CPT Category II codes

The What, Why and When for using CPT Category II Codes

- Supplemental tracking codes used for performance measurement that describe clinical components, usually included in E&M or clinical services. Therefore, they do not have a relative value associated with them and are not reimbursable.
- Use is optional and may not be used as a substitute for Category I codes.
- 5-character alpha-numeric codes which always end with the character "F".
- When specific measure criteria have been met, these codes identify opportunities for better clinical outcomes for your patient's care, closes gaps in care more accurately and quickly, which leads to enhanced performance on HEDIS measures for your practice.
- Helps track member screenings to help you monitor care and avoid sending unnecessary reminders.
- Efficient process reduces the need for chart reviews and medical record requests.
- If clinical and documentation requirements are met, there is no limitation on how often these codes can be submitted.

Tips For Implementing CPT Category II Coding into Your Practice

- Work with your system vendor to add these codes into your EMR and Practice Management System.
    - Inquire about automation. Some systems can automatically translate clinical data elements into the appropriate CPT II codes and ensure these codes are included on the claim.
- Develop workflows for clinical office staff, billers, and coders for proper code submission.
- These codes may be submitted on claims with other applicable codes. They are entered in the procedure code field, just like your regular CPT codes are billed.
    - Check payer specific guidelines for submitting Category II codes. Some payers may require a professional service is performed on the date the Category II services are reported.
- Verify the charge amount criteria with your EMR/Practice Management and Clearinghouse vendors. These codes will be entered with either a .00 or .01 charge amount.

CPT Category II Codes			
HEDIS Measure Name and Documentation Guidelines	**CPT II code**	**CPT Category II Code Description**	**Charge Amount**
Controlling High Blood Pressure (CBP) Medical record stating hypertension diagnosis and the following blood pressure screening documentation: •Date and most recent results of the blood pressure reading. •The blood pressure reading must occur on or after the date of the second diagnosis of hypertension. •Documentation must be from provider managing the condition. *Note: Two codes (one from 3074F-3077F and one from 3078F-3080F) must be reported to identify the lowest systolic and lowest diastolic reading to satisfy the CBP measure.*	3074F	Most recent systolic blood pressure <130 mm Hg	.00 or .01
	3075F	Most recent systolic blood pressure 130-139 mm Hg	.00 or .01
	3077F	Most recent systolic blood pressure >/=140 mm Hg	.00 or .01
	3078F	Most recent diastolic blood pressure <80 mm Hg	.00 or .01
	3079F	Most recent diastolic blood pressure 80-89 mm Hg	.00 or .01
	3080F	Most recent diastolic blood pressure >/=90 mm Hg	.00 or .01
Eye Exam for Patients with Diabetes (EED) Medical record stating a confirmed diagnosis of diabetes to include the following retinal eye exam documentation: •A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that a retinal or dilated eye exam was completed by an eye care professional (optometrist or ophthalmologist). •Evidence of bilateral or unilateral eye enucleation anytime during the patient's history through 12/31 of the current calendar year. •A negative retinal or dilated eye exam (negative for retinopathy) by an eye care specialist in the year prior *Note:* *Any provider can report the appropriate CPT Category II code. Report 2022F-2033F with date of eye exam, not the date of service (DOS) when the report was reviewed. Report 3072F with the current year DOS. An eye exam result documented as "unknown" does not meet criteria.*	2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy	.00 or .01
	2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy	.00 or .01
	2024F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy	.00 or .01
	2025F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy	.00 or .01
	2026F	Eye imaging validation to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy	.00 or .01
	2033F	Eye imaging validation to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy	.00 or .01
	3072F	Low risk for retinopathy (no evidence of retinopathy in prior year)	.00 or .01
Glycemic Status Assessment for Patients with Diabetes (GSD) Medical record stating a confirmed diagnosis of diabetes to include the following HbA1c screening documentation: •Document the date and result(s) or provide a copy of the lab report with the most recent HbA1c control indictor used regardless of data source. *Note: Report CPT Category II code with the date of the A1c test, not the date of the office visit when the test was reviewed.*	3044F	Most recent hemoglobin A1c (HbA1c) level less than 7.0%	.00 or .01
	3046F	Most recent hemoglobin A1c level greater than 9.0%	.00 or .01
	3051F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0%	.00 or .01
	3052F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0%	.00 or .01
Advanced Care Planning (ACP) Medical record should include the following discussions between a qualified health care professional and the patient: •Discuss the patient's health care wishes if they become unable to make decisions about their care with or without completing legal forms. This may include living wills, instruction directives, health care proxy, health care power of attorney.	1123F	Advance care planning discussed and documented advance care plan or surrogate decision maker documented in the medical record	.00 or .01
	1124F	Advance care planning discussed and documented in the medical record, patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan	.00 or .01
	1157F	Advance care plan or similar legal document present in the medical record	.00 or .01

	1158F	Advance care planning discussion documented in the medical record	.00 or .01
Care for Older Adults (COA) Functional Status •Notation that activities of daily living (bathing, dressing, eating, walking, etc.) or instrumental activities of daily living (grocery shopping, driving, meal preparation, laundry, taking medications, etc.) were assessed or documentation of result of assessment using a standardized functional status assessment.	1170F	Functional status assessed	.00 or .01
Care for Older Adults (COA) Medication List	1159F	Medication list documented in medical record	.00 or .01
Care for Older Adults (COA) Medication Review Medication list and evidence of medication review by prescribing practitioner or clinical pharmacist, including date when performed or notation that member in not taking any medication and date when noted, which may include transitional care management services during the same outpatient visit. *Note: Both 1159F and 1160F must be reported to satisfy the medication review component of COA measure.*	1160F	Review of all medications by a prescribing practitioner or clinical pharmacist (such as, prescriptions, OTCs, herbal therapies, and supplements) documented in the medical record	.00 or .01
Prenatal and Postpartum Care (PPC) Stand Alone Prenatal Visits ***See details under CPT Category II Code Description***	0500F	Initial prenatal care visit (report at first prenatal encounter with health care professional providing obstetrical care. Report also date of visit and, in a separate field, the date of the last menstrual period [LMP]).	.00 or .01
	0501F	Prenatal flow sheet documented in medical record by first prenatal visit (documentation includes at minimum blood pressure, weight, urine protein, uterine size, fetal heart tones, and estimated date of delivery). Report also: date of visit and, in a separate field, the date of the last menstrual period [LMP] (Note: If reporting 0501F Prenatal flow sheet, it is not necessary to report 0500F Initial prenatal care visit)	.00 or .01
	0502F	Subsequent prenatal care visit [Excludes: patients who are seen for a condition unrelated to pregnancy or prenatal care (e.g., an upper respiratory infection; patients seen for consultation only, not for continuing care)]	.00 or .01
Prenatal and Postpartum Care (PPC) Postpartum Visits	0503F	Postpartum care visit	.00 or .01
Transitions of Care (TRC)-Medication Reconciliation Post-Discharge Medical record should include a medication reconciliation by a qualified health care professional post-discharge in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record. •The medication list may include medication names only or may include medication names, dosages, and frequency, over the counter (OTC) medications and herbal or supplemental therapies. *Notes: The medication reconciliation must be documented on the date of discharge through 30 days after the discharge (31 days total).* *1111F can be reported when the post-discharge medication reconciliation is done during a telephone call or during the transitional care management (TCM).*	1111F	Discharge medications reconciled with the current medication list in outpatient medical record	.00 or .01