified health care professional” is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. These professionals are distinct from “clinical staff.” A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service but who does not individually report that professional service. Other policies may also affect who may report specific services.

Throughout the CPT code set the use of terms such as “physician,” “qualified health care professional,” or “individual” is not intended to indicate that other entities may not report the service. In selected instances, specific instructions may define a service as limited to professionals or limited to other entities (eg, hospital or home health agency).

Instructions, typically included as parenthetical notes with selected codes, indicate that a code should not be reported with another code or codes. These instructions are intended to prevent errors of significant probability and are not all inclusive. For example, the code with such instructions may be a component of another code and therefore it would be incorrect to report both codes even when the component service is performed. These instructions are not intended as a listing of all possible code combinations that should not be reported, nor do they indicate all possible code combinations that are appropriately reported. When reporting codes for

services provided, it is important to assure the accuracy and quality of coding through verification of the intent of the code by use of the related guidelines, parenthetical instructions, and coding resources, including *CPT Assistant* and other publications resulting from collaborative efforts of the American Medical Association with the medical specialty societies (ie, *Clinical Examples in Radiology*).

Because Category I or Category III codes may incorporate multiple components (bundled) that could be reported separately with other existing codes, “unbundling” of codes into their component parts for reporting purposes or combining those components with an unlisted code is inappropriate. For example, it would be inappropriate to separately report both codes 42825, *Tonsillectomy, primary or secondary; younger than age 12*, and 42830, *Adenoidectomy, primary; younger than age 12*, for removal of the tonsils and adenoids, because these two procedures are reported together using code 42820, *Tonsillectomy and adenoidectomy; younger than age 12*. Multiple Category I or Category III codes may be reported together to describe the totality of service rendered for a given patient encounter if they represent separately reportable services. Individual components of a procedure or service specified as part of a Category I or Category III code descriptor are reported neither separately with an existing CPT code nor with an unlisted code. Procedural steps necessary to reach the operative site and to close the operative site are also not reported separately, unless otherwise instructed by CPT guidelines or parenthetical notes. For example, a laparoscopic cholecystectomy should not be reported together with a code for the incision or a code for the repair of the surgical wound because these are inherent procedural steps needed to accomplish the cholecystectomy. However, if an excision of a benign lesion requires a complex repair for closure, both the lesion excision and the complex repair code are reported separately because the Repair (Closure) Guidelines indicate that “complex repair does not include excision of benign (11400-11446) or malignant (11600-11646) lesions.”

Format of the Terminology

The CPT code set has been developed as stand-alone descriptions of medical procedures. However, some of the procedures in the CPT codebook 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; with biopsy
25105 with synovectomy

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

25105 Arthrotomy, wrist joint; with synovectomy

Requests to Update the CPT Nomenclature

The effectiveness of the CPT nomenclature depends on constant updating to reflect changes in medical practice. This can only be accomplished through the interest and timely suggestions of practicing physicians and other qualified health care professionals, specialty/professional societies, state medical associations, organizations, agencies, individual users of the CPT code set, and other stakeholders. Accordingly, the AMA welcomes correspondence, inquiries, and suggestions concerning CPT coding and nomenclature for old and new procedures and services, as well as any matters relating to the CPT code set.

For information on submission of an application to add, delete, or revise codes contained in the CPT code set, please see www.ama-assn.org/go/cpt-processfaq or contact:

CPT Editorial Research & Development
American Medical Association
330 North Wabash Avenue
Suite 39300
Chicago IL 60611-5885

Code change applications are available at the AMA's CPT website at <https://www.ama-assn.org/practice-management/cpt/cpt-code-change-applications>.

All proposed changes to the CPT code set will be considered by the CPT Editorial Panel in consultation with medical specialty societies as represented by the CPT Advisory Committee, other health care professional societies as represented by the Health Care Professionals Advisory Committee (HCPAC), and other interested parties.

Application Submission Requirements

All complete CPT code change applications are reviewed and evaluated by the CPT staff, the CPT/HCPAC Advisory Committee, and the CPT Editorial Panel. Strict conformance with the following is required for review of a code change application:

- Submission of a complete application, including all necessary supporting documents;
- Adherence to all posted deadlines;
- Cooperation with requests from the CPT staff and/or Editorial Panel members for clarification and information; *and*
- Compliance with CPT Lobbying Policy.

► General CPT Code Criteria ◀

► All code-change applications must satisfy each of the following criteria: ◀

- The proposed descriptor is unique, well-defined, and describes a procedure or service that is clearly identified and distinguished from existing procedures and services already in the CPT code set;

- The descriptor structure, guidelines, and instructions are consistent with the current CPT Editorial Panel standards for maintenance of the code set;
- The proposed descriptor for the procedure or service is neither a fragmentation of an existing procedure or service nor currently reportable as a complete service by one or more existing codes (with the exclusion of unlisted codes). However, procedures and services frequently performed together may require new or revised codes;
- The structure and content of the proposed code descriptor accurately reflects the procedure or service as typically performed. If always or frequently performed with one or more other procedures or services, the descriptor structure and content will reflect the typical combination or complete procedure or service;
- The descriptor for the procedure or service is not proposed as a means to report extraordinary circumstances related to the performance of a procedure or service already described in the CPT code set; *and*
- The procedure or service satisfies the category-specific criteria set forth below.

Category-Specific Requirements

Category I Criteria

A proposal for a new or revised Category I code must satisfy all of the following criteria:

- All devices and drugs necessary for performance of the procedure or service have received FDA clearance or approval when such is required for performance of the procedure or service;
- The procedure or service is performed by many physicians or other qualified health care professionals across the United States;
- The procedure or service is performed with frequency consistent with the intended clinical use (ie, a service for a common condition should have high volume, whereas a service commonly performed for a rare condition may have low volume);
- The procedure or service is consistent with current medical practice; *and*

- The clinical efficacy of the procedure or service is documented in literature that meets the requirements set forth in the CPT code change application.

Category II Criteria

The following criteria are used by the CPT/HCPAC and the CPT Editorial Panel for evaluating Category II code applications:

- Measurements that were developed and tested by a national organization;
- Evidence-based measurements with established ties to health outcomes;
- Measurements that address clinical conditions of high prevalence, high risk, or high cost; *and*
- Well-established measurements that are currently being used by large segments of the health care industry across the country.

In addition, all of the following are required:

- Definition or purpose of the measure is consistent with its intended use (quality improvement and accountability, or solely quality improvement)
- Aspect of care measured is substantially influenced by the physician (or other qualified health care professional or entity for which the code may be relevant)
- Reduces data collection burden on physicians (or other qualified health care professionals or entities)
- Significant
 - Affects a large segment of health care community
 - Tied to health outcomes
 - Addresses clinical conditions of high prevalence, high costs, high risks
- Evidence-based
 - Agreed upon
 - Definable

- Measurable
- Risk-adjustment specifications and instructions for all outcome measures submitted or compelling evidence as to why risk adjustment is not relevant
- Sufficiently detailed to make it useful for multiple purposes
- Facilitates reporting of performance measure(s)
- Inclusion of select patient history, testing (eg, glycohemoglobin), other process measures, cognitive or procedure services within CPT, or physiologic measures (eg, blood pressure) to support performance measurements
- Performance measure–development process that includes
 - Nationally recognized expert panel
 - Multidisciplinary
 - Vetting process

Category III Criteria

The following **criteria** are used by the CPT/HCPAC Advisory Committee and the CPT Editorial Panel for evaluating Category III code **applications**:

- The procedure or service is currently or recently performed in humans; *and*

At least one of the following additional criteria has been met:

- The application is supported by at least one CPT or HCPAC advisor representing practitioners who would use this procedure or service; *or*
- The actual or potential clinical efficacy of the specific procedure or service is supported by peer reviewed literature, which is available in English for examination by the CPT Editorial Panel; *or*
- There is (a) at least one Institutional Review Board–approved protocol of a study of the procedure or service being performed; (b) a description of a current and ongoing United States trial outlining the efficacy of the procedure or service; or (c) other evidence of evolving clinical utilization.

Audio-Video (Appendix P) and Audio-Only (Appendix T) Telemedicine Services Criteria

The following criteria are used by the Current Procedural Terminology/Health Care Professional Advisory Committee (CPT/HCPAC) and the CPT Editorial Panel for evaluating inclusion of services in [Appendix P](#) (synchronous audio-video) and [Appendix T](#) (synchronous audio-only) telemedicine services. Any request for inclusion in [Appendix P](#) and [Appendix T](#) must satisfy the following criteria:

- The totality and quality of the communication of information exchanged between the physician or other qualified health care professional (QHP) and the patient during the synchronous telemedicine service must be of an amount and a nature that would be sufficient to meet the requirements for the same service if services were to be rendered during an in-person face-to-face interaction; *and*
- The evidence supports the benefits of performing the service through telecommunications technology. These benefits may include, but are not limited to, the following:
 - Facilitate a diagnosis or treatment plan that may reduce complications
 - Decrease diagnostic or therapeutic interventions
 - Decrease hospitalizations
 - Decrease in-person visits to the emergency department
 - Decrease in-person visits to physician or other QHP offices, including urgent care centers
 - Increase rapidity of resolution
 - Decrease quantifiable symptoms
 - Reduce recovery time
 - Enhance access to care, such as for rural and vulnerable patients;*and*
- A service is ineligible for inclusion in [Appendix T](#) without also being requested for inclusion, or has current inclusion, in [Appendix P](#).

(For a listing of CPT codes that may be used for synchronous real-time interactive audio-video telemedicine services when appended with modifier 95, see [Appendix P](#))

(For a listing of CPT codes that may be used for synchronous real-time interactive audio-only telemedicine services when appended with modifier 93, see [Appendix T](#))

Guidelines

Specific guidelines are presented at the beginning of each of the 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, **Radiology Guidelines** provide a definition of the unique term, “radiological supervision and interpretation.” While in **Anesthesia**, a discussion of reporting time is included.

A written report (eg, handwritten or electronic) signed by the interpreting individual should be considered an integral part of a radiologic procedure or interpretation. Please see the guidelines regarding Imaging Guidance in each individual section.

Add-on Codes

Some of the listed procedures are commonly carried out in addition to the primary procedure performed. These additional or supplemental procedures are designated as add-on codes with the **+** symbol and they are listed in [Appendix D](#) of the CPT codebook. Add-on codes in CPT 2026 can be readily identified by specific descriptor nomenclature that includes phrases such as “each additional” or “(List separately in addition to primary procedure).”

The add-on code concept in CPT 2026 applies only to add-on procedures or services performed by the same physician. Add-on codes describe additional intra-service work associated with the primary procedure, eg, additional digit(s), lesion(s), neurorrhaphy(s), vertebral segment(s), tendon(s), joint(s).

