

What Are CPT Codes?

CPT stands for **Current Procedural Terminology**. These are 5-digit codes that describe exactly what medical service, procedure, or test was performed on a patient. CPT codes were created and are maintained by the **American Medical Association (AMA)**.

Every time a doctor sees a patient, runs a test, performs surgery, or provides any medical service, a CPT code is used on the claim to tell the insurance company what was done. Without the correct CPT code, the insurance company cannot pay the claim properly.

CPT codes are used on CMS-1500 (professional) claims by physicians, nurse practitioners, therapists, and other individual providers. They are also used on UB-04 (institutional) claims alongside revenue codes for outpatient hospital services.

★ **KEY RULE:** Choosing the **WRONG** CPT code = wrong payment or denial. Always select the code that most accurately matches what was documented in the medical record. Never code for a service that was not documented.

How CPT Codes Are Organized

CPT codes are divided into three categories and multiple sections. Here is the full overview:

Category / Section	Code Range	What It Covers
Category I — Evaluation & Management	99202–99499	Office visits, hospital visits, consultations, preventive care, telehealth
Category I — Anesthesia	00100–01999	Anesthesia for all types of surgical procedures
Category I — Surgery	10004–69990	All surgical procedures from skin to neurosurgery
Surgery: Integumentary (Skin)	10004–19499	Skin lesions, wound repairs, grafts, breast surgery
Surgery: Musculoskeletal	20100–29999	Bones, joints, muscles, tendons, casts, fractures
Surgery: Respiratory	30000–32999	Nose, throat, larynx, trachea, lungs
Surgery: Cardiovascular	33010–37799	Heart, arteries, veins, cardiac procedures
Surgery: Digestive	40490–49999	Mouth, esophagus, stomach, intestines, liver, colon
Surgery: Urinary	50010–53899	Kidney, ureter, bladder, urethra
Surgery: Male Genital	54000–55899	Male reproductive system
Surgery: Female Genital	56405–58999	Female reproductive system
Surgery: Maternity	59000–59899	Pregnancy, delivery, postpartum care
Surgery: Endocrine	60000–60699	Thyroid, parathyroid, adrenal glands
Surgery: Nervous System	61000–64999	Brain, spinal cord, peripheral nerves
Surgery: Eye & Ocular	65091–68899	Eye surgeries and procedures

Category / Section	Code Range	What It Covers
Surgery: Auditory (Ear)	69000–69979	Ear surgeries and procedures
Category I — Radiology	70010–79999	X-ray, ultrasound, CT, MRI, nuclear medicine, radiation therapy
Category I — Pathology & Lab	80047–89398	Blood tests, urinalysis, cultures, tissue analysis, drug testing
Category I — Medicine	90281–99199	Vaccines, psychiatry, dialysis, ophthalmology, therapy, home health
Category II — Performance Measures	0001F–9007 F	Optional tracking codes; used for quality reporting, NOT billing
Category III — New Technology	0042T–0812 T	Emerging procedures; temporary codes for new tech being studied
HCPCS Level II	A0000–V999 9	Supplies, equipment, drugs, ambulance — not in AMA CPT book

99202–99499 | EVALUATION & MANAGEMENT (E&M;) CODES

E&M; codes are the most commonly billed CPT codes. They describe patient visits — from a quick 10-minute office check-in to a complex hospital admission. Since 2021, the level of E&M; for office visits is determined by **Medical Decision Making (MDM)** or **Total Time** — not the old 1995/1997 documentation guidelines.

CPT Code	Visit Type	Medical Decision Making (MDM)	Typical Time (Minutes)	Common Example
99202	New patient — Office (Level 2)	Straightforward: 1 problem, low risk, minimal data review	15–29 min	Sore throat in a healthy adult; simple prescription given
99203	New patient — Office (Level 3)	Low complexity: 1–2 problems, low risk, limited data	30–44 min	New patient with controlled hypertension; medication started
99204	New patient — Office (Level 4)	Moderate complexity: multiple problems, moderate risk	45–59 min	New patient with diabetes + hypertension; multiple meds ordered
99205	New patient — Office (Level 5)	High complexity: severe problems, high risk, extensive review	60–74 min	New patient with cancer, multiple comorbidities, complex management
99211	Established patient — Level 1 (nurse visit)	No MDM by physician required	Under 10 min	Blood pressure check, flu shot only — no physician E&M; needed
99212	Established patient — Office (Level 2)	Straightforward MDM	10–19 min	Follow-up for resolved ear infection; no changes made
99213	Established patient — Office (Level 3)	Low complexity MDM	20–29 min	Follow-up for hypertension; medication refill, labs ordered
99214	Established patient — Office (Level 4)	Moderate complexity MDM	30–39 min	Follow-up for poorly controlled diabetes; medication adjustment
99215	Established patient — Office (Level 5)	High complexity MDM	40–54 min	Complex patient with multiple conditions requiring extensive management
99221	Hospital Inpatient — Initial (Level 1)	Straightforward or low MDM	30 min	Uncomplicated cellulitis requiring IV antibiotics in hospital
99222	Hospital Inpatient — Initial (Level 2)	Moderate MDM	50 min	Pneumonia requiring admission, multiple comorbidities
99223	Hospital Inpatient — Initial (Level 3)	High complexity MDM	70 min	Sepsis, multi-system failure, complex management on admission
99231	Hospital Subsequent — Level 1	Straightforward/low MDM	25 min	Daily rounding — patient improving, minor issues only
99232	Hospital Subsequent — Level 2	Moderate MDM	35 min	Daily rounding — patient with ongoing issues, plan adjusted

