COUNCIL FOR AFFORDABLE
HEALTH COVERAGE

September 14, 2026

The Honorable Dr. Mehmet Oz
Administrator, Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS-1848-P

Submitted electronically via regulations.gov

Dear Administrator Oz:

On behalf of the Council for Affordable Health Coverage (CAHC), a nonpartisan coalition of employers, providers, consumer groups, and patient advocates working to advance market-based solutions to lower health care costs, I write in response to the request for information (RFI) in the July 16, 2026, *Federal Register* regarding the Current Procedural Terminology (CPT-4®) coding system.

For brevity our response to the questions in the RFI will use the following abbreviations:

- **CPT** - Current Procedural Terminology (CPT-4®) coding system
- **PCS** – ICD-10-PCS, International Classification of Diseases, 10th Revision procedure coding system
- **ICD-9-CM** - International Classification of Diseases, 9th Revision Clinical Modification
- **MS-DRGs** - Medicare Severity Diagnosis Related Groups used in the Inpatient Prospective Payment System (IPPS)
- **APCs** - Ambulatory Payment Classifications used in the Outpatient Prospective Payment System (OPPS)
- **AMA** – American Medical Association
- **NCVHS** - National Committee on Vital and Health Statistics

Our response is grounded in the analysis[1] published in *Health Affairs Forefront* on March 12, 2026, “It’s Time to Standardize on A Single Code Set for Reporting Health Care Services,” which I co-authored with health care coding and reimbursement expert Richard F. Averill. Mr. Averill

[1] Averill, White, "It’s Time To Standardize On A Single Code Set For Reporting Health Care Services," *Health Affairs Forefront*, March 12, 2026

served as principal investigator on the CMS contracts to design, develop and implement PCS, MS-DRGs and APCs. Our responses to the RFI draws on our published analysis.

We strongly agree with the concern expressed in the Federal Register that "reliance on a private organization [AMA] with such an obvious conflict of interest" is not appropriate because control over the determination of the procedure codes and associated resource requirements "will influence payments to its members".

Moving from CPT to ICD-10 PCS is an appropriate course of action because it will end the obvious conflict of interest, reduce administrative costs and improve documentation. It is in the best interest of patients, the public and the country.

Our comments below are in response to the direct questions posed by CMS.

(1) What, if any, evidence is there for CMS to consider regarding the harms or challenges associated with AMA's monopoly over CPT–4 licenses for health care entities? Please cite potential improvements to patient care diverted or delayed due to AMA'S monopoly over CPT-4 codes, including inhibited innovations and acquisition or maintenance costs of CPT® licensure.

The best study on the impact of the AMA monopoly on innovations is the "Current Common Procedural Terminology (CPT®) Coding Process Challenges: Impact on the HealthTech Innovation Ecosystem" by the Stanford Byers Center for Biodesign, School of Medicine, Stanford University.[2] The study found the AMA process for recognizing a new technology with a CPT category 1 code was time consuming, unpredictable and difficult especially for startups. The AMA requirement that there be widespread use was a particular challenge because physicians may be reluctant to use a technology when there is reimbursement uncertainty. The study concluded:

> "For those with novel innovations requiring assignment of a new code, the significant challenges posed to patient access by the current [AMA] criteria could be improved with a more transparent, predictable, and achievable process, so that healthcare innovation and patient access to FDA-cleared and clinically proven therapies can flourish."

This gatekeeping on innovation limits patient access to new therapies or services that could save their lives or mitigate the impact of disease. Indeed, the study concludes that the AMA process and criteria "prevents companies and investors from developing the most novel of technologies that are not categorized through previously established procedures". It is inherently anti-patient.

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[2] Ariana, Modina, Waugh et al., "Current Common Procedural Terminology (CPT®) Coding Process Challenges: Impact on the HealthTech Innovation Ecosystem", *Health Management, Policy and Innovation*, 2024.

Beyond an impediment to innovation, the AMA license fees amount to a tax on health information thereby harming the healthcare system by diverting financial resources from other priorities. Senator Cassidy, Chairman of the Senate Committee on Health, Education, Labor, and Pensions has described the AMA's current business practices as, "Your organization [AMA] has abused this government-backed monopoly by charging exorbitant fees to anyone using the CPT code set, including doctors, hospitals, health plans, and health IT vendors. These fees inevitably are passed on by CPT users to patients in the form of higher health care costs."[3] In 2025, the AMA reported $296.4 million in revenue from "Books and Digital Content." After expenses, this category netted $267.5 million in profit.[4] [5] Licenses and sales of CPT represent the overwhelming share of this revenue. It is inherently inflationary.