Add-on codes are always performed in addition to the primary service or procedure and must never be reported as a stand-alone code. The inclusionary parenthetical notes following the add-on codes are designed to include the typical base code(s) and not every possible reportable code combination. When the add-on procedure can be reported bilaterally and is performed bilaterally, the appropriate add-on code is reported twice, unless the code descriptor, guidelines, or parenthetical instructions for that particular add-on code instructs otherwise. Do not report modifier 50, *Bilateral Procedures*, in conjunction with add-on codes. All add-on codes in the CPT code set are exempt from the multiple procedure concept. See the definitions of modifier 50 and 51 in [Appendix A](#).

Modifiers

A modifier provides the means to report or 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. Modifiers also enable health care professionals to effectively respond to payment policy requirements established by other entities. 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 had both a professional and technical component.
- A service or procedure was performed by more than one physician or other health care professional and/or in more than one location.
- A service or procedure was 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 add modifier 26 to report the professional component.

73090 with modifier 26 = 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 procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. Modifier 62 would be applicable. For instance, a neurological surgeon and an otolaryngologist are working as co-surgeons in performing transphenoidal excision of a pituitary neoplasm.

The first surgeon would report:

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

and the second surgeon would report:

61548 62 = Hypophysectomy or excision of pituitary 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 also be reported with modifier 62 added. It should be noted that if a co-surgeon 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 modifier 80 or modifier 82 added, as appropriate. A complete listing of modifiers is found in [Appendix A](#).

Place of Service and Facility Reporting

Some codes have specified places of service (eg, evaluation and management codes are specific to a setting). Other services and procedures may have instructions specific to the place of service (eg, therapeutic, prophylactic, and diagnostic injections and infusions). The CPT code set is designated for reporting physician and other qualified health care professional services. It is also the designated code set for reporting services provided by organizations or facilities (eg, hospitals) in specific circumstances. Throughout the CPT code set, the use of terms such as “physician,” “qualified health care professional,” or “individual” is not intended to indicate that other entities may not report the service. In selected instances, specific instructions may define a service as limited to professionals or limited to other entities (eg, hospital or home health agency). The CPT code set uses the term “facility” to describe such providers and the term “nonfacility” to describe services settings or circumstances in which no facility reporting may occur. Services provided in the home by an agency are facility services. Services provided in the home by a physician or other qualified health care professional who is not a representative of the agency are nonfacility services.

Unlisted Procedure or Service

Category I and Category III codes describe the vast majority of procedures and services currently performed in the United States and should be used to report these procedures and services that are accurately described in existing CPT codes. It is recognized that there may be services or procedures performed by physicians or other qualified health care professionals (QHPs) that are not found in the CPT code set. Therefore, a number of specific code numbers have been designated for reporting unlisted procedures. When an unlisted procedure code is used, the service or procedure should be described (see specific section guidelines). Each of these unlisted codes (with the appropriate accompanying topical entry) relates to a specific section of the code set and is presented in the guidelines of that section.

The CPT code set’s instructions to use an unlisted procedure code do not preclude the reporting of an appropriate code that may be found elsewhere in the CPT code set. It may be appropriate to report multiple Category I or Category III codes together to describe the totality of a service rendered for a given patient encounter, provided each code represents a separately reportable service. Similarly, it is appropriate to report an unlisted code together with a Category I or Category III code(s) for the same patient encounter on the same date of service when a separately reportable portion of a provided procedure or service is not described by an existing CPT code(s).

Example

Reporting unlisted code(s) with Category I code(s): When both radiofrequency ablation of the greater saphenous vein and stab phlebectomy using less than 10 incisions are performed in the same operative session, both codes 36475, *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated*, and 37799, *Unlisted procedure, vascular surgery*, may be reported because there is no code for stab phlebectomy with less than 10 incisions.

While uncommon, if multiple separately reportable unlisted services are performed on the same patient on the same date of service by the same physician or other QHP, then multiple unlisted codes may be reported. If the two procedures are performed in the same anatomic region, then multiple units of the same unlisted code may be reported with modifier 59 appended to the additional unit(s). If two unlisted services are performed in two different anatomic regions, then two different unlisted codes may be reported.

Example

Reporting multiple separately reportable unlisted services: If two unlisted arthroscopic procedures are performed on two separate joints by the same surgeon on the same date of service, then two units of 29999, *Unlisted procedure, arthroscopy*, may be reported with modifier 59 appended to the second unit.

Note that unlisted codes are not used to separately report component(s) of an existing Category I or Category III service.

Example

It would not be appropriate to use 39599, *Unlisted procedure, diaphragm*, to separately report suturing of the diaphragm performed as a component of a paraesophageal hernia repair, which is reported with code 43281, *Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh*.

Because unlisted codes do not include descriptor language that specifies the components of a particular service, modifiers that describe alteration of a service or procedure may not be used. For example, it would not be appropriate to append modifier 52, *Reduced Services*, to an unlisted code. However, modifiers to indicate laterality (ie, modifier 50, *Bilateral Procedure*); distinction (ie, modifier 59, *Distinct Procedural Service*); assistant-at-surgery (modifier 80, *Assistant Surgeon*); and place of service (eg, modifier 95, *Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System*; modifier 93, *Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System*) may be used, when indicated.

Results, Testing, Interpretation, and Report

Results are the technical component of a service. Testing leads to results; results lead to interpretation. Reports are the work product of the interpretation of test results. Certain procedures or services described in CPT involve a technical component (eg, tests), which produces “results” (eg, data, images, slides). For clinical use, some of these results require interpretation. Some CPT descriptors specifically require interpretation and reporting in order to report that code.

Special Report

A service that is rarely provided, unusual, variable, or new may require a special report. 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.


Time

The CPT code set contains many codes with a time basis for code selection. The following standards shall apply to time measurement, unless there are code or code-range-specific instructions in guidelines, parenthetical instructions, or code descriptors to the contrary. Time is the face-to-face time with the patient. Phrases such as “interpretation and report” in the code descriptor are not intended to indicate in all cases that report writing is part of the reported time. A unit of time is attained when the mid-point is passed. For example, an hour is attained when 31 minutes have elapsed (more than midway between zero and 60 minutes). A second hour is attained when a total of 91 minutes has elapsed. The evaluation and management (E/M) codes that use total time on the date of the encounter have a required time threshold for time-based reporting; therefore, the mid-point concept does not apply. See also the **Evaluation and Management (E/M) Services Guidelines**. When another service is performed concurrently with a time-based service, the time associated with the concurrent service should not be included in the time used for reporting the time-based service. Some services measured in units other than days extend across calendar dates. When this occurs, a continuous service does not reset and create a first hour. However, any disruption in the service does create a new initial service. For example, if intravenous hydration (96360, 96361) is given from 11 PM to 2 AM, 96360 would be reported once and 96361 twice. For facility reporting on a single date of service or for continuous services that last beyond midnight (ie, over a range of dates), report the total units of time provided continuously.

Code Symbols



A summary listing of additions, deletions, and revisions applicable to the CPT codebook is found in [Appendix B](#). New procedure numbers added to the CPT codebook 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. These symbols indicate CPT Editorial Panel actions. The AMA reserves the right to correct typographical errors and make stylistic improvements.

CPT add-on codes are annotated by the + symbol and are listed in [Appendix D](#). 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 or services. A list of codes exempt from modifier 51 usage is included in [Appendix E](#). The ✎ symbol is used to identify codes for vaccines that are pending FDA approval (see [Appendix K](#)). The # symbol is used to identify codes that are listed out of numerical sequence (see [Appendix N](#)). The ★ symbol is used to identify codes that may be used to report audio-video telemedicine services when appended by modifier 95

(see [Appendix P](#)). The  symbol is used to identify codes that may be used to report audio-only telemedicine services when appended by modifier 93 (see [Appendix T](#)).

Resequenced codes that are not placed numerically are identified with the **#** symbol, and a reference placed numerically (ie, Code is out of numerical sequence. See...) as a navigational alert to direct the user to the location of the out-of-sequence code (see [Appendix N](#)).

Resequencing is utilized to allow placement of related concepts in appropriate locations within the families of codes regardless of the availability of numbers for sequential numerical placement.

► Duplicate proprietary laboratory analyses (PLA) tests are annotated by the  symbol. PLA codes describe proprietary clinical laboratory analyses and can be either provided by a single (“sole-source”) laboratory or licensed or marketed to multiple providing laboratories (eg, cleared or approved by the Food and Drug Administration [FDA]). All codes that are included in the PLA section are also included in [Appendix O](#), with the procedure’s proprietary name. In some instances, the descriptor language of PLA codes may be identical, and the code may only be differentiated by the listed proprietary name in Appendix O. When more than one PLA test has an identical descriptor, the codes will be denoted by the  symbol. Even though the Proprietary Laboratory Analyses section of the code set is located at the end of the Pathology and Laboratory section of the code set, a PLA code does not fulfill Category I code criteria. ◀

Alphabetical Reference Index




This codebook features an expanded alphabetical index that includes listings by procedure and anatomic site. Procedures and services commonly known by their eponyms or other designations are also included.




CPT 2026 in Electronic Formats

CPT 2026 procedure codes and descriptions are available as downloadable data files. The CPT data files are available in ASCII and EBCDIC formats and provide a convenient way to import the CPT 2026 codes and descriptions into existing documentation or into any billing and claims reporting software that accepts a text (.TXT) file format. The data files contain the complete official AMA CPT guidelines, descriptor package, and new descriptors for consumers and clinicians.

The *CPT Professional* codebook is also available as an e-book. For more information about CPT electronic formats, call 800 621-8335 or visit amastore.com.

References to AMA Resources

The symbols   and  appear after many codes throughout this codebook, which indicate that the AMA has published reference material regarding that particular code.

The symbol  refers to the *CPT Changes: An Insider’s View*, an annual book with all of the coding changes for the current year, the  refers to the *CPT Assistant* monthly newsletter. The symbol  refers to the quarterly newsletter *Clinical Examples in Radiology*.

Example

36598 Contrast injection(s) for radiologic evaluation of existing central venous access device, including fluoroscopy, image documentation and report

➔ *CPT Changes: An Insider's View* 2006

➔ *Clinical Examples in Radiology* Winter 06:15

In this example, the blue reference symbol indicates that in the 2006 edition of *CPT Changes: An Insider's View* information is available that may assist in understanding the application of the code. The red reference symbol indicates that the 2006 Winter issue of *Clinical Examples in Radiology* page 15 should be consulted.

CPT Assistant and *Clinical Examples in Radiology* are available online. Benefits exclusive to the online versions include:

- Monthly (*CPT Assistant*) and quarterly (*Clinical Examples in Radiology*) updates! The home screen notifies you when a new issue is available, and you can review the latest issue in its entirety.
- Unlimited access to every archived issue and article dating back to when the newsletters first published.
- A historical CPT code list that references when a code was added, deleted, and/or revised since 1990.
- Simple search capabilities, including intuitive menus and a cumulative index of article titles.
- A full archive of *CPT Assistant* articles (1990-2025) is also available in the *CPT Professional* print and digital app bundle (see the following information about the *CPT QuickRef* app).