CPT Code	Visit Type	Medical Decision Making (MDM)	Typical Time (Minutes)	Common Example
99233	Hospital Subsequent — Level 3	High complexity MDM	50 min	Daily rounding — unstable patient, significant management changes
99238	Hospital Discharge — under 30 minutes	Standard discharge	Under 30 min	Discharge with instructions, prescriptions, follow-up scheduled
99239	Hospital Discharge — over 30 minutes	Complex discharge	Over 30 min	Complex discharge requiring extensive coordination and documentation
99281	Emergency Dept — Level 1	Minor problem, self-limited	Varies	Splinter removal, insect bite, minor rash
99282	Emergency Dept — Level 2	Low complexity	Varies	Simple laceration, UTI in healthy adult
99283	Emergency Dept — Level 3	Moderate complexity	Varies	Ankle sprain with x-ray, asthma with nebulizer treatment
99284	Emergency Dept — Level 4	Moderate-high complexity	Varies	Chest pain rule-out, abdominal pain with CT scan
99285	Emergency Dept — Level 5	High complexity, high risk	Varies	Chest pain — STEMI, altered mental status, multi-trauma
99291	Critical Care — first 30–74 min	Life-threatening condition	30–74 min	ICU patient on ventilator, septic shock, active cardiac arrest management
99292	Critical Care — each additional 30 min	Continuation of critical care	Per 30 min	Add-on code to 99291; bill for each additional 30 min of critical care
99304	SNF Initial — Level 1	Straightforward MDM	25 min	New SNF admission for simple wound care
99305	SNF Initial — Level 2	Moderate MDM	35 min	New SNF admission for rehab after hip fracture
99306	SNF Initial — Level 3	High complexity MDM	45 min	New SNF admission — medically complex, multiple diagnoses
99307	SNF Subsequent — Level 1	Straightforward MDM	10 min	Stable SNF patient, minor issues
99308	SNF Subsequent — Level 2	Low MDM	15 min	SNF patient with one issue being monitored
99309	SNF Subsequent — Level 3	Moderate MDM	25 min	SNF patient with worsening condition needing plan change
99310	SNF Subsequent — Level 4	High complexity MDM	35 min	SNF patient with acute change, possible hospital transfer decision

CPT Code	Visit Type	Medical Decision Making (MDM)	Typical Time (Minutes)	Common Example
99341	Home Visit — New patient Level 1	Straightforward MDM	15 min	New home patient — simple, stable condition
99342	Home Visit — New patient Level 2	Low MDM	25 min	New home patient — one problem being managed
99344	Home Visit — New patient Level 4	Moderate MDM	60 min	New home patient with multiple chronic conditions
99345	Home Visit — New patient Level 5	High MDM	75 min	New home patient — unstable, complex management
99347	Home Visit — Established Level 1	Straightforward MDM	15 min	Follow-up home visit — stable, no new problems
99348	Home Visit — Established Level 2	Low MDM	25 min	Follow-up home visit — one monitored issue
99349	Home Visit — Established Level 3	Moderate MDM	40 min	Follow-up home visit — multiple issues, plan adjusted
99350	Home Visit — Established Level 4	High MDM	60 min	Follow-up home visit — unstable, high-risk patient
99381	Preventive — New patient, infant (under 1)	Well-child visit	Varies	Annual wellness visit for baby under 1 year old
99382	Preventive — New patient, age 1–4	Well-child visit	Varies	Toddler wellness exam, developmental screening
99383	Preventive — New patient, age 5–11	Well-child visit	Varies	School-age child annual physical
99384	Preventive — New patient, age 12–17	Well-child visit	Varies	Teen annual physical, sports physical
99385	Preventive — New patient, age 18–39	Adult wellness visit	Varies	Annual physical for young adult
99386	Preventive — New patient, age 40–64	Adult wellness visit	Varies	Annual physical for middle-aged adult
99387	Preventive — New patient, age 65+	Adult wellness visit	Varies	Senior annual physical, Medicare Annual Wellness Visit
99391	Preventive — Established, infant	Well-child visit	Varies	Follow-up wellness for baby — existing patient
99395	Preventive — Established, age 18–39	Adult wellness visit	Varies	Annual physical — established young adult patient
99396	Preventive — Established, age 40–64	Adult wellness visit	Varies	Annual physical — established middle-aged patient