The unfettered control over the royalties the AMA charges also harm the healthcare system by stifling any criticism of the AMA policies and positions. Any organization that publicly questions the CPT royalty fears being punished in the next round of royalty negotiations. The mere possibility that the AMA might wield its monopolist power is enough to limit criticism of the AMA policies and positions by the segments of the healthcare industry that utilize CPT codes. Similarly, any criticism of the AMA policies and positions by physicians and specialty societies is stifled because the AMA can eliminate or fail to create codes for procedures or services, limiting billing for legitimate health services. The mere possibility that there might not be a code available limits any criticism of the AMA policies and positions. Indeed, the monopolist power of the AMA may inhibit some segments of the healthcare industry from responding to this RFI. It is inherently stifling of open discussion.

The license restrictions imposed by the AMA are completely contrary to the drive for more transparency in the pricing of healthcare services. CPT licensees are restricted from copying, redistribution, derivative works and commercial uses not authorized by the CPT license. CMS uses CPT under the AMA's intellectual-property restrictions. Indeed, to download a full description of the CPT codes used by CMS from the CMS website, the terms and conditions of a point and click AMA license agreement must be accepted. As more third parties seek to link pricing to procedures and present that information to consumers, AMA stands in the way of transparency by erecting financial barriers to transparency tools. Because these tools provide pricing information to enable cost-conscious choices, AMA indirectly increases costs. It is inherently anti-consumer.

The AMA influence over the codes for reporting procedures and the establishing RUCs can lead to a broken system with extreme distortions such as having two percent of physicians account for one quarter of Medicare physician payments.[6] Former CMS Administrator Thomas Scully has said "A private trade association should not have that sort of control over the biggest

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[3] Cassidy, Letter to Bobby Mukkamala, President, American Medical Association, October 6, 2025
[4] Internal End User Agreement: Royalty Rates for 2026 and 2027 Annual Releases of Specified Content, AMA, perma.cc/9DK6-T8Z3 (archived Aug. 11, 2026).
[5] AMA, Physicians' Powerful Ally in Patient Care: 2025 Annual Report 25 (Ex.C).
[6] Abelson, Cohen, "Sliver of Medicare Doctors Get Big Share of Payouts", *New York Times*, April 9, 2014

spending account in the government. It's an outrageous travesty of democracy".[7] It is inherently anti-democratic.

More than 150 million Americans are covered by Medicare and Medicaid, costing taxpayers more than $2 trillion annually. Medicare directly incorporates CPT's classifications into its reimbursement formula, which in turn influences the rates that private insurers pay. Because CMS has required the use of CPT in Medicare and Medicaid reimbursement claims and because AMA's control of CPT, taxpayers help foot the bill for AMA's monopoly. It is inherently against the public's interest.

(2) What, if any, evidence is there that the generation of CPT–4 codes follows a process of identification of medical necessity? What opportunities or examples from other populations, sites of care, or international health systems could instruct a process of identification of medical necessity in the CPT–4 code development process?

While the AMA process does require the clinical efficacy of the procedure or service to be documented in the literature and the procedure to be in widespread use, there does not appear to be any explicit evaluation of medical necessity in the AMA process. In general, medical necessity requires that a procedure be reasonable and necessary to diagnose or treat an illness or injury or to improve function. CMS uses medical and scientific evidence in making national coverage decisions (NCDs) regarding the medical necessity of a procedure. The decision by the AMA to create a CPT code not only includes an implicit assessment of whether a procedure meets basic medical necessity criteria, but it also determines which aspects of the performance of a procedure necessitates a potential differential payment level. For example, the CPT-4 codes for endoscopy of the esophagus differentiate whether the endoscope was rigid or flexible, or whether the endoscope was inserted through the nose or mouth. Each subtle nuance of how the endoscopy is performed could impact the RUC and ultimately payment. Incorporating minor subtle variations in how a procedure is performed into the coding system exacerbates the perverse incentives inherent in a fee-for-service payment system.

(3) A combination of CPT–4 and HCPCS codes were formally adopted by HHS as the legal standard for national coding for physician and other services as part of implementing HIPAA (45 CFR 162.1002(a)(5)). If CMS were to revisit this standard in future rulemaking, which if any alternatives exist to CPT– 4 for CMS to consider as part of the national coding standard for physician services? Would CMS need to specify a separate legal standard, or could CMS allow for private competition to supplement the existing CPT–4 coding standard?