The *CPT QuickRef* app is available for iOS (Apple) and Android devices (smart phones and tablets). The *QuickRef* app contains important coding and billing tools, including:

- The entire CPT 2026 code set (all codes and their descriptors with almost all illustrations and guidelines), plus the entire 2025 code set to facilitate the year-end code set transition.
- Facility and non-facility RVUs and Global Days.
- Medicare Physician Fee Schedule calculator that can be set to a specific geographic region (GPCI).
- *CPT Assistant* Archive: all content and every issue of *CPT Assistant* from 1990 through 2025, linked to the pertinent CPT codes and available for browsing.

- Official AMA CPT coding guidelines linked to each CPT code.
- More than 200 AMA-created colorized procedural and anatomical illustrations
- Modifiers
- Keyword and code number search
- Favorites capability, to store most-frequently used codes or modifiers for easy access.

For more information, call 800 621-8335.

Illustrated Anatomical and Procedural Review

It is essential that coders have a thorough understanding of medical terminology and anatomy to code accurately. The following section reviewing the basics of vocabulary and anatomy can be used as a quick reference to help you with your coding. It is not intended as a replacement for up-to-date medical dictionaries and anatomy texts, which are essential tools for accurate coding.

Prefixes, Suffixes, and Roots

Although medical terminology may seem complex, many medical terms can be broken into component parts, which makes them easier to understand. Many of these terms are derived from Latin or Greek words, but some include the names of physicians.

Prefixes are word parts that appear at the beginning of a word and modify its meaning; suffixes are found at the end of words. By learning what various prefixes and suffixes mean, it is possible to decipher the meaning of a word quickly. The following lists are a quick reference for some common prefixes and suffixes.

Numbers

Prefix	Meaning	Example
mono-, uni-	one	monocyte, unilateral
bi-	two	bilateral
tri-	three	triad
quadr-	four	quadriplegia
hex-, sex-	six	hexose
diplo-	double	diplopia

Surgical Procedures

Suffix	Meaning	Example
-centesis	puncture a cavity to remove fluid	amniocentesis
-ectomy	surgical removal (excision)	appendectomy
-ostomy	a new permanent opening	colostomy
-otomy	cutting into (incision)	tracheotomy
-orrhaphy	surgical repair/suture	herniorrhaphy
-opexy	surgical fixation	nephropexy
-oplasty	surgical repair	rhinoplasty
-otripsy	crushing, destroying	lithotripsy

Conditions

Prefix	Meaning	Example
ambi-	both	ambidextrous
aniso-	unequal	anisocoria

dys-	bad, painful, difficult	dysphoria
eu-	good, normal	euthanasia
hetero-	different	heterogeneous
homo-	same	homogeneous
hyper-	excessive, above	hypergastric
hypo-	deficient, below	hypogastric
iso-	equal, same	isotonic
mal-	bad, poor	malaise
megalo-	large	megalocardia

Suffix	Meaning	Example
-algia	pain	neuralgia
-asthenia	weakness	myasthenia
-emia	blood	anemia
-iasis	condition of	amebiasis
-itis	inflammation	appendicitis
-lysis	destruction, break down	hemolysis
-lytic	destroy, break down	hemolytic
-oid	like	lipoid
-oma	tumor	carcinoma
-opathy	disease of	arthropathy
-orrhagia	hemorrhage	menorrhagia
-orrhoea	flow or discharge	amenorrhoea
-osis	abnormal condition of	tuberculosis
-paresis	weakness	hemiparesis
-plasia	growth	hyperplasia
-plegia	paralysis	paraplegia
-pnea	breathing	apnea

Directions and Positions

Prefix	Meaning	Example
ab-	away from	abduction
ad-	toward	adduction
ecto, exo-	outside	ectopic, exocrine
endo-	within	endoscope
epi-	upon	epigastric
infra-	below, under	infrastructure
ipsi-	same	ipsilateral
meso-	middle	mesopexy
meta-	after, beyond, transformation	metastasis
peri-	surrounding	pericardium

retro-
trans-

behind, back
across, through

retroversion
transvaginal

Word

Meaning

anterior or ventral

at or near the front surface of the body

posterior or dorsal

at or near the back surface of the body

superior

above

inferior

below

lateral

side

distal

farthest from center

proximal

nearest to center

medial

middle

supine

face up or palm up

prone

face down or palm down

sagittal

vertical body plane, divides the body into equal right and left sides

transverse

horizontal body plane, divides the body into top and bottom sections

coronal

vertical body plane, divides the body into front and back sections

Additional References

For best coding results, you will need to use other reference materials in addition to your CPT[®] coding books. These references include medical dictionaries and anatomy books.

Medical Dictionaries

Dorland's Illustrated Medical Dictionary, 33rd ed.
Philadelphia, PA: Elsevier; 2020.

Stedman's CPT[®] Dictionary, 2nd ed.
Chicago, IL: American Medical Association; 2009.
OP:300609

Stedman's Medical Dictionary. 28th ed.
Philadelphia, PA: Lippincott; 2005.

Anatomy References

Bernard, SP. *Netter's Atlas of Human Anatomy for CPT[®] Surgery*.
Chicago, IL: American Medical Association; 2015.
OP495015

Kirschner, CG. *Netter's Atlas of Human Anatomy for CPT[®] Coding*, 3rd ed.
Chicago, IL: American Medical Association; 2019.
OP490619

Netter, FH. *Atlas of Human Anatomy*, 6th ed.
Philadelphia, PA; Elsevier; 2014.
OP936714

Lists of Illustrations

To further aid coders in properly assigning CPT codes, the codebook contains a number of anatomical and procedural illustrations.

Anatomical Illustrations

Thirty-six anatomical illustrations are located on the following pages:

Page	Illustration Title
xxv	Body Planes—3/4 View
xxv	Body Aspects—Side View
xxv	Body Planes—Front View
79	Structure of Skin
119	Skeletal System
120	Skull—Front and Lateral Views
120	Thoracic Vertebra—Superior View
120	Lumbar Vertebra—Superior View
120	Lumbar Vertebrae—Lateral View
122	Bones, Muscles, and Tendons of Hand
123	Bones and Muscles of Foot
125	Muscular System—Front
126	Muscular System—Back
151	Visual Definitions of Spinal Anatomy and Procedures A. Vertebral interspace (non-bony) and segment (bony) B. Foraminotomy and facetectomy
152	C. Laminotomy, hemilaminectomy, and laminectomy D. Corpectomy
205	Paranasal Sinuses
206	Respiratory System
227	Aortic Anatomy
228	Cardiac Anatomy, Heart Blood Flow
230	Circulatory System, Arteries
231	Circulatory System, Veins
232	Brachial Artery
233	Lymphatic System
336	Digestive System
398	Urinary System
424	Male Genital System
435	Female Genital System
456	Nervous System
457	Brain Anatomy
457	Sagittal Section of Brain and Brain Stem
498	Eye Anatomy
500	Anterior Segment of the Eye
515	Ear Anatomy
523	Endocrine System
773	Coronary Artery Segments
833	Cranial Nerves

Procedural Illustrations

Procedural illustrations are placed throughout the codebook and are associated with the following specific CPT codes.

CPT Code(s)	Illustration Title
11005	Debridement of Abdominal Wall
11102, 11103	Tangential Biopsy of Skin
11104, 11105	Punch Biopsy of Skin
11106, 11107	Incisional Biopsy of Skin
11200, 11201	Removal of Skin Tags
11300-11313	Shaving of Epidermal and Dermal Lesion
11400, 11600	Excision of Lesion
11423, 11600, 11606, 11642	Measuring and Coding the Removal of a Lesion
11719-11765	Lateral Nail View
11719-11765	Dorsal Nail View
—	Extensive Undermining
14000-14061	Adjacent Tissue Repairs
15730	Midface Flap Surgery
15731	Axial Pattern Forehead Flap
16000-16030	Lund-Browder Diagram and Classification Method Table for Burn Estimations
17004	Destruction, Benign or Premalignant Lesions
20552, 20553	Trigger Point Injection
20610	Arthrocentesis, Aspiration, or Injection of Major Joint or Bursa
20664	Halo Application for Thin Skull Osteology
20690	Uniplane External Fixation System
20692	Multiplane External Fixation System
20932	Postoperative Osteoarticular Allograft Left Humerus Fixed with Plates
20933	Parosteal Osteosarcoma Replaced with Hemicortical Intercalary Allograft
20934	Osteosarcoma Femur with Complete Intercalary Allograft with Plate Fixation
21196	Reconstruction of Mandibular Rami
22510	Percutaneous Vertebroplasty
22548	Arthrodesis (Anterior Transoral Technique)
22554	Anterior Approach for Cervical Fusion
22558	Anterior Approach for Lumbar Fusion (Anterior Retroperitoneal Exposure)
—	Visual Definitions of Spinal Anatomy and Procedures A. Vertebral interspace (non-bony) and segment (bony) B. Foraminotomy and facetectomy C. Laminotomy, hemilaminectomy, and laminectomy D. Corpectomy
22630, 63052	Examples of TLIF, PLIF, and Laminectomy Techniques and Procedures
22630, 63052	A. Examples of posterior interbody fusion techniques (22630) B. Examples of posterior interbody fusion techniques and laminectomy at same interspace (22630, 63052)
22840	Non-Segmental Spinal Instrumentation
22842-22844	Segmental Spinal Instrumentation
22853, 22854, 22859	Spinal Prosthetic Devices
27125	Partial Hip Replacement With or Without Bipolar Prosthesis
27130	Total Hip Replacement
27235	Percutaneous Treatment of Femoral Fracture
27236	Open Treatment of Femoral Fracture
27405, 27427	Posterolateral Corner of the Knee

28289	Hallux Rigidus Correction
28291	Hallux Rigidus Correction with Implant
28292	Hallux Valgus Correction
28292	Hallux Valgus Correction with Proximal Phalanx Base Resection
28295	Hallux Valgus Correction with Proximal First Metatarsal Osteotomy
28296	Hallux Valgus Correction with Distal First Metatarsal Osteotomy
28297	Hallux Valgus Correction with Metatarsal-Medial Cuneiform Joint Arthrodesis
28298	Hallux Valgus Correction with Proximal Phalanx Osteotomy
28299	Hallux Valgus Correction with Double Osteotomy
29824	Arthroscopy, Shoulder, Distal Claviculectomy (Mumford Procedure)
29866-29887	Arthroscopy of the Knee
29894-29899	Arthroscopy of the Ankle
30465	Surgical Repair of Vestibular Stenosis
31070	Sinusotomy, Frontal
31231-31294	Sinus Endoscopy
31622-31661	Bronchoscopy
32554, 32555	Thoracentesis
32601-32665	Thoracoscopy
32674	Mediastinal Lymph Nodes: Station Number and Descriptions
32994	Cryoablation Therapy of Pulmonary Tumors
33210	Temporary Pacemaker
33212-33214	A. Implanted Pacemaker—Single Chamber
33213-33214	B. Implanted Pacemaker—Two Chambers
33224-33226	Biventricular Pacing
33510-33516	A. Coronary Artery Bypass—Venous Grafting Only—Single Graft
33510-33516	B. Coronary Artery Bypass—Venous Grafting Only—Three Coronary Grafts
33517-33530	Coronary Artery Bypass—Combined Arterial-Venous Grafting
33517-33530	Coronary Artery Bypass—Sequential Combined Arterial-Venous Grafting
33621	Initial Hybrid Palliation
33622	Hybrid Reconstruction
33820	Patent Ductus Arteriosus
33864	Aortic Root Remodeling: Coronary Arteries Reimplanted
33894, 33895	Coarctation of the Aorta and Its Repair
33927-33929	Total Heart Implantation Device
33979	Insertion of Implantable Single Ventricle Assist Device
34705, 34706, 34709, 34710, 34711	Endovascular Repair
34717, 34718	Endovascular Repair
35371-35372	Thromboendarterectomy
35571	Bypass Graft, Vein
35600	Harvest of Upper Extremity Artery
36002	Injection Procedure (eg, Thrombin) for Percutaneous Treatment of Extremity Pseudoaneurysm
36222-36228	Angiography, Carotid Artery
36555-36556	Insertion of Non-Tunneled Centrally Inserted Central Venous Catheter
36557-36558	Insertion of Tunneled Central Venous Catheter
36570, 36571, 36576, 36578	Implantable Venous Access Port
36572	Peripherally Inserted Central Catheter
36821	Arteriovenous Anastomosis, Direct
36825-36830	Arteriovenous Fistula
37191	Vena Cava Filter