CPT Code	Visit Type	Medical Decision Making (MDM)	Typical Time (Minutes)	Common Example
99397	Preventive — Established, age 65+	Adult wellness visit	Varies	Senior annual physical — established patient
99421	Online Digital E&M — 5–10 min	Asynchronous patient portal message	5–10 min total	Patient sends portal message, physician reviews and responds
99422	Online Digital E&M — 11–20 min	Asynchronous patient portal message	11–20 min total	More complex portal inquiry with clinical decision making
99423	Online Digital E&M — 21+ min	Asynchronous patient portal message	21+ min total	Complex portal interaction requiring significant physician time
99441	Telephone E&M — 5–10 min	Phone call by established patient	5–10 min	Quick phone consult — doesn't need an in-person follow-up
99442	Telephone E&M — 11–20 min	Phone call by established patient	11–20 min	Moderate phone consult with clinical decision-making
99443	Telephone E&M — 21–30 min	Phone call by established patient	21–30 min	Complex phone management without office visit needed
99446	Interprofessional Consult — written	Non-face-to-face consult between physicians	5–10 min	PCP calls specialist for advice; not a formal referral
99447	Interprofessional Consult — 11–20 min	Phone/internet consult, requesting MD	11–20 min	More involved specialist advice without patient present
99448	Interprofessional Consult — 21–30 min	Phone/internet consult, requesting MD	21–30 min	Complex case discussion between physicians
99449	Interprofessional Consult — 31+ min	Phone/internet consult, requesting MD	31+ min	Extended specialist advisory consult
99453	Remote Patient Monitoring — setup	Set up of monitoring device	One time	Setting up blood pressure cuff, glucose monitor for remote tracking
99454	Remote Patient Monitoring — device supply	Monthly device supply and data transmission	Per 30 days	Billing for the device and daily readings transmitted
99457	Remote Patient Monitoring — 20 min	Monthly clinical staff time	20+ min/month	Review of remote monitoring data by clinical staff
99458	Remote Patient Monitoring — add-on	Each additional 20 min	Per 20 min	Add-on to 99457 for extended monthly monitoring review
99487	Complex Chronic Care Management	Multiple chronic conditions, complex	60+ min/month	Care coordination for patients with 2+ complex chronic conditions
99489	Complex CCM — additional 30 min	Add-on to 99487	Per 30 min	Extended CCM time beyond first hour

CPT Code	Visit Type	Medical Decision Making (MDM)	Typical Time (Minutes)	Common Example
99490	Chronic Care Management	Multiple chronic conditions	20+ min/month	Monthly care coordination for 2+ chronic conditions
99491	CCM — physician time	Physician-directed CCM	30+ min/month	When physician personally performs CCM services

CPT Modifiers — The Most Important Ones

A modifier is a 2-digit code added after the CPT code (e.g., 99213-25) that gives the insurance company extra information about the service. Modifiers explain things like: Was a procedure done on both sides of the body? Was it done by two surgeons? Was the service reduced? **Using the wrong modifier — or forgetting one — can cause denials or incorrect payment.**

Modifier	Name	Plain English Meaning	When To Use It
-22	Increased Procedural Services	The procedure took significantly more work than usual	Operative report must support unusual complexity. Add extra documentation.
-24	Unrelated E&M During Global Period	The office visit was for a completely different problem than the surgery	Patient had surgery last week, came in today for unrelated ear pain — use -24
-25	Significant, Separate E&M on Same Day as Procedure	The E&M visit was separate from and not part of the procedure done that day	Doctor saw patient for diabetes (E&M), then removed a mole same day — use -25 on E&M
-26	Professional Component	Billing only for the doctor's reading/ interpretation, not the equipment	Radiologist bills -26 for reading an X-ray; hospital bills the machine with -TC
-32	Mandated Services	Service was required by an outside entity (court, insurer, employer)	Court-ordered psych eval, workers comp required exam, insurance-mandated review
-33	Preventive Services	Service is a preventive screening covered at 100% by ACA rules	Colonoscopy as a preventive screening — no cost-share; waives patient deductible
-47	Anesthesia by Surgeon	The operating surgeon also performed the anesthesia (regional anesthesia)	Surgeon does their own nerve block during the procedure — rare but applicable
-50	Bilateral Procedure	Exact same procedure was done on both sides of the body	Bilateral knee replacement, bilateral tube placement — one code + -50
-51	Multiple Procedures	More than one procedure was done during the same operative session	Second and subsequent procedures in same session — tells payer to apply reduction rules
-52	Reduced Services	The service was partially reduced or eliminated at the doctor's discretion	Procedure started but could not be completed; reduced time or scope
-53	Discontinued Procedure	Procedure was started but stopped for a medical reason or patient risk	Patient had adverse reaction mid-procedure; service could not be completed safely
-54	Surgical Care Only	One surgeon does the operation but another doctor handles follow-up care	Surgeon performs surgery, refers post-op care to local physician — bill -54 for surgery

