

AAO OMEC EDUCATIONAL SERIES

Understanding the CPT® Coding System & the CPT® Editorial Panel

A Physician Education Guide for AAO Members | 2026 Edition

1. What Is the CPT® Coding System?

Current Procedural Terminology (CPT®) is a standardized medical code set developed and maintained by the American Medical Association (AMA). First published in 1966, CPT provides physicians and other health care professionals with a uniform language for describing the medical, surgical, and diagnostic services they perform.

For osteopathic physicians, CPT codes are the primary vehicle for communicating the nature and complexity of services rendered — to payers, hospitals, auditors, and regulators alike. Using the correct CPT codes accurately and consistently is essential not only to appropriate reimbursement, but to demonstrating the distinct clinical value of osteopathic care.

Why CPT Matters to You as a Physician

- Determines how your services are identified and paid by Medicare, Medicaid, and commercial insurers
- Establishes the foundation for calculating Relative Value Units (RVUs) and physician payment under the RBRVS system
- Serves as the basis for payer medical policies, edits, and bundling rules that directly affect your revenue
- Supports utilization review, coding audits, and medical necessity determinations
- Enables local, regional, and national comparisons of health care utilization and outcomes

**KEY
FACT**

In 2000, CPT was designated by the Department of Health and Human Services as the national standard coding system for physician and other health care professional services and procedures under HIPAA — making its use mandatory for all covered entities transmitting health care information electronically.

2. A Brief History of CPT®

Understanding how CPT evolved helps explain why the system is structured the way it is today — and why staying current matters for practice management.

Year / Edition	Milestone
1966 — 1st Edition	AMA publishes CPT to standardize procedure documentation and coding; primarily surgical procedures.
1970 — 2nd Edition	Expanded to include diagnostic and therapeutic procedures; 5-digit coding system introduced (replacing 4-digit).
1977 — 4th Edition	Major updates reflecting medical technology advances; periodic updating process established.
1983	CMS (then HCFA) adopts CPT as part of HCPCS; CPT becomes mandatory for Medicare Part B reporting.
1986	CMS requires state Medicaid agencies to use HCPCS/CPT in Medicaid Management Information Systems.
2000	CPT designated as the national HIPAA coding standard for physician services and procedures.
Present	CPT is updated annually (Jan. 1) with quarterly updates in fast-moving clinical areas; approximately 10,000 codes maintained.

Notably, no taxpayer money has ever been spent to develop or maintain CPT. The code set is completed annually through the voluntary work of physicians, specialty societies, and other stakeholders — at no cost to the U.S. government.

3. CPT Code Categories

CPT codes are organized into three categories, each serving a distinct purpose in the health care system:

Category	Description & Examples
Category I (5-digit numeric)	The core of CPT — codes describing procedures and services consistent with contemporary medical practice that are widely performed. Includes E/M services (99202–99215), OMT (98925–98929), and surgical procedures. These codes carry

	assigned RVUs and are paid under the RBRVS fee schedule.
Category II (4 digits + F)	Optional supplemental tracking codes for performance measurement and quality reporting. Not paid separately; used to document services that support quality improvement initiatives (e.g., patient education, medication management).
Category III (4 digits + T)	Temporary codes for emerging technologies, services, and procedures. Allow data collection on new services before they are considered for Category I designation. CMS may assign payment; others may not be covered.

FOR DO PHYSICIANS	<i>Osteopathic Manipulative Treatment (OMT) codes 98925–98929 are Category I codes with assigned RVUs under the Medicare RBRVS fee schedule. They are separately payable from Evaluation & Management (E/M) services when Modifier 25 is correctly appended and documentation supports a separately, significant identifiable E/M service — a distinction currently under attack by several commercial payers through automated bundling edits.</i>
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4. The CPT® Editorial Panel

The CPT Editorial Panel is the authoritative body responsible for maintaining, revising, and updating the CPT code set. Authorized by the AMA Board of Trustees, the Panel has final authority to add, revise, or delete CPT codes, descriptors, rules, and guidelines.

Panel Composition (21 Members)

The Panel is deliberately structured to represent the breadth of the medical and health care community:

- 12 seats appointed by national medical specialty societies (representing practicing physicians across specialties)
- 1 seat — Panel Chair (selected by AMA Board of Trustees)
- 1 seat — Panel Vice Chair (selected by AMA Board of Trustees)
- 2 seats — CPT Health Care Professionals Advisory Committee (HCPAC) members
- 1 seat — Blue Cross and Blue Shield Association
- 1 seat — America’s Health Insurance Plans (AHIP)
- 1 seat — American Hospital Association
- 1 seat — At-large organizational member
- 1 seat — Umbrella organization representing private health care insurers

In addition, CMS, CDC, and FDA each hold one non-voting liaison seat, providing federal input into the Panel's deliberations without having voting authority.

WHY IT MATTERS

Payer organizations hold seats on the CPT Editorial Panel. This structural reality means that code definitions, bundling policies, and payment rules are shaped — in part — by entities with a financial interest in restricting physician reimbursement. Understanding this dynamic is essential context for osteopathic physicians navigating payer-driven denial patterns.