37254-37257	Transluminal Balloon Angioplasty
37246	Transluminal Balloon Angioplasty
37700	Ligation and Division of Long Saphenous Vein
38230	Bone Marrow Harvesting for Transplantation
38746	Mediastinal Lymph Nodes: Station Number and Descriptions
43235	Esophagogastroduodenoscopy
43260	Endoscopic Retrograde Cholangiopancreatography (ERCP)
43280	Laparoscopic Fundoplasty
43284	Laparoscopic Esophageal Sphincter Augmentation
43287	Ivor Lewis Esophagectomy
43327, 43328	Nissen Fundoplasty
43753	Gastric Intubation
43846	Gastric Bypass for Morbid Obesity
44127	Enterectomy, Resection for Congenital Atresia
44140	Colectomy, Partial
44160	Colectomy With Removal of Terminal Ileum and Ileocolostomy
45171-45172	Rectal Tumor Excision
45378	Colonoscopy
45385, 45388	Colonoscopy With Lesion Ablation or Removal
46020	Placement of Seton
46250-46262	Hemorrhoidectomy of Internal Prolapsed Hemorrhoid Columns
47533, 47534, 47538, 47539, 47540	Percutaneous Biliary Stent(s) and Drain Placement
47562	Laparoscopic Cholecystectomy
49320	Laparoscopy
49591-49618	Measuring Total Length of Anterior Abdominal Hernia Defect(s)
50020	Drainage of Renal Abscess
50060-50075	Nephrolithotomy With Calculus Removal
50432	Introduction of Catheter Into Renal Pelvis
50545	Laparoscopic Radical Nephrectomy
50546	Laparoscopic Nephrectomy
50590	Lithotripsy
50605	Indwelling Ureteral Stent
50820	Ureteroileal Conduit
50947	Laparoscopic Ureteroneocystostomy
51798	Measurement of Postvoiding
51990	Laparoscopic Sling Suspension Urinary Incontinence
52005	Cystourethroscopy With Ureteral Catheterization
52601	Transurethral Resection of Prostate, Complete
52648	Contact Laser Vaporization of Prostate
53855	Temporary Prostatic Urethral Stent Insertion
54692	Laparoscopic Orchiopexy
57106	Vaginectomy, Partial Removal of Vaginal Wall
57111	Vaginectomy, Complete Removal of Vaginal Wall (Radical Vaginectomy)
57426	Laparoscopic Revision of Prosthetic Vaginal Graft
58548, 58575	Radical and Total Hysterectomy
58563	Hysteroscopy
59001	Amniocentesis, Therapeutic Amniotic Fluid Reduction
59150	Laparoscopic Treatment of Ectopic Pregnancy
59400-59410	Vaginal Delivery
59510-59515	Cesarean Delivery

60220	Thyroid Lobectomy
60512	Posterior View of the Pharynx
60650	Laparoscopic Adrenalectomy
61700	Intracranial Aneurysm, Intracranial Approach
61867-61868, 61885	Placement of Cranial Neurostimulator
62223	Cerebrospinal Fluid (CSF) Shunt (Ventricular Peritoneal)
62362	Intrathecal or Epidural Drug Infusion Pump Implantation
63005	Lumbar Laminectomy
63047	Example of Laminectomy at Single Interspace
63650	Percutaneous Implantation of Neurostimulator Electrodes
63655	Placement of Neurostimulator Electrodes Through Laminectomy
64568-64570	Open Implantation Neurostimulator Electrodes, Cranial Nerve (Vagus Nerve Stimulation)
64581	Open Implantation of Sacral Nerve Neurostimulator Electrode Array
64642	Chemodeneration of Extremity
65450	Cryotherapy of Lesion on Cornea
65820	Goniotomy
66150-66172, 66183	Minimally Invasive Glaucoma Surgery (External Approach)
67027	Intravitreal Drug Delivery System
67107	Repair of Retinal Detachment
67311-67346	Extraocular Muscles of Right Eye
67311-67312	Strabismus Surgery—Horizontal Muscles
67314-67316	Strabismus Surgery—Vertical Muscles
67320	Transposition Procedure
67335	Strabismus Surgery—Adjustable Sutures
67820-67825	Trichiasis
68761	Closure of Lacrimal Punctum by Plug
68816	Probing of Nasolacrimal Duct
69433-69436	Tympanostomy
69635-69646	Tympanoplasty
69930	Cochlear Device Implantation
69990	Operating Microscope
75600-75630	Aortography
75820-75822	Venography
77067	Screening Mammography
91034	Esophageal Acid Reflux Test
92201, 92202	Extended Ophthalmoscopy
92235	Fluorescein Angiography
92601-92604	A View of the Outer Cochlear Implant
92978	Intravascular Ultrasound (Coronary Vessel or Graft)
93312-93318	Transesophageal Echocardiography (TEE)
93451	Right Heart Catheterization
93452	Left Heart Catheterization
93454	Coronary Angiography Without Concomitant Left Heart Catheterization
93571	Intravascular Distal Blood Flow Velocity
95829	Intraoperative Electrocorticography (ECoG)
95836	Extraoperative ECoG
97810-97811	Acupuncture, Needle
0253T, 0449T, 0450T, 0474T, 0671T	Minimally Invasive Glaucoma Surgery (Internal Approach)