Modifier	Name	Plain English Meaning	When To Use It
-55	Postoperative Management Only	Doctor provides only the follow-up care after another surgeon operated	Local physician takes over post-op care — bill -55 for the follow-up period
-56	Preoperative Management Only	Doctor provides only the preoperative evaluation and preparation	Internist clears patient for surgery only — bill -56 for pre-op services
-57	Decision for Surgery	E&M visit where the decision to perform surgery was made	Major surgery: The visit when the surgeon decided to operate — protects the E&M from bundling
-58	Staged or Related Procedure During Global Period	A planned second procedure done during the first procedure's global period	Planned second-stage surgery — expected and documented in the operative plan
-59	Distinct Procedural Service	Two procedures that normally bundle but were separate/distinct today	Services on different sites, different sessions, or different encounters on same day
-62	Two Surgeons	Two surgeons of different specialties are both required for one procedure	Complex spine surgery needing both neurosurgeon and orthopedic surgeon — both bill -62
-63	Procedure on Infants Under 4kg	Operating on a very small infant (under 4 kilograms / about 8.8 lbs)	Neonatal/infant surgery — extra complexity due to patient size
-66	Surgical Team	Three or more surgeons needed for a highly complex procedure	Multi-team surgery; each surgeon bills their CPT + -66
-73	Discontinued Outpatient Procedure Before Anesthesia	Outpatient procedure stopped before anesthesia was given	Patient arrived, prepped, but procedure cancelled before anesthesia started
-74	Discontinued Outpatient Procedure After Anesthesia	Outpatient procedure stopped after anesthesia was already administered	Procedure cancelled after patient was under; bill for the anesthesia + -74
-76	Repeat Procedure by Same Physician	Same procedure done again by same doctor on same day	Bilateral cataract same day by same surgeon, or EKG repeated for comparison
-77	Repeat Procedure by Another Physician	Same procedure done again but by a different physician same day	Second doctor repeats the same procedure in same session
-78	Unplanned Return to OR for Related Complication	Patient had to go back to OR due to a complication from earlier surgery	Post-op bleeding requiring return to OR — within the global period of first surgery
-79	Unrelated Procedure During Global Period	Surgery done during the global period of a different surgery — completely unrelated	Patient had knee surgery, returns for appendectomy within knee's 90-day global period

Modifier	Name	Plain English Meaning	When To Use It
-80	Assistant Surgeon	A second surgeon assists the primary surgeon during the procedure	Designated assistant surgeon bills the same CPT code + -80
-81	Minimum Assistant Surgeon	Minimal assistance was required during the procedure	Less involvement than a full assistant; PA, resident, or brief surgical assist
-82	Assistant Surgeon When Qualified Resident Not Available	Teaching hospital — no resident available so a second physician assisted	Must document that no qualified resident was available at that time
-90	Reference (Outside) Laboratory	Lab test was sent to an outside reference laboratory for processing	Physician bills for the test but sends specimen to Quest, LabCorp, or similar lab
-91	Repeat Clinical Diagnostic Lab Test	Same lab test repeated on same day for a different specimen or result	Blood glucose drawn at 8am AND at 2pm — second test uses -91
-92	Alternative Lab Platform Testing	Lab test performed using a different platform than typically used	Rapid CLIA-waived tests or point-of-care testing with non-standard platforms
-93	Synchronous Telemedicine Service	Live real-time video/audio telemedicine visit	Video visit with patient — audio/video both required; confirms telemedicine mode
-95	Synchronous Telemedicine Service via Interactive Audio & Video	Real-time two-way telemedicine with both audio and video interaction	Required by some payers to specify audio-video telehealth vs audio-only
-FQ	Audio-Only Telemedicine	Telemedicine delivered by audio telephone only (no video)	Phone call with patient for E&M when no video available; some payers require this
-GQ	Asynchronous Telemedicine	Store-and-forward telemedicine (recorded and reviewed later)	Photos or data sent to provider who reviews later — not live
-GT	Interactive Audio & Video Telemedicine	HCPCS modifier for telemedicine; similar to -93 or -95	Required by some Medicare programs for telemedicine identification
-KX	Requirements Met	Documentation on file supports the service being billed	Medicare requires this for some DME, therapy, and SNF services
-LT	Left Side	Service was performed on the left side of the body	Left knee, left ear, left eye — use when bilateral code not applicable
-RT	Right Side	Service was performed on the right side of the body	Right shoulder, right hand, right eye — used to specify laterality
-TC	Technical Component	Billing only for the equipment/technology used, not interpretation	Hospital or facility bills -TC for the machine; radiologist bills -26 for reading