As described in the RFI, the HIPAA statute (Pub. L. 104–191) does not specify that CPT be used to report physician services. The law gives HHS authority to designate specific coding and data standards, and the current licensing agreement between HHS and AMA may be terminated

[7] Haley Edwards, "Special Deal", *Washington Monthly, July 201*3

by either party after 90 days' notice. HIPPA required HHS to adopt standards for electronic health transactions that incorporate code sets.[8] HHS has specified through subsequent regulation that CPT be used as the national coding standard for reporting physician services.[9] HHS has the authority to replace CPT as a HIPAA standard without a new act of Congress. Indeed, effective October 1, 2015, through the standard federal notice-and-comment rulemaking process, HHS replaced the ICD-9-CM Volume 3 procedures as the national standard for reporting inpatient procedures with PCS. As demonstrated by the process used to establish PCS as the new national standard for reporting inpatient procedures, a HIPAA designated procedure code set can be replaced without Congress amending HIPAA itself.

There would be no need to specify a separate legal standard and the standard federal notice-and-comment rulemaking process can be used. The issues and benefits of replacing CPT with PCS are more fully discussed in our answers to questions 4 and 5.

Having private competition to supplement the existing CPT coding standard should not be considered. That would simply replace or augment CPT with a different private coding system with similar issues. There would continue to be separate coding systems in use with all the associated overhead and administrative complexity. The National Committee on Vital and Health Statistics (NCVHS), the statutory public advisory body to the Secretary of Health and Human Services on health information policy, has long advocated for a unified, single procedure coding system to cover both inpatient and ambulatory care, thereby reducing administrative burden and creating greater data uniformity. In 1993, the NCVHS issued a report recommending[10]:

- "The National Committee on Vital and Health Statistics recommends development and adoption of a single system for classification of health care services and procedures to be used in all settings in which health care is delivered in the United States.
- The Secretary of the Department of Health and Human Services should assume the responsibility for the development and maintenance of a single classification system as a collaborative effort involving those who have an interest or stake in a new system.
- Development of the single procedure classification system should be given immediate priority, and implementation should be coordinated with national health reform. "

NCVHS reaffirmed its recommendation for a unified procedure coding system at their 50th Anniversary Symposium in 2000[11]. Given that PCS is used for reporting inpatient procedures, PCS should be considered as a replacement for CPT, thereby achieving the NCVHS objective of a unified, single procedure coding system controlled and maintained by HHS.

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[8] 42 U.S.C. §1320d-2(c)
[9] 42 C.F.R. §433.112(b)(2); CMS, State Medicaid Manual §11300 (rev. 18); 45 C.F.R. §162.1002(a)(5), (b)(1), (c)(1)
[10] National Committee on Vital and Health Statistics, *National Committee on Vital and Health Statistics 1993*, HHS, May 1994, p.8
[11] National Committee on Vital and Health Statistics, *50th Anniversary Symposium*, HHS, June 2000, p.41.

(4) What objective alternatives exist, or could be developed, to maintain a more objective process to the current AMA CPT-4 and RUC committee processes? How would these alternatives support or inhibit innovation?

PCS is an existing alternative to CPT codes. PCS is a public domain federal classification education developed and maintained by CMS, whereas CPT is copyrighted intellectual property of the AMA. The PCS update process is controlled by CMS and is an open federal process involving formal requests, CMS technical/clinical review, publication of proposed changes, and public comment. CMS makes final decisions on PCS modifications and additions. It is open, transparent, and promotes accountability. While the CPT update process includes a semi-public request and clinical review process, the AMA CPT editorial panel which is overrepresented by specialty societies makes the final decisions on CPT modifications and additions.

PCS versus CPT

CPT is essentially a list of terms (labels) that describe health care procedures (a nomenclature). In contrast, PCS is a classification system that organizes procedures into logical classes based on shared characteristics and the objective of a procedure. The basic design of CPT does not follow a systematic logical structure and lacks any organizing principles making it out-of-date from an information science perspective and medical content perspective. To have the necessary uniform and unbiased data required to control health care costs and evaluate quality of care, a modern, comprehensive and precise procedure coding system is needed.

Since CPT is structured as essentially a list of codes, CPT typically requires an individually defined new code for modifications, additions or new technology. Since PCS has a systematic seven-character, multiaxial structure in which each character conveys a defined attribute of the procedure, PCS can often accommodate modifications, additions or new technology by adding a new character combination using the existing PCS character values. When genuinely new concepts are needed, such as a new type of device, CMS can add a new character value and modify the appropriate PCS tables.