Figure 1A

Body Planes — 3/4 View

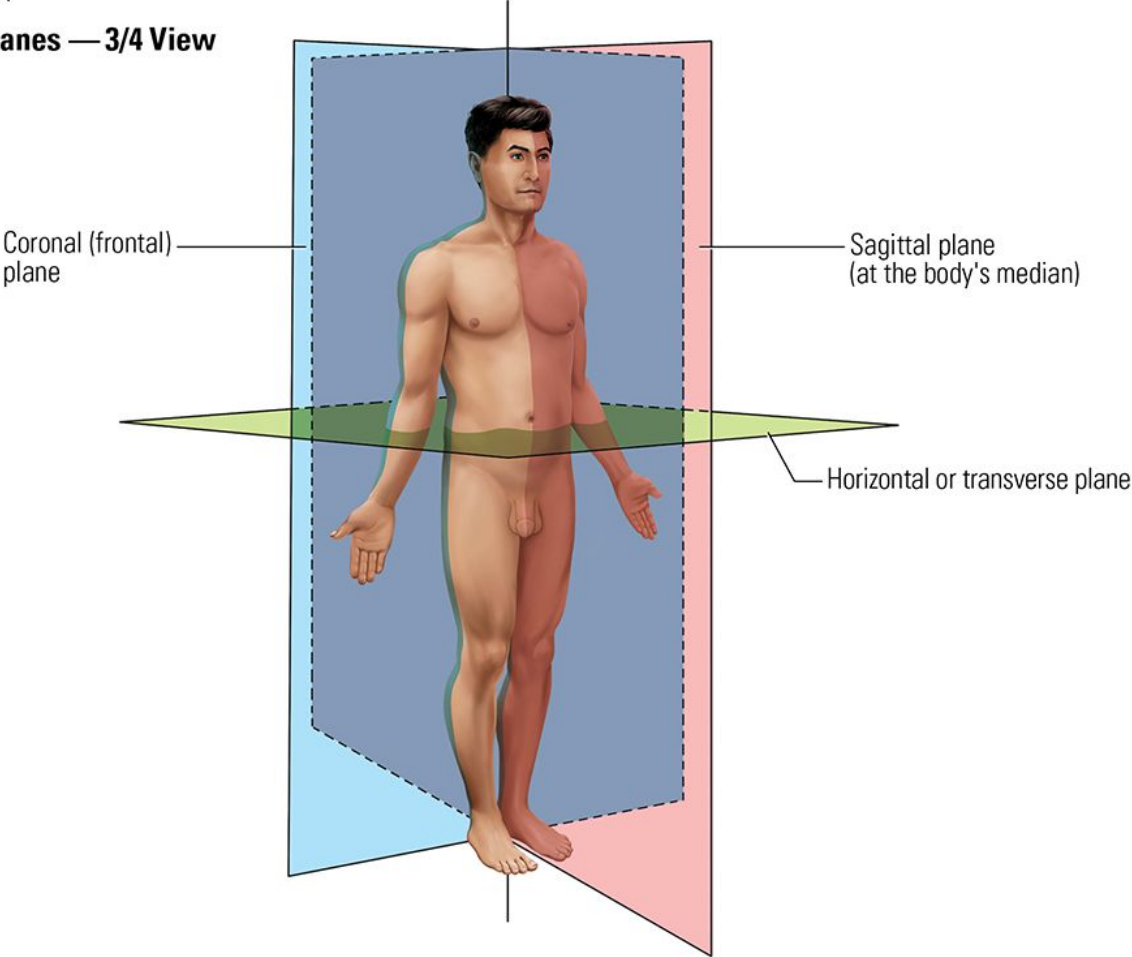


Figure 1B

Body Aspects — Side View

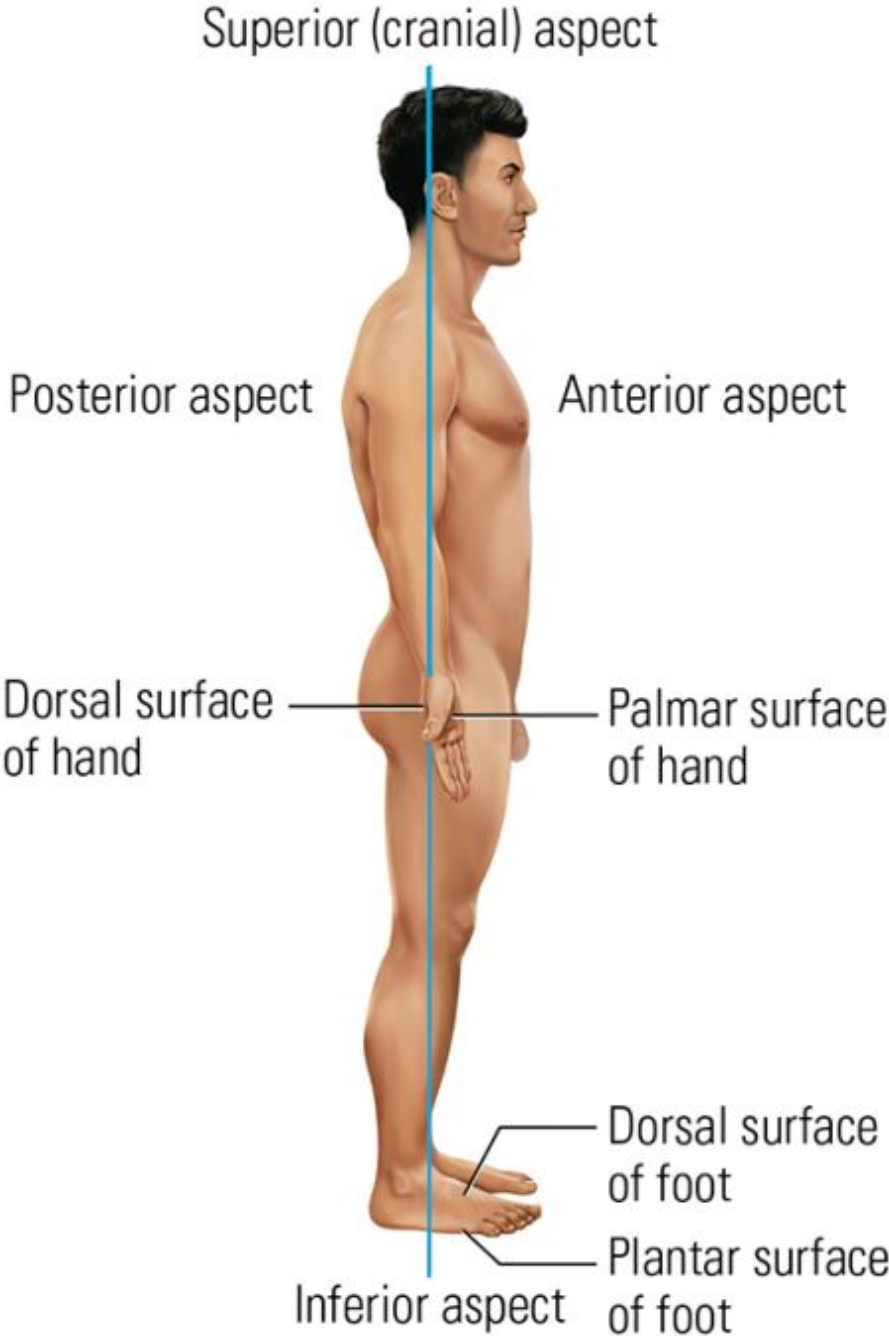
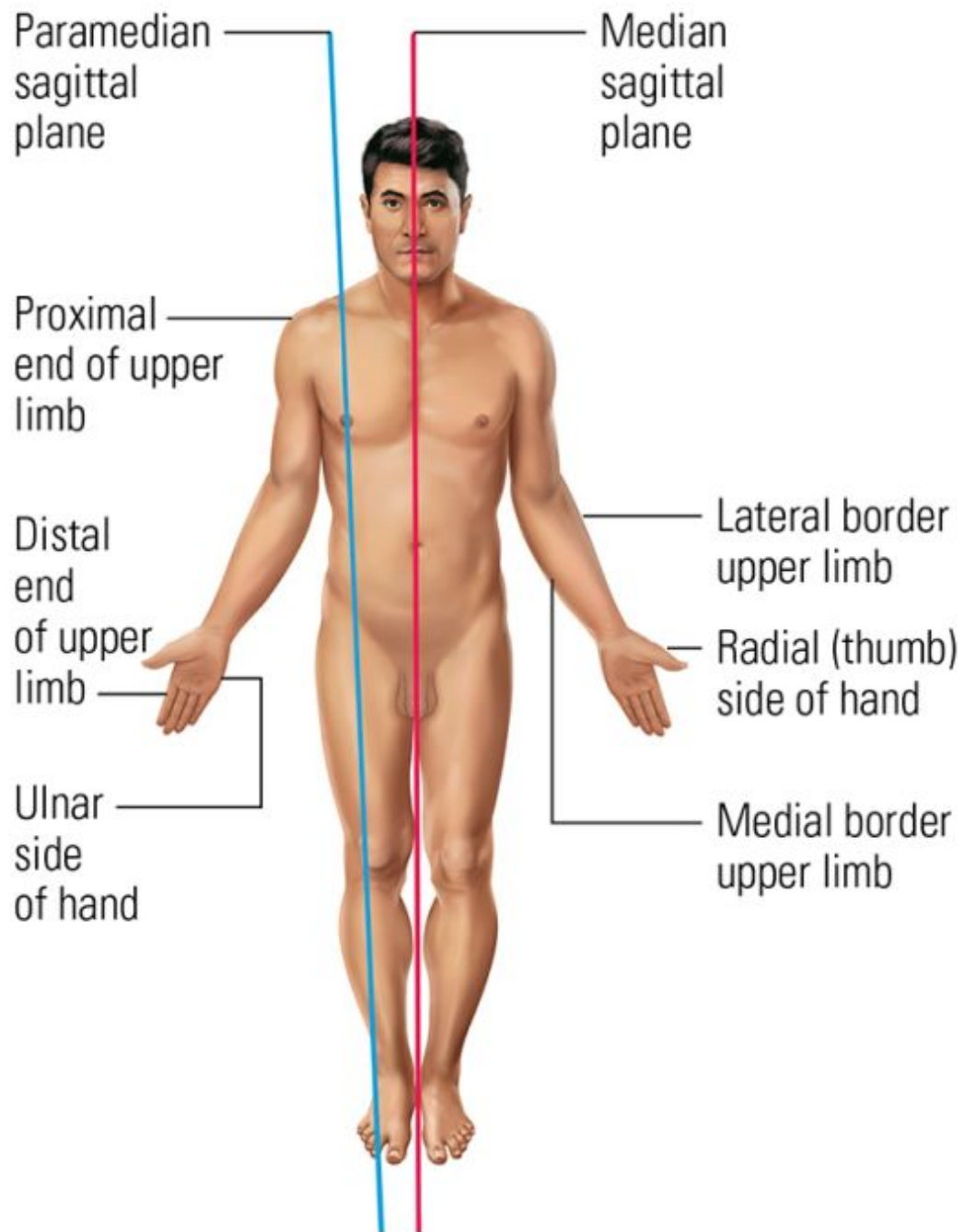


Figure 1C
Body Planes — Front View



Evaluation and Management Tables

Office or Other Outpatient Services

Patient: New					
Code	99202	99203	99204	99205	
REQUIRED ELEMENTS					
Medically Appropriate History and/or Examination	X	X	X	X	
Medical Decision Making (MDM) Level					
Straightforward	X				
Low		X			
Moderate			X		
High				X	
Or					
Total Time (On Date of the Encounter)					
Minutes	15	30	45	60	

Telemedicine: Synchronous Audio-Video E/M Services

Patient: New					
Code	98000	98001	98002	98003	
REQUIRED ELEMENTS					
Medically Appropriate History and/or Examination	X	X	X	X	
Medical Decision Making (MDM) Level					
Straightforward	X				
Low		X			
Moderate			X		
High				X	
Or					
Total Time (On Date of the Encounter)					
Minutes	15	30	45	60	

Office or Other Outpatient Services

Patient: Established					
Code	99211	99212	99213	99214	99215
REQUIRED ELEMENTS					
Medically Appropriate History and/or Examination	N/A	X	X	X	X
Medical Decision Making (MDM) Level					
Straightforward		X			
Low			X		
Moderate	N/A			X	
High					X
Or					
Total Time (On Date of the Encounter)					
Minutes	N/A	10	20	30	40

Telemedicine: Synchronous Audio-Video E/M Services

Patient: Established					
Code	98004	98005	98006	98007	
REQUIRED ELEMENTS					
Medically Appropriate History and/or Examination	X	X	X	X	
Medical Decision Making (MDM) Level					
Straightforward	X				
Low		X			
Moderate			X		
High				X	
Or					
Total Time (On Date of the Encounter)					
Minutes	10	20	30	40	

Telemedicine: Synchronous Audio-Only E/M Services

Patient: New				
Code	98008	98009	98010	98011
REQUIRED ELEMENTS				
More than 10 Minutes of Medical Discussion	X	X	X	X
Medically Appropriate History and/or Examination	X	X	X	X
Medical Decision Making (MDM) Level				
Straightforward	X			
Low		X		
Moderate			X	
High				X
Or				
Total Time (On Date of the Encounter)				
Minutes	15	30	45	60

Telemedicine: Brief Synchronous Communication Technology Service

Patient: Established	
Code	98016
Medical Discussion	5-10 Minutes

Telemedicine: Synchronous Audio-Only E/M Services

Patient: Established				
Code	98012	98013	98014	98015
REQUIRED ELEMENTS				
More than 10 Minutes of Medical Discussion	X	X	X	X
Medically Appropriate History and/or Examination	X	X	X	X
Medical Decision Making (MDM) Level				
Straightforward	X			
Low		X		
Moderate			X	
High				X
Or				
Total Time (On Date of the Encounter)				
Minutes	10	20	30	40

Initial Hospital Inpatient Or Observation Care

Patient: New or Established			
Code	99221	99222	99223
REQUIRED ELEMENTS			
Medically Appropriate History and/or Examination	X	X	X
Medical Decision Making (MDM) Level			
Straightforward or Low	X		
Moderate		X	
High			X
Or			
Total Time (On Date of the Encounter)			
Minutes	40	55	75

Subsequent Hospital Inpatient Or Observation Care

Patient: New or Established			
Code	99231	99232	99233
REQUIRED ELEMENTS			
Medically Appropriate History and/or Examination	X	X	X
Medical Decision Making (MDM) Level			
Straightforward or Low	X		
Moderate		X	
High			X
Or			
Total Time (On Date of the Encounter)			
Minutes	25	35	50

Office or Other Outpatient Consultations

Patient: New or Established				
Code	99242	99243	99244	99245
REQUIRED ELEMENTS				
Medically Appropriate History and/or Examination	X	X	X	X
Medical Decision Making (MDM) Level				
Straightforward	X			
Low		X		
Moderate			X	
High				X
Or				
Total Time (On Date of the Encounter)				
Minutes	20	30	40	55

Hospital Inpatient or Observation Care Services (Including Admission and Discharge Services)

Patient: New or Established			
Code	99234	99235	99236
REQUIRED ELEMENTS			
Medically Appropriate History and/or Examination	X	X	X
Medical Decision Making (MDM) Level			
Straightforward or Low	X		
Moderate		X	
High			X
Or			
Total Time (On Date of the Encounter)			
Minutes	45	70	85