Modifi er	Name	Plain English Meaning	When To Use It
-XE	Separate Encounter	A separate encounter on the same day (more specific than -59)	Different session, same day — patient seen twice in ER for unrelated conditions
-XP	Separate Practitioner	A different practitioner performed the service (more specific than -59)	Two different providers performed two different services on same day
-XS	Separate Structure	Service was on a different anatomic structure (more specific than -59)	Removed a lesion from the back AND from the arm — two different body sites
-XU	Unusual Non-Overlapping Service	Service is not overlapping with the component of the main service	Similar to -59 but must truly be non-overlapping by definition

Surgery — Skin & Integumentary | 10004–19499

CPT	Procedure	Plain English	Key Billing Note
10005	FNA Biopsy with imaging — 1st lesion	Fine needle aspiration guided by ultrasound — first spot	Add +10006 for each additional lesion. Always document imaging guidance.
10060	Incision & Drainage — simple abscess	Draining a simple skin abscess or infected cyst	For complex or recurrent abscess use 10061. Document size and location.
10061	Incision & Drainage — complicated	Draining a complicated skin abscess (pilonidal, carbuncle, etc.)	Requires more work than 10060; document the complexity in the note.
10120	Removal of foreign body, subcutaneous	Removing a splinter or object under the skin — simple	Use 10121 for deeply embedded foreign body requiring extensive dissection.
11042	Debridement, 20 sq cm or less	Cleaning and removing dead tissue from skin/subcutaneous layer	For wound debridement. Add 11045 for each additional 20 sq cm.
11100	Biopsy of skin — single lesion	Cutting a small piece of skin for laboratory analysis	Add 11101 for each additional lesion biopsied at same visit.
11200	Removal of skin tags — up to 15	Removing skin tags (benign growths) up to 15 at once	Add 11201 for each additional 10 tags beyond 15.
11300	Shave removal of lesion — trunk, 0.5cm or less	Shaving off a small skin growth on the trunk or neck	Use the code matching the size and body location of the lesion.
11400	Excision, benign lesion — trunk, 0.5cm or less	Cutting out a benign skin growth with a margin of normal skin	Code selection depends on size AND location. Measure the excised diameter.
11600	Excision, malignant lesion — trunk, 0.5cm or less	Cutting out a cancerous or pre-cancerous skin growth	Requires pathology to confirm malignancy. Document margins.
12001	Simple repair, 2.5cm or less — scalp/face/hands	Closing a simple wound with sutures — small and simple	Code by total length AND anatomic location. Simple = one layer closure.
12031	Intermediate repair, 2.5cm or less — face	Closing a wound requiring two layers (deep + surface)	Intermediate = deeper closure. Layer count and length determine code.
13100	Complex repair, 1.1–2.5cm — trunk/arms/legs	Complex wound closure requiring special techniques	Complex = undermining, retention sutures, or reconstructive approach needed.
17000	Destruction, premalignant lesion — 1st lesion	Freezing or burning an actinic keratosis (precancerous lesion)	Add 17003 for each additional lesion (2–14). 17004 for 15 or more lesions.
17110	Destruction of benign lesions — up to 14	Removing warts or other benign lesions up to 14 at one visit	Use 17111 for 15 or more benign lesions at one visit.

CPT	Procedure	Plain English	Key Billing Note
19301	Mastectomy, partial	Removing part of the breast (lumpectomy)	Use with appropriate breast modifier. Sentinel node biopsy may be separate.
19302	Partial mastectomy with lymph node removal	Lumpectomy PLUS axillary lymph node dissection	Combined procedure; verify if sentinel node biopsy was also done separately.
19303	Mastectomy, simple, complete	Complete removal of one entire breast	Simple = no lymph node dissection. Use -LT or -RT modifier.