The 1993 NCVHS recommendations specified that the unified procedure coding system should be comprehensive, hierarchical, flexible, and serves present and future needs in the public and private sectors of health care. NCVHS listed the limitations of CPT relative to meeting these standards:

- “Lack of space for expansion
- Overlapping and duplicative codes
- Inconsistent and noncurrent use of terminology
- Lack of codes for preventive services
- Nonhierarchical structure
- Physician service orientation (not multidisciplinary)

- Poorly defined, non-discrete coding categories, with variable coding detail" [12]

The NCVHS recommendations also specified in detail the essential characteristics that a procedure classification system should possess.[13] The NCVHS detailed characteristics are listed in a Table at the end of our comments. Included in table is a comparison of CPT and PCS for each of the NCVHS characteristics. As the comparisons indicate, PCS meets virtually all NCVHS characteristics while CPT fails to meet many NCVHS detailed characteristics. Replacing CPT with PCS will achieve the NCVHS objective of a single procedure coding system that meets the NCVHS essential characteristics of a procedure classification system.

The PCS process for accommodating modifications, additions and new technology has been fully functional for a decade and has successfully kept PCS current with new and emerging technologies. PCS coding is linked with Medicare's New Technology Add-on Payment (NTAP) process. A technology generally must be uniquely identifiable in Medicare hospital claims to receive a NTAP. Consequently, manufacturers seeking an NTAP frequently also request a new PCS code. This ongoing process keeps PCS up to date new innovative technologies by supporting the data collection and evaluation of these new technologies.

(5) What are the benefits and drawbacks of paying for physician procedural services on the basis of the underlying International Classification of Diseases, 10th Revision (ICD–10) procedure code, as an alternative to CPT–4 code?

PCS reflects best practices in current information science and medical content procedures. CPT does not. As discussed in the response to question 4, PCS is a public domain federal classification developed and maintained by CMS that is fully functional with an ongoing update process that keeps PCS up to date with new and emerging technologies. It frees the Medicare and Medicaid programs from regulatory capture, and the market from AMA's monopoly and costs.

There is a growing consensus that the Medicare program should not pay more for services provided in a high-cost setting when it is safe and appropriate to provide those services in a lower-cost setting. To date, site neutral reform proposals have focused on payments involving HOPDs, ambulatory surgery centers and physician offices. CMS has begun to gradually eliminate the requirement that some procedures can only be performed in an inpatient site of service (the inpatient-only list), thereby making more procedures eligible to be performed in a hospital outpatient department. This is essentially a first step toward establishing a hospital site-neutral inpatient-outpatient payment system. The biggest barrier to comprehensive inpatient/outpatient site neutrality adoption is the incompatibility of CPT and PCS making the identification of the same procedure across the inpatient and outpatient sites of service difficult. An inpatient/outpatient site neutral payment system can produce substantial Medicare

[12] National Committee on Vital and Health Statistics, *National Committee on Vital and Health Statistics 1993*, HHS, May 1994, p.58
[13] National Committee on Vital and Health Statistics, *National Committee on Vital and Health Statistics 1993*, HHS, May 1994, p.64

savings.[14] Replacing CPT with PCS will create a unified single procedure coding system that eliminates the problem of CPT and PCS incompatibility and frees CMS to pursue innovative inpatient/outpatient site neutral payment system reforms.

PCS' only drawback is the need to extend PCS to cover all outpatient services and the time needed to convert existing outpatient systems and processes to PCS. However, the very successful 2015 conversion of all systems and processes from ICD-9-CM diagnosis codes to ICD-10-CM diagnosis codes along with the conversion of inpatient systems from ICD-9-CM procedure codes to PCS procedure codes can serve as a roadmap for the conversion process. Prior to 2015, a complete evaluation and testing of PCS was performed.[15] Similarly, the extension to PCS to cover all outpatient services will require evaluation and testing.

(5) How could the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD–10–PCS) services be grouped or bundled into payment categories, similar to Medicare Severity Diagnosis Related Groups (MS–DRGs), or Outpatient Prospective Payment System (OPPS) Ambulatory Payment Classifications (APCs)? What other alternatives exist for bundling or grouping procedural services?