Inpatient or Observation Consultations

Patient: New or Established				
Code	99252	99253	99254	99255
REQUIRED ELEMENTS				
Medically Appropriate History and/or Examination	X	X	X	X
Medical Decision Making (MDM) Level				
Straightforward	X			
Low		X		
Moderate			X	
High				X
Or				
Total Time (On Date of the Encounter)				
Minutes	35	45	60	80

Emergency Department Services

Patient: New or Established					
Code	99281	99282	99283	99284	99285
REQUIRED ELEMENTS					
Medically Appropriate History and/or Examination	N/A	X	X	X	X
Medical Decision Making (MDM) Level					
Straightforward		X			
Low			X		
Moderate	N/A			X	
High					X
Total Time (On Date of the Encounter)					
N/A					

Subsequent Nursing Facility Care

Patient: New or Established				
Code	99307	99308	99309	99310
REQUIRED ELEMENTS				
Medically Appropriate History and/or Examination	X	X	X	X
Medical Decision Making (MDM) Level				
Straightforward	X			
Low		X		
Moderate			X	
High				X
Or				
Total Time (On Date of the Encounter)				
Minutes	10	20	30	45

Initial Nursing Facility Care

Patient: New or Established			
Code	99304	99305	99306
REQUIRED ELEMENTS			
Medically Appropriate History and/or Examination	X	X	X
Medical Decision Making (MDM) Level			
Straightforward or Low	X		
Moderate		X	
High			X
Or			
Total Time (On Date of the Encounter)			
Minutes	25	35	50

Home or Residence Services

Patient: New				
Code	99341	99342	99344	99345
REQUIRED ELEMENTS				
Medically Appropriate History and/or Examination	X	X	X	X
Medical Decision Making (MDM) Level				
Straightforward	X			
Low		X		
Moderate			X	
High				X
Or				
Total Time (On Date of the Encounter)				
Minutes	15	30	60	75

Home or Residence Services

Patient: Established				
Code	99347	99348	99349	99350
REQUIRED ELEMENTS				
Medically Appropriate History and/or Examination	X	X	X	X
Medical Decision Making (MDM) Level				
Straightforward	X			
Low		X		
Moderate			X	
High				X
Or				
Total Time (On Date of the Encounter)				
Minutes	20	30	40	60

Reporting Critical Care Time

Total Duration of Critical Care	CPT Codes
Less than 30 minutes	Appropriate E/M codes
30–74 minutes (30 minutes–1 hour 14 minutes)	99291 x1
75–104 minutes (1 hour 15 minutes–1 hour 44 minutes)	99291 x1 and 99292 x1
105–134 minutes (1 hour 45 minutes–2 hours 14 minutes)	99291 x1 and 99292 x2
135–164 minutes (2 hours 15 minutes–2 hours 44 minutes)	99291 x1 and 99292 x3
165–194 minutes (2 hours 45 minutes–3 hours 14 minutes)	99291 x1 and 99292 x4
195 minutes or longer (3 hours 15 minutes–etc)	99291 and 99292 as appropriate

Neonatal and Pediatric Critical/Intensive Care

Initial Inpatient Neonatal and Pediatric Critical Care				
Code	99468	99471	99475	99291–99292
Age	28 days or younger	29 days–24 mos	2–5 yrs	6 yrs +
Subsequent Inpatient Neonatal and Pediatric Critical Care				
Code	99469	99472	99476	99291–99292
Age	28 days or younger	29 days–24 mos	2–5 yrs	6 yrs +
Initial Neonatal Intensive Care				
Code	99477			
Age	28 days of age or younger			
	Requires intensive observation, frequent interventions, and other intensive care services			
Continuing Neonatal and Infant Inpatient Low Birth-Weight Intensive Care				
Code	99478	99479	99480	99231–99233
Weight	less than 1,500 g	1,500–2,500 g	2,501–5,000 g	+5,000 g

Evaluation and Management (E/M) Services Guidelines

The following is a listing of headings and subheadings that appear within the Evaluation and Management section of the CPT codebook. The subheadings or subsections denoted with asterisks (*) below have special instructions unique to that subsection. Where these are indicated, special notes or guidelines will be presented preceding those procedural terminology listings, referring to that subsection specifically. Note that all code ranges in each subsection are listed as they appear in the subsection, even if the code numbers are out of numerical sequence and/or repeated in the next subsection.

E/M Guidelines Overview*

Classification of Evaluation and Management (E/M) Services*

New and Established Patients*

Initial and Subsequent Services*

Split or Shared Visits*

Multiple Evaluation and Management Services on the Same Date*

Services Reported Separately*

History and/or Examination*

Levels of E/M Services*

Guidelines for Selecting Level of Service Based on Medical Decision Making*

Number and Complexity of Problems Addressed at the Encounter*

Amount and/or Complexity of Data to Be Reviewed and Analyzed*

Risk of Complications and/or Morbidity or Mortality of Patient Management*

Guidelines for Selecting Level of Service Based on Time*

Unlisted Service*

Special Report*

Evaluation and Management

Office or Other Outpatient Services* (99202-99215)

New Patient (99202-99205)

Established Patient (99211-99215)

Telemedicine Services* (98000-98016)

Synchronous Audio-Video Evaluation and Management Services* (98000-98007)

New Patient (98000-98003)

Established Patient (98004-98007)

Synchronous Audio-Only Evaluation and Management Services* (98008-98015)

New Patient (98008-98011)

Established Patient (98012-98015)

Brief Synchronous Communication Technology Service (eg, Virtual Check-In)* (98016)

Hospital Inpatient and Observation Care Services* (99221-99239)

Initial Hospital Inpatient or Observation Care (99221-99223)

New or Established Patient* (99221-99223)

Subsequent Hospital Inpatient or Observation Care (99231-99233)

Hospital Inpatient or Observation Care Services (Including Admission and Discharge Services)* (99234-99236)

Hospital Inpatient or Observation Discharge Services* (99238-99239)

Consultations* (99242-99255)

Office or Other Outpatient Consultations (99242-99245)

New or Established Patient* (99242-99245)

Inpatient or Observation Consultations (99252-99255)

New or Established Patient* (99252-99255)

Emergency Department Services (99281-99288)

New or Established Patient* (99281-99285)

Other Emergency Services* (99288)

Critical Care Services* (99291-99292)

Nursing Facility Services* (99304-99316)

Initial Nursing Facility Care (99304-99306)

New or Established Patient* (99304-99306)

Subsequent Nursing Facility Care (99307-99310)

Nursing Facility Discharge Services* (99315-99316)

Home or Residence Services* (99341-99350)

New Patient (99341-99345)

Established Patient (99347-99350)

Prolonged Services (99358-99360)

Prolonged Service Without Direct Patient Contact on Date Other Than the Face-to-Face Evaluation and Management Service* (99358-99359)

Prolonged Clinical Staff Services With Physician or Other Qualified Health Care Professional Supervision* (99415-99416)

Prolonged Service With or Without Direct Patient Contact on the Date of an Evaluation and Management Service* (99417-99418)

Standby Services* (99360)

Case Management Services* (99366-99368)

Medical Team Conferences* (99366-99368)

Medical Team Conference, Direct (Face-to-Face) Contact With Patient and/or Family (99366)

Medical Team Conference, Without Direct (Face-to-Face) Contact With Patient and/or Family (99367-99368)

Care Plan Oversight Services* (99374-99380)

Preventive Medicine Services* (99381-99429)

New Patient (99381-99387)

Established Patient (99391-99397)

Counseling Risk Factor Reduction and Behavior Change Intervention (99401-99429)

New or Established Patient* (99401-99412)

Preventive Medicine, Individual Counseling (99401-99404)

Behavior Change Interventions, Individual (99406-99409)

Preventive Medicine, Group Counseling (99411-99412)

Other Preventive Medicine Services (99429)

Non-Face-to-Face Services (99421-99458)

Telephone Services

Online Digital Evaluation and Management Services* (99421-99423)

Interprofessional Telephone/Internet/Electronic Health Record Consultations* (99446-99452)

Digitally Stored Data Services/Remote Physiologic Monitoring* (99453-99474)

Remote Physiologic Monitoring Treatment Management Services* (99470-99458)

Special Evaluation and Management Services* (99450-99456)

Basic Life and/or Disability Evaluation Services (99450)

Work Related or Medical Disability Evaluation Services (99455-99456)

Newborn Care Services* (99460-99463)

Delivery/Birthing Room Attendance and Resuscitation Services (99464-99465)

Inpatient Neonatal Intensive Care Services and Pediatric and Neonatal Critical Care Services (99466-99480)

Pediatric Critical Care Patient Transport* (99466-99486)

Inpatient Neonatal and Pediatric Critical Care* (99468-99476)

Initial and Continuing Intensive Care Services* (99477-99480)

Cognitive Assessment and Care Plan Services* (99483)

Care Management Services* (99490-99427)

Care Planning*

Chronic Care Management Services* (99490-99437)

Complex Chronic Care Management Services* (99487-99489)

Principal Care Management Services* (99424-99427)

Psychiatric Collaborative Care Management Services* (99492-99494)

Transitional Care Management Services* (99495-99496)

Advance Care Planning* (99497-99498)

General Behavioral Health Integration Care Management* (99484)

Other Evaluation and Management Services (99459, 99499)

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.

E/M Guidelines Overview

The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, “Hospital Inpatient and Observation Care,” special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter with the patient and/or family/caregiver. (For 99211 and 99281, the face-to-face services may be performed by clinical staff.)

In the **Evaluation and Management** section (98000-98016, 99202-99499), there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Telemedicine Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home or Residence Services
- Prolonged Service With or Without Direct Patient Contact on the Date of an Evaluation and Management Service

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories, such as office visits, hospital inpatient or observation care 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 inpatient and observation care 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.

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified (eg, office or other outpatient visit). Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided in the Guidelines for Selecting Level of Service Based on Time.)

The place of service and service type are defined by the location where the face-to-face encounter with the patient and/or family/caregiver occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.

New and Established Patients

Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** 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 other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the **exact** same specialty **and subspecialty** as the physician.

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.

The Decision Tree for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Coding Tip

Instructions for Use of the CPT Codebook

When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician. A "physician or other qualified health care professional" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his or her scope of practice and independently reports that professional service. These professionals are distinct from "clinical staff." A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional, and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specific professional service but does not individually report that professional service. Other policies may also affect who may report specific services.

CPT Coding Guidelines, Introduction, Instructions for Use of the CPT Codebook

Initial and Subsequent Services

Some categories apply to both new and established patients (eg, hospital inpatient or observation care). These categories differentiate services by whether the service is the initial service or a subsequent service. For the purpose of distinguishing between initial or subsequent visits, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. An initial service is when the patient has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the inpatient, observation, or nursing facility admission and stay.

A subsequent service is when the patient has received professional service(s) from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the admission and stay.