Surgery — Musculoskeletal | 20100–29999

CPT	Procedure	Plain English	Key Billing Note
20550	Injection, tendon sheath or ligament	Cortisone or other injection into a tendon or ligament	Does not include the drug itself. Bill the drug separately with J-code.
20551	Injection, tendon origin/insertion	Injection at the point where tendon attaches to bone	Common for tennis elbow, plantar fasciitis. Separate drug billing required.
20600	Aspiration or injection, small joint	Draining fluid or injecting a small joint (finger, toe, wrist)	Small joint = interphalangeal, acromioclavicular, temporomandibular
20605	Aspiration or injection, intermediate joint	Draining or injecting an intermediate joint (elbow, ankle)	Intermediate = elbow, wrist, ankle. Specify with -LT or -RT.
20610	Aspiration or injection, large joint	Draining or injecting a large joint (knee, hip, shoulder)	Most common joint injection code. Use -LT/-RT. Commonly knee or shoulder.
20611	Aspiration/injection, large joint, with imaging	Same as 20610 but with ultrasound or fluoroscopic guidance	Use when image guidance was used and documented. Includes 77002 or 76942.
27130	Total hip replacement	Replacing the entire hip joint with a prosthesis	Bill implant cost separately with invoice. Use -LT or -RT modifier.
27447	Total knee replacement	Replacing the entire knee joint with a prosthesis	Very common procedure. Bill implant separately. Use -LT or -RT.
29827	Arthroscopy, shoulder with rotator cuff repair	Shoulder scope surgery with rotator cuff tear repair	Complete repair; specify if partial tear vs complete tear in documentation.
29881	Arthroscopy, knee with meniscectomy	Knee scope with removal of torn meniscus tissue	Specify medial vs lateral meniscus. -LT or -RT modifier required.
29880	Arthroscopy, knee — both menisci	Knee scope with removal of BOTH menisci	Only use when both medial AND lateral menisci are treated in same session.
29888	Arthroscopy, knee — ACL reconstruction	Knee scope with rebuilding of the ACL ligament	Specify graft type (autograft, allograft) in documentation. -LT or -RT.

Radiology | 70010–79999

CPT	Procedure	Plain English	Key Billing Note
70450	CT Head without contrast	CT scan of the brain — no dye used	Most common head CT. Used for headache, trauma, stroke screening.
70460	CT Head with contrast	CT scan of the brain with dye injected	Used when tumor, infection, or abscess is suspected.
70470	CT Head with and without contrast	CT brain — done both without AND with dye	Two-phase study; more comprehensive than with or without alone.
70553	MRI Brain with and without contrast	MRI of the brain — both phases	Most comprehensive brain MRI; used for MS, tumors, complex cases.
71046	Chest X-Ray — 2 views	Chest X-ray in two pictures (PA and lateral)	Standard chest X-ray. Document 'PA and lateral' in the order.
71250	CT Chest without contrast	CT scan of the lungs and chest — no dye	Used for pulmonary embolism screening (if without protocol) or lung nodules.
71270	CT Chest with and without contrast	CT chest — both phases with and without dye	Two-phase chest CT; more comprehensive study for complex findings.
72148	MRI Lumbar Spine without contrast	MRI of the lower back — no dye used	Most common spine MRI. Herniated disc, stenosis evaluation.
72158	MRI Lumbar Spine with and without contrast	MRI lower back — both phases, with and without dye	Used when infection, tumor, or post-surgical change is suspected.
73721	MRI Joint of lower extremity	MRI of the knee, ankle, or other lower leg joint	Specify the joint. -LT/-RT required. Knee MRI most common.
74178	CT Abdomen & Pelvis with contrast	CT scan of the belly AND pelvis — with dye	Combined abdomen/pelvis CT; more efficient than billing separately.
74177	CT Abdomen & Pelvis without contrast	CT belly and pelvis — no dye used	Used when contrast is contraindicated (kidney disease, allergy).
76700	Abdominal Ultrasound — complete	Full ultrasound of all abdominal organs	Includes liver, gallbladder, spleen, pancreas, kidneys, aorta.
76705	Abdominal Ultrasound — limited	Ultrasound of just one or a few abdominal organs	Specify which organ(s) were examined in the report.
76817	OB Ultrasound, transvaginal	Vaginal ultrasound during pregnancy	Typically early pregnancy. Document gestational age and findings.
77067	Screening Mammography, bilateral	Breast cancer screening mammogram, both breasts	Annual preventive service. No patient cost-share under ACA for preventive.
78452	Myocardial Perfusion Imaging — multiple studies	Nuclear stress test — heart imaging at rest and with stress	SPECT imaging of the heart; must be paired with stress test code.
93000	Electrocardiogram — routine, 12-lead	Standard 12-lead EKG with interpretation	Includes the tracing AND the doctor reading it. Do not bill 93010/93005 separately.

