Implementing CPT Category II Codes

Select Health's Quality Provider Program highly encourages implementation of CPT category II codes.

WHAT ARE CPT CATEGORY II CODES?

- Tracking codes that close care gaps and facilitate data collection for the purpose of quality performance measurement
- Codes comprised of four digits followed by the letter "F"

WHY SHOULD WE BILL CPT CATEGORY II CODES?

Providers who implement CPT category II codes will improve efficiencies in closing patient care gaps and in data collection for performance measurement through:

- **Improved efficiency:** These codes reduce the administrative burden of staff members who have been tasked with maximizing earnings from value-based payment programs.
- **Performance measurement:** Report services and/or values based on nationally recognized, evidence-based guidelines for improving the quality of patient care.

The table below lists CPT category II codes that are helpful for participation in various payers' quality performance and/or value-based payment programs.

NOTE: CPT category II codes cannot be used in place of CPT category I or category III codes.

Table 1. Key CPT Category II Codes

Measure	Code	Definition
A1c Results	3044F	Most recent hemoglobin A1c level < 7.0%
	3046F	Most recent hemoglobin A1c level > 9.0%
	3051F	Most recent hemoglobin A1c level > to 7.0% and < 8.0%
	3052F	Most recent hemoglobin A1c level > 8.0% and < or = to 9.0%
Advance Care Planning	1123F	Advance Care Planning discussed and documented - advance care plan or surrogate decision maker documented in the medical record
	1124F	Advance Care Planning discussed and documented in the medical record - patient did not wish or was able to name a surrogate decision maker or provide an advance care plan
	1157F	Advance care plan or similar legal document present in the medical record
	1158F	Advance care planning discussion documented in the medical record
Blood Pressure Control	3074F	Most recent systolic blood pressure < 130 mm Hg
	3075F	Most recent systolic blood pressure 130–139 mm Hg
	3077F	Most recent systolic blood pressure > 140 mm Hg
	3078F	Most recent diastolic blood pressure < 80 mm Hg
	3079F	Most recent diastolic blood pressure 80–89 mm Hg
	3080F	Most recent diastolic blood pressure > 90 mm Hg

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Table 1. Key CPT Category II Codes, Continued

Diabetic Eye Exam	2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with retinopathy
	2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without retinopathy
	2024F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with retinopathy
	2025F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without retinopathy
	2026F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with retinopathy
	2033F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; without retinopathy
Functional Status	1170F	Functional status assessed
LDL Testing	3048F	Most recent LDL-C < 100 mg/dL
	3049F	Most recent LDL-C 100–129 mg/dL
	3050F	Most recent LDL-C > to 130 mg/dL
Medication List	1159F	Medication list documented in medical record
Medication Reconciliation	1111F	Discharge medications reconciled with the current medication list in outpatient medical record
Medication Review	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
Postpartum and Prenatal Care	0503F	Postpartum care visit
	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
	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
	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)

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