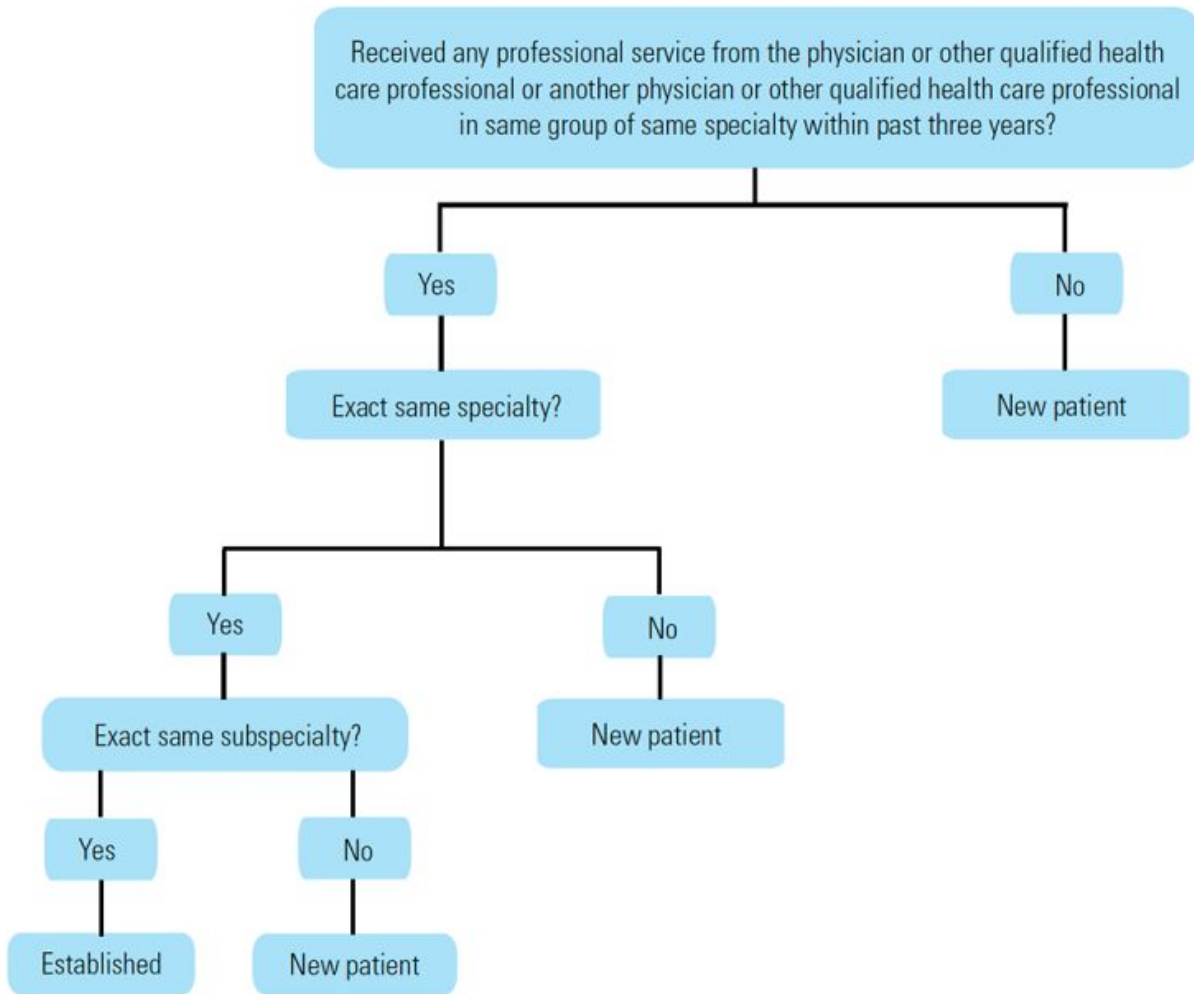
In the instance when a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.

For reporting hospital inpatient or observation care services, a stay that includes a transition from observation to inpatient is a single stay. For reporting nursing facility services, a stay that includes transition(s) between skilled nursing facility and nursing facility level of care is the same stay.

Split or Shared Visits

Physician(s) and other qualified health care professional(s) (QHP[s]) may act as a team in providing care for the patient, working together during a single E/M service. The split or shared visits guidelines are applied to determine which professional may report the service. If the physician or other QHP performs a substantive portion of the encounter, the physician or other QHP may report the service. If code selection is based on total time on the date of the encounter, the service is reported by the professional who spent the majority of the face-to-face or non-face-to-face time performing the service. For the purpose of reporting E/M services within the context of team-based care, performance of a substantive part of the MDM requires that the physician(s) or other QHP(s) made or approved the management plan for the ***number and complexity of problems addressed at the encounter*** and takes responsibility for that plan with its inherent ***risk of complications and/or morbidity or mortality of patient management***. By doing so, a physician or other QHP has performed two of the three elements used in the selection of the code level based on MDM. If ***the amount and/or complexity of data to be reviewed and analyzed*** is used by the physician or other QHP to determine the reported code level, assessing an independent historian's narrative and the ordering or review of tests or documents do not have to be personally performed by the physician or other QHP, because the relevant items would be considered in formulating the management plan. Independent interpretation of tests and discussion of management plan or test interpretation must be personally performed by the physician or other QHP if these are used to determine the reported code level by the physician or other QHP.

Decision Tree for New vs Established Patients



Multiple Evaluation and Management Services on the Same Date

The following guidelines apply to services that a patient may receive for hospital inpatient care, observation care, or nursing facility care. For instructions regarding transitions to these settings from the office or outpatient, home or residence, or emergency department setting, see guidelines for **Hospital Inpatient and Observation Care Services** or **Nursing Facility Services**.

A patient may receive E/M services in more than one setting on a calendar date. A patient may also have more than one visit in the same setting on a calendar date. The guidelines for multiple E/M services on the same date address circumstances in which the patient has received multiple visits or services from the same physician or other QHP or another physician or other QHP of the exact same specialty and subspecialty who belongs to the same group practice.

Per day: The hospital inpatient and observation care services and the nursing facility services are “per day” services. When multiple visits occur over the course of a single calendar date in the same setting, a single service is reported. When using MDM for code level selection, use the aggregated MDM over the course of the calendar date. When using time for code level selection, sum the time over the course of the day using the guidelines for reporting time.

Multiple encounters in different settings or facilities: A patient may be seen and treated in different facilities (eg, a hospital-to-hospital transfer). When more than one primary E/M service is reported and time is used to select the code level for either service, only the time spent providing that individual service may be allocated to the code level selected for reporting that service. No time may be counted twice when reporting more than one E/M service. Prolonged services are also based on the same allocation and their relationship to the primary service. The designation of the facility may be defined by licensure or regulation. Transfer from a hospital bed to a nursing facility bed in a hospital with nursing facility beds is considered as two services in two facilities because there is a discharge from one type of designation to another. An intra-facility transfer for a different level of care (eg, from a routine unit to a critical care unit) does not constitute a new stay, nor does it constitute a transfer to a different facility.

Emergency department (ED) and services in other settings (same or different facilities): Time spent in an ED by a physician or other QHP who provides subsequent E/M services may be included in calculating total time on the date of the encounter when ED services are not reported and another E/M service is reported (eg, hospital inpatient and observation care services).

Discharge services and services in other facilities: Each service may be reported separately as long as any time spent on the discharge service is not counted towards the total time of a subsequent service in which code level selection for the subsequent service is based on time. This includes any hospital inpatient or observation care services (including admission and discharge services) time (99234, 99235, 99236) because these services may be selected based on MDM or time. When these services are reported with another E/M service on the same calendar date, time related to the hospital inpatient or observation care service (including admission and discharge services) may not be used for code selection of the subsequent service.

Discharge services and services in the same facility: If the patient is discharged and readmitted to the same facility on the same calendar date, report a subsequent care service instead of a discharge or initial service. For the purpose of E/M reporting, this is a single stay.

Discharge services and services in a different facility: If the patient is admitted to another facility, for the purpose of E/M reporting this is considered a different stay. Discharge and initial services may be reported as long as time spent on the discharge service is not counted towards the total time of the subsequent service reported when code level selection is based on time.

Critical care services (including neonatal intensive care services and pediatric and neonatal critical care): Reporting guidelines for intensive and critical care services that are performed on the same calendar date as another E/M service are described in the service specific section guidelines.

Transitions between office or other outpatient, home or residence, or emergency department and hospital inpatient or observation or nursing facility: See the guidelines for **Hospital Inpatient and Observation Care Services** or **Nursing Facility Services**. If the patient is seen in two settings and only one service is reported, the total time on the date of the encounter or the aggregated MDM is used for determining the level of the single reported service. If prolonged services are reported, use the prolonged services code that is appropriate for the primary service

reported, regardless of where the patient was located when the prolonged services time threshold was met. The choice of the primary service is at the discretion of the reporting physician or other QHP.

Services Reported Separately

Any specifically identifiable procedure or service (ie, identified with a specific CPT code) performed on the date of E/M services may be reported separately.

The ordering and actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when the professional interpretation of those tests/studies is reported separately by the physician or other qualified health care professional reporting the E/M service. Tests that do not require separate interpretation (eg, tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation, but may be counted as ordered or reviewed for selecting an MDM level. The 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 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 and, if required, with modifier 26 appended.

The physician or other qualified health care professional 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. 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 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.

History and/or Examination

E/M codes that have levels of services include a medically appropriate history and/or physical examination, when performed. The nature and extent of the history and/or physical examination are determined by the treating physician or other qualified health care professional reporting the service. The care team may collect information, and the patient or caregiver may supply information directly (eg, by electronic health record [EHR] portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional. The extent of history and physical examination is not an element in selection of the level of these E/M service codes.

Levels of E/M Services

Select the appropriate level of E/M services based on the following:

1. The level of the MDM as defined for each service, **or**
2. The total time for E/M services performed on the date of the encounter.

Within each category or subcategory of E/M service based on MDM or time, 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. Each level of E/M services may be used by all physicians or other qualified health care professionals.

Guidelines for Selecting Level of Service Based on Medical Decision Making

Four types of MDM are recognized: straightforward, low, moderate, and high. The concept of the level of MDM does not apply to 99211, 99281.

MDM includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. MDM is defined by three elements. The elements are:

- ***The number and complexity of problem(s) that are addressed during the encounter.***
- ***The amount and/or complexity of data to be reviewed and analyzed.***
These data include medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. This includes information obtained from multiple sources or interprofessional communications that are not reported separately and interpretation of tests that are not reported separately. Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter. Ordering a test

may include those considered but not selected after shared decision making. For example, a patient may request diagnostic imaging that is not necessary for their condition and discussion of the lack of benefit may be required. Alternatively, a test may normally be performed, but due to the risk for a specific patient it is not ordered. These considerations must be documented. Data are divided into three categories:

- Tests, documents, orders, or independent historian(s). (Each unique test, order, or document is counted to meet a threshold number.)
 - Independent interpretation of tests (not separately reported).
 - Discussion of management or test interpretation with external physician or other qualified health care professional or appropriate source (not separately reported).
- ***The risk of complications and/or morbidity or mortality of patient management.*** This includes decisions made at the encounter associated with diagnostic procedure(s) and treatment(s). This includes the possible management options selected and those considered but not selected after shared decision making with the patient and/or family. For example, a decision about hospitalization includes consideration of alternative levels of care. Examples may include a psychiatric patient with a sufficient degree of support in the outpatient setting or the decision to not hospitalize a patient with advanced dementia with an acute condition that would generally warrant inpatient care, but for whom the goal is palliative treatment.