CPT	Procedure	Plain English	Key Billing Note
80047	Basic Metabolic Panel (BMP)	8 blood tests: sodium, potassium, CO2, chloride, glucose, BUN, creatinine, calcium	Panel must include all components. Do not bill components separately.
80053	Comprehensive Metabolic Panel (CMP)	14 blood tests — includes all BMP tests plus liver function tests	Most common chemistry panel. Must include ALL 14 components.
80061	Lipid Panel	Cholesterol, triglycerides, HDL, LDL — 4 tests	Fasting status should be documented. All 4 components required.
81001	Urinalysis with microscopy	Urine test looking at cells and crystals under microscope	More comprehensive than 81002. Documents microscopic review.
81002	Urinalysis without microscopy	Dipstick urine test only — no microscope used	Quick, less detailed. For routine screenings. Cannot bill with 81001.
81003	Urinalysis — automated, without microscopy	Automated dipstick reading by a machine	Machine reads the dipstick; no manual review. Cannot bill with 81001 or 81002.
83036	Hemoglobin A1c	3-month average blood sugar test for diabetics	Key diabetes monitoring test. Report result as percentage. No fasting needed.
84153	PSA — Total	Prostate cancer screening blood test	Used for prostate cancer screening in men. Age guidelines apply for coverage.
84443	TSH — Thyroid Stimulating Hormone	Thyroid function test (most sensitive thyroid test)	First-line thyroid test. Reflexive T4 may be added based on result.
85027	Complete Blood Count (CBC) without differential	Red cells, white cells, platelets — no breakdown of white cell types	Automated count only. Use 85025 when differential is included.
85025	Complete Blood Count with automated differential	CBC with full breakdown of white blood cell types	Most complete CBC. Includes neutrophils, lymphocytes, monocytes, etc.
86140	C-Reactive Protein (CRP)	Inflammation marker in the blood	Standard CRP; not the high-sensitivity version. Use 86141 for hs-CRP.
86200	CCP Antibody (anti-CCP)	Rheumatoid arthritis specific blood test	Highly specific for RA. Often ordered with RF (86430) together.
86580	TB Test — intradermal (PPD)	Tuberculosis skin test (Mantoux method)	Document placement and reading. Two visits: placement and result read.
86703	HIV-1/HIV-2 Antibody with HIV Antigen	4th generation HIV combination test (Ag/Ab)	Standard HIV screening; detects both antibody AND antigen (p24).
87340	Hepatitis B Surface Antigen (HBsAg)	Hepatitis B infection test — active infection	Positive means active HBV infection. Used for screening and diagnosis.
87491	Chlamydia — Nucleic Acid Amplification (NAAT)	Chlamydia STI test by DNA amplification	Most sensitive Chlamydia test. Often paired with 87591 (gonorrhea NAAT).

CPT	Procedure	Plain English	Key Billing Note
87591	Gonorrhea — Nucleic Acid Amplification (NAAT)	Gonorrhea STI test by DNA amplification	Most sensitive gonorrhea test. Often billed with 87491 (Chlamydia NAAT).
87635	SARS-CoV-2 (COVID-19) PCR	PCR test for active COVID-19 infection	For active infection testing. Antibody test uses different code (86769).
88305	Surgical Pathology — Gross and Microscopic	Pathologist examines tissue (biopsy) under microscope	Level IV pathology code. Covers most biopsy specimens. Document specimen type.
88342	Immunohistochemistry, per antibody	Special staining test on tissue for one antibody marker	Add for each antibody used. Needed for cancer typing and receptor status.

Medicine — Immunizations & Injections | 90281–90799

CPT	Procedure	Plain English	Key Billing Note
90460	Immunization admin, first vaccine — counseling	Administering first shot to patient under 18, with counseling	Must document counseling was provided. Add 90461 for each additional component.
90471	Immunization admin — first injection	Giving the first vaccine injection (age 18+)	For adult vaccinations. Add 90472 for each additional vaccine given same day.
90686	Influenza vaccine — seasonal, standard	Standard-dose flu shot for adults	Quadrivalent (4-strain) standard flu vaccine. Use 90694 for high-dose (seniors).
90707	MMR vaccine	Measles, mumps, and rubella vaccine (live)	Two doses in childhood. Requires refrigeration; document lot number and site.
90714	TD vaccine	Tetanus and diphtheria booster for adults	Adult booster; given every 10 years. Use 90715 for Tdap (adds pertussis).
90715	Tdap vaccine	Tetanus, diphtheria, pertussis (whooping cough) vaccine	For adults who need pertussis protection. Given once as adult booster.
90732	Pneumococcal vaccine — PPSV23	23-valent pneumonia vaccine for adults and high-risk patients	For adults 65+ and high-risk under 65. Not the same as PCV13 (90670).
90734	Meningococcal vaccine — MenACWY	Meningitis vaccine for college students and high-risk	Required for many colleges. Document manufacturer, lot, site, date.
90756	Influenza vaccine — quadrivalent, intranasal	Nasal spray flu vaccine (FluMist)	For healthy non-pregnant patients ages 2–49. Not injectable.
96360	Hydration IV infusion — first 31 min to 1 hr	Giving IV fluids for dehydration — first hour	Hydration only (saline, dextrose). Cannot bill with another infusion for same port.
96365	Therapeutic/Diagnostic IV infusion — first hour	IV drug or substance infusion — first hour	For actual medications (not just fluids). More complex than 96360.
96372	Therapeutic/Prophylactic injection — IM or SQ	Giving a medication shot into muscle or under skin	Most common injection code. Excludes immune globulins and vaccines.