The MS-DRGs were converted from ICD-9-CM procedures to PCS and was fully operational on October 1, 2015. The conversion required hospitals to modify EHRs, encoders, billing systems, the DRG grouper, clinical documentation programs, coder training, quality-measure systems, interfaces with payers, and internal analytics. CMS had to make Medicare processing changes and conduct extensive end-to-end testing before implementation. There was no significant breakdown in inpatient billing or Medicare claims processing when the ICD-10-CM diagnosis and the PCS version of MS-DRGs went live. Despite the switch being a hard cutover, the actual cutover went smoothly.

It is important to recognize that the 2015 conversion was a conversion of all systems from ICD-9-CM diagnosis codes to ICD-10-CM diagnosis codes plus the conversion of inpatient systems from ICD-9-CM procedure codes to PCS procedure codes. Thus, the 2015 conversion was significantly larger in scope than a conversion from CPT codes to PCS. Indeed, the inpatient conversion to PCS is complete and the diagnosis portion of all other systems like APCs to ICD-10-CM diagnoses is already completed. Plus, extensive PCS training and educational material was developed for the 2015 conversation and is readily available to facilitate the replacement of CPT with PCS. CMS already has an operational process for annual updates to PCS and extensive experience successfully updating PCS.

There are several lessons from the conversion of MS-DRGs to PCS that are applicable to the conversion of APCs to PCS.

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[14] Averill, Wadhwa, Mills, "What to Expect from Site-Neutral Payment System from Medicare", *Healthcare Financial Management*, February-March 2026

[15] Averill, Mullin, Steinbeck, Goldfield, Grant, Butler, "Development of the ICD-10 Procedure Coding System (ICD-10-PCS)", Final Report -CMS Website, 2012

- A one-to-one code translation between ICD-9-CM procedures and PCS was not always possible so the conversion process could not be fully automated. PCS sometimes required multiple codes to replicate an ICD-9-CM procedure code. A one-to-one translation was used as a starting point, but clinical review was necessary to finalize the PCS MS-DRGs.
- Because there was no claims database available coded with PCS codes to compute the associated MS-DRG payment weights, the initial MS-DRG conversion could not take advantage of the additional specificity of PCS. So, the initial PCS MS-DRG version was a replication of the ICD-9-CM MS-DRG version. Optimization of MS-DRGs for PCS specificity had to occur in subsequent years after PCS coded data became available.

This process to replicate the MS-DRGs was quite effective with the PCS MS-DRGs and the ICD-9-CM MS-DRG having only 1.68 percent of patients assigned to different MS-DRG with the PCS MS-DRGs yielding a net payment increase of 0.05 percent.[16]

A conversion of APCs would replicate the process used to convert MS-DRGs to PCS.

- Create a one-to-one code translation between CPT-4 procedures and PCS (commercial mappings are available) that can be used as a starting point for converting the APCs.
- Because PCS was created for inpatient care, some outpatient services that have CPT-4 codes will not have a PCS equivalent code (e.g., the Evaluation and Management codes in CPT). Additional PCS codes will need to be created. However, the multiaxial structure of PCS makes the addition of new codes a straightforward process.
- Perform a complete clinical review to finalize PCS APC replication.
- Optimize the APCs for PCS specificity in subsequent years after PCS coded data become available.

Note that the conversion of APCs to ICD-10-CM diagnosis codes was completed in the 2015 conversion. Any other system for bundling or grouping procedural services that is currently based on CPT codes will require a conversion process similar to the process outlined for APCs.

As was done for the MS-DRG conversion, CMS will need to conduct extensive end-to-end testing before implementation as well as provide education to all impacted segments of the healthcare industry. Fortunately, all the PCS training and educational materials developed for the 2015 conversion are still appliable. Compared to the 2015 conversion the conversion of CPT codes to PCS is more modest in scope.

Recommendation

Any proposal to replace CPT with PCS will meet strong opposition from the AMA and medical specialty societies. However, much of the criticism of the proposal will be speculative because

[16] Mills, Butler, McCullough, Boa, Averill, "Impact of the Transition to ICD-10 on Medicare Inpatient Hospital Payments", *Medicare & Medicaid Research Review*, 1(2), 2011)

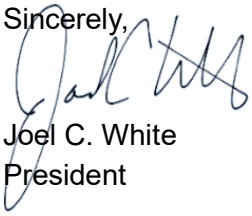
PCS has yet to be fully converted to encompass all services covered by CPT. Therefore, we recommend the following:

RECOMMENDATION: CMS should extend PCS to cover all outpatient services. Using the extended PCS, CMS should create a PCS version of the APCs. Using the PCS version of the APCs, CMS should perform a payment impact analysis similar to the payment impact analysis performed for the PCS version of MS-DRGs. CMS should publish for public review and comment a description of the process used to extend PCS to cover all outpatient services, the definition manual for the extended PCS, the definition manual for the PCS version of the APCs and the results of the payment impact analysis. CMS can then make an informed decision on whether to replace CPT with PCS. The timeframe to complete this evaluation process should not exceed one year.