Shared decision making involves eliciting patient and/or family preferences, patient and/or family education, and explaining risks and benefits of management options.

MDM may be impacted by role and management responsibility.

When the physician or other qualified health care professional is reporting a separate CPT code that includes interpretation and/or report, the interpretation and/or report is not counted toward the MDM when selecting a level of E/M services. When the physician or other qualified health care professional is reporting a separate service for discussion of

management with a physician or another qualified health care professional, the discussion is not counted toward the MDM when selecting a level of E/M services.

The Levels of Medical Decision Making (MDM) table ([Table 1](#)) is a guide to assist in selecting the level of MDM for reporting an E/M services code. The table includes the four levels of MDM (ie, straightforward, low, moderate, high) and the three elements of MDM (ie, number and complexity of problems addressed at the encounter, amount and/or complexity of data reviewed and analyzed, and risk of complications and/or morbidity or mortality of patient management). To qualify for a particular level of MDM, two of the three elements for that level of MDM must be met or exceeded.

Examples in the table may be more or less applicable to specific settings of care. For example, the decision to hospitalize applies to the outpatient or nursing facility encounters, whereas the decision to escalate hospital level of care (eg, transfer to ICU) applies to the hospitalized or observation care patient. See also the introductory guidelines of each code family section.

The elements listed in [Table 1](#), Levels of Medical Decision Making, are defined in the guidelines for number and complexity of problems addressed at the encounter, amount and/or complexity of data to be reviewed and analyzed, and risk of complications and/or morbidity or mortality of patient management.

Number and Complexity of Problems Addressed at the Encounter

One element used in selecting the level of service is the number and complexity of the problems that are addressed at the encounter. Multiple new or established conditions may be addressed at the same time and may affect MDM. Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition. Comorbidities and underlying diseases, in and of themselves, are not considered in selecting a level of E/M services **unless** they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and

analyzed or the risk of complications and/or morbidity or mortality of patient management. The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Therefore, presenting symptoms that are likely to represent a highly morbid condition may “drive” MDM even when the ultimate diagnosis is not highly morbid. The evaluation and/or treatment should be consistent with the likely nature of the condition. Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.

The term “risk” as used in the definition of this element relates to risk from the condition. While condition risk and management risk may often correlate, the risk from the condition is distinct from the risk of the management.

Problem: A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.

Problem addressed: A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice. Notation in the patient’s medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. Referral without evaluation (by history, examination, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. For hospital inpatient and observation care services, the problem addressed is the problem status on the date of the encounter, which may be significantly different than on admission. It is the problem being managed or co-managed by the reporting physician or other qualified health care professional and may not be the cause of admission or continued stay.

Table 1: Levels of Medical Decision Making (MDM)

Elements of Medical Decision Making			
Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to Be Reviewed and Analyzed <i>*Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.</i>	Risk of Complications and/or Morbidity or Mortality of Patient Management
Straightforward	Minimal <ul style="list-style-type: none"> 1 self-limited or minor problem 	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
Low	Low <ul style="list-style-type: none"> 2 or more self-limited or minor problems; or <ul style="list-style-type: none"> 1 stable, chronic illness; or <ul style="list-style-type: none"> 1 acute, uncomplicated illness or injury; or <ul style="list-style-type: none"> 1 stable, acute illness; or <ul style="list-style-type: none"> 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care 	Limited <i>(Must meet the requirements of at least 1 out of 2 categories)</i> Category 1: Tests and documents <ul style="list-style-type: none"> Any combination of 2 from the following: <ul style="list-style-type: none"> Review of prior external note(s) from each unique source*; Review of the result(s) of each unique test*; Ordering of each unique test* or Category 2: Assessment requiring an independent historian(s) <i>(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)</i>	Low risk of morbidity from additional diagnostic testing or treatment
Moderate	Moderate <ul style="list-style-type: none"> 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or <ul style="list-style-type: none"> 2 or more stable, chronic illnesses; or <ul style="list-style-type: none"> 1 undiagnosed new problem with uncertain prognosis; or <ul style="list-style-type: none"> 1 acute illness with systemic symptoms; or <ul style="list-style-type: none"> 1 acute, complicated injury 	Moderate <i>(Must meet the requirements of at least 1 out of 3 categories)</i> Category 1: Tests, documents, or independent historian(s) <ul style="list-style-type: none"> Any combination of 3 from the following: <ul style="list-style-type: none"> Review of prior external note(s) from each unique source*; Review of the result(s) of each unique test*; Ordering of each unique test*; Assessment requiring an independent historian(s) or Category 2: Independent interpretation of tests <ul style="list-style-type: none"> Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or Category 3: Discussion of management or test interpretation <ul style="list-style-type: none"> Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported) 	Moderate risk of morbidity from additional diagnostic testing or treatment <i>Examples only:</i> <ul style="list-style-type: none"> Prescription drug management Decision regarding minor surgery with identified patient or procedure risk factors Decision regarding elective major surgery without identified patient or procedure risk factors Diagnosis or treatment significantly limited by social determinants of health
High	High <ul style="list-style-type: none"> 1 or more chronic illnesses with severe exacerbation, 	Extensive <i>(Must meet the requirements of at least 2 out of 3 categories)</i>	High risk of morbidity from additional diagnostic testing or treatment

- progression, or side effects of treatment;
- or**
- **1** acute or chronic illness or injury that poses a threat to life or bodily function
- Category 1: Tests, documents, or independent historian(s)**
- **Any combination of 3 from the following:**
 - Review of prior external note(s) from each unique source*;
 - Review of the result(s) of each unique test*;
 - Ordering of each unique test*;
 - Assessment requiring an independent historian(s)
- or**
- Category 2: Independent interpretation of tests**
- Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
- or**
- Category 3: Discussion of management or test interpretation**
- Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
- Examples only:*
- Drug therapy requiring intensive monitoring for toxicity
 - Decision regarding elective major surgery with identified patient or procedure risk factors
 - Decision regarding emergency major surgery
 - Decision regarding hospitalization or escalation of hospital-level care
 - Decision not to resuscitate or to de-escalate care because of poor prognosis
 - Decision regarding parenteral controlled substances
-

Minimal problem: A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician’s or other qualified health care professional’s supervision (see 99211, 99281).

Self-limited or minor problem: A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.

Stable, chronic illness: A problem with an expected duration of at least one year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition). “Stable” for the purposes of categorizing MDM is defined by the specific treatment goals for an individual patient. A patient who is not at his or her treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. For example, a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity **without** treatment is significant.

Acute, uncomplicated illness or injury: A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute, uncomplicated illness.

Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care: A recent or new short-term problem with low risk of morbidity for which treatment is required. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. The treatment required is delivered in a hospital inpatient or observation level setting.

Stable, acute illness: A problem that is new or recent for which treatment has been initiated. The patient is improved and, while resolution may not be complete, is stable with respect to this condition.

Chronic illness with exacerbation, progression, or side effects of treatment: A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects.

Undiagnosed new problem with uncertain prognosis: A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment.

Acute illness with systemic symptoms: An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, see the definitions for *self-limited or minor problem* or *acute, uncomplicated illness or injury*. Systemic symptoms may not be general but may be single system.

Acute, complicated injury: An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity.

Chronic illness with severe exacerbation, progression, or side effects of treatment: The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require escalation in level of care.

Acute or chronic illness or injury that poses a threat to life or bodily function: An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment. Some symptoms may represent a condition that is significantly probable and poses a potential threat to life or bodily function. These may be included in this category when the evaluation and treatment are consistent with this degree of potential severity.

Amount and/or Complexity of Data to Be Reviewed and Analyzed

One element used in selecting the level of services is the amount and/or complexity of data to be reviewed or analyzed at an encounter.

Analyzed: The process of using the data as part of the MDM. The data element itself may not be subject to analysis (eg, glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment. Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they are counted in that encounter. Tests that are ordered outside of an encounter may be counted in the encounter in which they are analyzed. In the case of a recurring order, each new result may be counted in the encounter in which it is analyzed. For example, an encounter that includes an order for monthly prothrombin times would count for one prothrombin time ordered and reviewed. Additional future results, if analyzed in a subsequent encounter, may be counted as a single test in that subsequent encounter. Any service for which the professional component is separately reported by the physician or other qualified health care professional reporting the E/M services is not counted as a data element ordered,

reviewed, analyzed, or independently interpreted for the purposes of determining the level of MDM.

Test: Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test. The differentiation between single or multiple tests is defined in accordance with the CPT code set. For the purpose of data reviewed and analyzed, pulse oximetry is not a test.

Unique: A unique test is defined by the CPT code set. When multiple results of the same unique test (eg, serial blood glucose values) are compared during an E/M service, count it as one unique test. Tests that have overlapping elements are not unique, even if they are identified with distinct CPT codes. For example, a CBC with differential would incorporate the set of hemoglobin, CBC without differential, and platelet count. A unique source is defined as a physician or other qualified health care professional in a distinct group or different specialty or subspecialty, or a unique entity. Review of all materials from any unique source counts as one element toward MDM.

Combination of data elements: A combination of different data elements, for example, a combination of notes reviewed, tests ordered, tests reviewed, or independent historian, allows these elements to be summed. It does not require each item type or category to be represented. A unique test ordered, plus a note reviewed and an independent historian would be a combination of three elements.

External: External records, communications and/or test results are from an external physician, other qualified health care professional, facility, or health care organization.

External physician or other qualified health care professional: An external physician or other qualified health care professional who is not in the same group practice or is of a different specialty or subspecialty. This includes licensed professionals who are practicing independently. The individual may also be a facility or organizational provider such as from a hospital, nursing facility, or home health care agency.

Discussion: Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries (eg, clinical staff or trainees). Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange. The discussion does not need to be on the date of the encounter, but it is counted only once and only when it is used in the decision making of the encounter. It may be asynchronous (ie, does not need to be in person), but it must be initiated and completed within a short time period (eg, within a day or two).

Independent historian(s): An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement is met. It does not include translation services. The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.

Independent interpretation: The interpretation of a test for which there is a CPT code, and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional who reports the E/M service is reporting or has previously reported the test. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test. A test that is ordered and independently interpreted may count both as a test ordered and interpreted.

Appropriate source: For the purpose of the **discussion of management** data element (see [Table 1](#), Levels of Medical Decision Making), an appropriate source includes professionals who are not health care professionals but may be involved in the management of the patient (eg, lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregivers. For the purpose of **documents reviewed**, documents from an appropriate source may be counted.