CPT	Procedure	Plain English	Key Billing Note
96374	IV push — single drug	Injecting a drug directly into an IV line quickly	Less than 15 minutes; provider must be present during injection.
96375	IV push — additional drug	Each additional drug pushed into IV at same visit	Add-on to 96374 or 96365. One line per additional drug.
96401	Chemotherapy — non-hormonal injection	Anti-cancer drug given by IM or SQ injection	For chemotherapy-type drugs only. Requires staff chemo training.
96413	Chemotherapy — IV infusion, first hour	Anti-cancer drug given by IV drip — first hour	More complex billing rules than regular infusions. Document start/stop times.
96416	Chemotherapy — prolonged, additional hour	Each additional hour of chemo infusion beyond first hour	Add-on to 96413. Bill one unit per additional hour.

Psychiatry & Psychotherapy | 90785–90899

CPT	Procedure	Plain English	Key Billing Note
90791	Psychiatric Diagnostic Evaluation	First-time mental health assessment — no medical services	No prescribing or medical management done at this visit. Initial eval only.
90792	Psychiatric Diagnostic Eval with Medical Services	First-time psych eval that includes prescribing or med management	Performed by MD/DO/NP who prescribes at the evaluation visit.
90832	Psychotherapy — 30 minutes	Therapy session (16–37 minutes)	Use when session is between 16 and 37 minutes. Document actual time.
90834	Psychotherapy — 45 minutes	Therapy session (38–52 minutes)	Use when session is between 38 and 52 minutes. Most common therapy code.
90837	Psychotherapy — 60 minutes	Therapy session (53+ minutes)	Use when session is 53 minutes or longer. Document actual time in notes.
90838	Psychotherapy with E&M — 60 min add-on	Add-on: 53 min of therapy done during an E&M visit	Must be combined with 99212–99215. Physician does both E&M AND therapy.
90839	Psychotherapy for Crisis — 60 minutes	Urgent mental health crisis therapy — first 60 minutes	Patient in acute crisis (suicidal, psychotic, etc.). Use 90840 for additional time.
90845	Psychoanalysis	Traditional psychoanalysis sessions	Rare in modern practice. Requires specific psychoanalytic training.
90846	Family Therapy — without patient present	Therapist meets with family members only (no patient)	Parent training, family psychoeducation without the identified patient present.
90847	Family Therapy — with patient present	Therapist meets with patient AND family members	Most common family therapy code. Patient participates in session.
90849	Multiple Family Group Therapy	Group therapy with multiple families at once	Several families meeting together with one or more therapists.
90853	Group Psychotherapy	Group therapy session — not family therapy	One therapist, multiple non-related patients in a group setting.

CPT	Procedure	Plain English	Key Billing Note
90870	Electroconvulsive Therapy (ECT)	Electric shock therapy for severe depression	Requires anesthesia separately. Used for treatment-resistant depression.
90901	Biofeedback Training	Training patient to control body functions with feedback	Relaxation, stress management. Document what physiological signal was monitored.
99484	Care Management for Behavioral Health Conditions	Monthly behavioral health integrated care management	For primary care practices with embedded behavioral health; 20+ min/month.

Top 10 CPT Coding Rules Every Biller Must Know

Rule #	The Rule	Why It Matters
1	Never code what is not documented in the medical record	If it's not written, it didn't happen. Coding undocumented services = fraud. Always.
2	Use the most specific code available that matches what was done	Vague or general codes lead to lower payment. Specific codes get paid correctly.
3	Understand NCCI (National Correct Coding Initiative) bundling rules	Some CPT codes are automatically bundled together and cannot be billed separately. Check before you bill.
4	Add modifiers to unbundle when clinically appropriate	If two normally bundled services were truly separate/distinct, the right modifier makes them billable.
5	Do not upcode — bill only the level that the documentation supports	Billing a 99215 when the note only supports a 99213 is upcoding. It's fraud and audited heavily.
6	Do not downcode out of fear of an audit	If the visit truly supports 99215, bill it. Downcoding means leaving earned money on the table.
7	Use the correct place of service (POS) code on every claim	POS affects how the service is paid. POS 11 (office) pays differently than POS 22 (outpatient hospital).
8	Match the diagnosis code (ICD-10) to the CPT code logically	The diagnosis must medically justify the procedure. A flu diagnosis with a cardiac catheterization = red flag.
9	Know your global surgical periods (0-day, 10-day, 90-day)	During the global period, follow-up visits for that surgery are included — do not bill them separately.
10	Update to the new CPT code book every January	AMA releases new, revised, and deleted codes every year. Using old codes = denials. Update your system annually.