CMS typically produces such a comprehensive report for public review and comment before adoption of any major reform. For example, before implementation of the Medicare Inpatient Prospective Payment System[17], the Outpatient Prospective Payment System[18] and PCS[19], CMS produced a report that fully described the proposed system and potential impact.

In 2015 the big issue was the IPPS payment impact on MS-DRGs. This time the big question will be the OPPS payment impact on APCs.

Sincerely,



Joel C. White
President

[17] Schweiker, Report to Congress Hospital Prospective Payment for Medicare, HSS, December 1992.
[18] Averill, Goldfield, Wynn, McGuire, Mullin, Gregg, Bender, "Design and Evaluation of a Prospective Payment System for Ambulatory Care", *Health Care Financing Review*, 15(1), Fall 1993
[19] Averill, Mullin, Steinbeck, Goldfield, Grant, Butler, "Development of the ICD-10 Procedure Coding System (ICD-10-PCS)", Final Report -CMS Website, 2012

NCVHS characteristics of a Procedure Coding System

NCVHS Characteristics	CPT-4	ICD-10-PCS
Hierarchical structure		
Ability to aggregate data from individual codes into larger categories	Other than body system no ability to aggregate by other components of a procedure	The ability to aggregate across all essential components of a procedure is provided
Each code has a unique definition forever - not reused	Some codes do not have a unique definition because the codes have been reused	All codes have a unique definition
Expandability		
Flexibility to add new procedures and technologies. Empty code numbers for expansion	Minimal flexibility. New procedures and technologies can be difficult to incorporate. Limited empty code numbers	Extensive flexibility. New procedures and technologies are easily incorporated. Virtually unlimited empty code values available
Mechanism for periodic updating	Minimally updated annually by AMA	Updated annually through Coordination and Maintenance Committee
Code expansion must not disrupt systematic code structure	Code expansions can be difficult to incorporate and often disrupts systematic code structure	Code expansions do not disrupt systematic structure
Comprehensive		
Provides NOS and NEC categories so that all possible procedures can be classified somewhere	All procedures can be categorized somewhere but with some codes containing distinct procedures	NEC and NOS categories are specific to each axis of code. All procedures can be categorized somewhere.
Includes all types of procedures	All types of procedures are included	All types of procedures are included
Applicability to all setting and types of providers	All settings and types of providers are covered. Has a physician service orientation.	All settings and types of providers are covered. Has an inpatient orientation. Requires extension for all ambulatory services

NCVHS characteristics of a Procedure Coding System – Continued

NCVHS Characteristics	CPT-4	ICD-10-PCS
Non-Overlapping		
Each procedure (or component of a procedure) is assigned to only one code	The same procedure when performed for different diagnoses can be assigned to different codes	Each procedure is assigned to only one code
Ease of Use		
Standardization of definitions and terminology	No standard definitions provided.	Standard definitions of all terminology provided
Adequate indexing and annotation for all users	Full index but specificity of index varies across codes	Full index with consistent specificity across codes
Setting and Provider Neutrality		
Same code regardless of who or where procedure is performed	Some codes are specific to who or where procedure is performed	Codes are independent of who or where procedure is performed
Multiaxial		
Body system(s) affected	Body system affected can generally be determined from code number	A specific character in the code specifies the body system affected
Technology used	Limited and inconsistent specification of technology used	Technology used is specified in the approach character of the code
Techniques/approaches used	Limited and inconsistent specification of techniques/ approaches used	Techniques/approaches used are specified in the approach character of the code
Physiological effect or pharmacological properties	Limited specification of Physiological effect or pharmacological properties	Limited specification of Physiological effect or pharmacological properties
Characteristics/composition of implant	Characteristics of implants are specified	Characteristics of implants are specified in the device character of the code
Limited to Classification of Procedures		
Should not include diagnostic information	Diagnostic information is included for some codes	No diagnostic information is included in the code
Other data elements (such as age) should be elsewhere in the record	Age is included for some codes	Age and no other data elements included in code