How the Panel Operates

- The Panel meets three times per year to review applications, proposals, and comments from the medical community
- The process is open and transparent — practicing physicians, medical device manufacturers, diagnostic developers, and advisors from more than 100 specialty societies all have direct input
- The Panel is authorized to revise, update, or modify CPT codes, descriptors, rules, and guidelines
- Annual updates take effect January 1; some dynamic areas receive quarterly updates
- All Panel members — including specialty society nominees — must be approved by the AMA Board of Trustees

5. The CPT® Advisory Committee

Supporting the Editorial Panel is the larger CPT Advisory Committee, whose members are primarily physicians nominated by the national medical specialty societies represented in the AMA House of Delegates. The Advisory Committee also includes the AMA Health Care Professionals Advisory Committee (HCPAC), representing allied health professionals and limited-license practitioners.

Advisory Committee Objectives

- Serve as a resource to the Panel on procedure coding and appropriate nomenclature within each specialty's scope
- Provide documentation regarding medical appropriateness of procedures under consideration for CPT inclusion
- Suggest revisions to the CPT code set based on specialty practice patterns and emerging services
- Review and support development of coding guidance and technical education materials
- Promote physician understanding and appropriate use of CPT codes within their specialty membership

The Advisory Committee meets annually — typically at the CPT February meeting — to discuss items of mutual concern and keep abreast of current coding and nomenclature issues.

**AAO
ROLE**

The AAO participates in the osteopathic physician community's engagement with the CPT Advisory Committee process through the AOA's seat in the AMA House of Delegates. This is one reason why coordinated advocacy — through channels like OMEC — is critical when payer policies contradict CPT coding guidelines for OMT and E/M services.

6. How a CPT Code Is Created or Changed

The process for adding, revising, or deleting a CPT code follows a structured pathway designed to ensure clinical accuracy and broad input:

Step	Description
1. Application Submission	A physician, specialty society, medical device manufacturer, or other stakeholder submits a formal application to the AMA requesting a new code or revision.
2. Staff Review	AMA CPT staff review the application for completeness and whether it meets criteria for a Category I or Category III code.
3. Advisory Committee Input	The Advisory Committee reviews the application and provides written comments and recommendations regarding clinical practice patterns and coding accuracy.
4. Panel Review at Meeting	The Editorial Panel considers the application, advisory comments, and public testimony at one of its three annual meetings.
5. Panel Vote	The Panel votes to accept, modify, or reject the proposed code/change. If accepted, the code enters the CPT update cycle.
6. Annual Publication	Approved codes take effect January 1 of the following year (or on a quarterly basis for dynamic areas).

Criteria for Category I code designation require that the procedure be: (1) performed by many physicians across the country, (2) consistent with contemporary medical practice, (3) clinically efficacious based on published peer-reviewed literature, and (4) not a fragmentation of an existing procedure.

7. CPT, HIPAA, and Your Practice

Under the Administrative Simplification provisions of HIPAA (1996), the Department of Health and Human Services established national standards for electronic health care transactions. CPT was designated as the required code set for physician services, with implementation mandated by October 16, 2003. After that date, all local codes were eliminated and national standard code sets became required.

CPT Is Required For:

- Physician services (including all E/M and OMT services)
- Physical and occupational therapy services
- Radiological procedures
- Clinical laboratory tests
- Other medical diagnostic procedures
- Hearing and vision services
- Transportation services, including ambulance

This HIPAA mandate has two important practical implications for osteopathic physicians: (1) payers cannot require use of non-standard codes or modifiers for services that have CPT representations; and (2) payers are required to process claims submitted using the nationally adopted code set — including CPT codes for OMT, E/M services, and applicable modifiers such as Modifier 25.

8. Key Takeaways for Osteopathic Physicians

- **Modifier 25 is a nationally recognized CPT modifier that allows separate billing for a significant, separately identifiable E/M service on the same date as a procedure such as OMT. Payers cannot unilaterally eliminate this modifier through internal policy without contradicting CPT guidelines. CPT Code 25 (Modifier)**
- **These are Category I CPT codes with established RVUs. They describe distinct services that are not bundled with E/M codes in CPT's official guidelines. OMT Codes 98925–98929**
- **Payer medical policies and automated edits that bundle or deny E/M services billed with OMT — when Modifier 25 is appropriately appended — are inconsistent with CPT's authoritative code definitions. The CPT Editorial Panel, not individual payers, has final authority over code meaning. Payer Policies vs. CPT Authority**
- **Specialty society participation in the CPT Advisory Committee process is how physician voices shape coding policy. AAO members are encouraged to report payer denial patterns that may reflect misinterpretation or misapplication of CPT guidelines to OMEC staff. Stay Engaged**

Resources & Additional Information

The following resources provide additional guidance on CPT coding, the Editorial Panel process, and physician payment policy:

- AMA CPT Editorial Panel: www.ama-assn.org/about/cpt-editorial-panel
- CPT Code Process Overview: www.ama-assn.org/about/cpt-editorial-panel/cpt-code-process
- Criteria for CPT Codes (Category I and III): www.ama-assn.org/practice-management/cpt/criteria-cpt-codes
- HIPAA Transaction & Code Set Standards: www.hhs.gov/hipaa/for-professionals/transactions-and-code-sets
- AAO OMEC Member Resources: Contact OMEC staff for appeals templates, payer denial tracking, and additional education materials