Medicare Advantage frequently used CPT II codes for HEDIS measures

What are CPT Category II codes?
Current Procedural Terminology Category II (CPT II) codes are supplemental tracking codes used for performance measurement to help support quality patient care. The Centers for Medicare & Medicaid Services (CMS) uses these codes across the country.

CPT II codes make it easier to track the delivery of quality care. The codes also simplify how quality performance measures are reported and eliminate the need for chart abstraction. Providers and hospitals can use these codes to report specific services that contribute to positive health outcomes and high-quality care.

Why use CPT II codes?
- Decrease the need to request a patient’s chart from a healthcare provider
- Identify and address care opportunities more quickly, which drive Healthcare Effectiveness Data and Information Set (HEDIS®) measures and Star Ratings improvements
- Provide access to more accurate medical data supporting a healthcare provider’s care plan through more targeted case management services
- Support healthcare providers by proactively addressing clinical care opportunities
- Help facilitate timely and accurate claim payment

CPT II code billing information
CPT II codes are billed in the procedure code field the same as CPT Category I codes. However, they are informational codes used to describe clinical components that are usually included in evaluation, management or clinical services. CPT II codes are not associated with any relative value and can be billed with a $0.00 charge amount. As these codes are for reporting purposes only, they are non-payable and will be processed accordingly.

Listed below are the HEDIS Star measures and their applicable CPT II codes.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Common CPT II codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care for Older Adults (COA)</td>
<td>Functional Status Assessment (FSA)</td>
</tr>
<tr>
<td></td>
<td>1170F: Functional status assessed</td>
</tr>
<tr>
<td>Medication Review (MDR)</td>
<td>1159F: Medication list documented in the medical record</td>
</tr>
<tr>
<td></td>
<td>1160F: Review of medications by prescribing practitioner or clinical pharmacist documented in the medical record</td>
</tr>
<tr>
<td></td>
<td>National provider identification [NPI] number required in addition to CPT II code to close care opportunity</td>
</tr>
<tr>
<td>Pain Screening (PNS)</td>
<td>1125F: Pain severity quantified; pain present</td>
</tr>
<tr>
<td></td>
<td>1126F: Pain severity quantified; no pain present</td>
</tr>
</tbody>
</table>
Comprehensive Diabetes Care*  
Blood Sugar Controlled (CDC-HbA1c)  
- 3044F: Most recent HbA1c level < 7.0%  
- 3046F: Most recent HbA1c level > 9.0%**  
- 3051F: Most recent HbA1c level ≥ 7.0% and < 8.0%  
- 3052F: Most recent HbA1c level ≥ 8.0% and < 9.0%  
3045F is included in the HEDIS 2020 value set; however, it is considered obsolete as of Dec. 31, 2019. Please use one of the codes listed above for dates of service beginning Jan. 1, 2020.

Medical Attention for Nephropathy (CDC-Neph)  
- 3060F: Positive microalbuminuria test result documented and reviewed  
- 3061F: Negative microalbuminuria test result documented and reviewed  
- 3062F: Positive macroalbuminuria test result documented and reviewed  
- 3066F: Documentation of treatment for nephropathy  
- 4010F: Evidence of Angiotensin Converting Enzyme (ACE)/Angiotensin Receptor Blockers (ARB) therapy

Eye Exam (CDC-Eye)  
NPI required in addition to CPT II code to close care opportunity

<table>
<thead>
<tr>
<th>Description</th>
<th>Without evidence of retinopathy†</th>
<th>With evidence of retinopathy‡</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed</td>
<td>• 2023F</td>
<td>• 2033F</td>
</tr>
<tr>
<td>Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed</td>
<td>• 2025F</td>
<td>• 2026F</td>
</tr>
<tr>
<td>Eye imaging validated to match diagnosis from seven standard field stereoscopic retinal photos results documented and reviewed</td>
<td>• 2033F</td>
<td>• 3072F</td>
</tr>
<tr>
<td>Low risk for retinopathy (no evidence of retinopathy in the prior year)</td>
<td>• 3072F</td>
<td>• N/A</td>
</tr>
</tbody>
</table>

Controlling Blood Pressure (CBP)*  
Systolic  
- 3074F: < 130 mmHg  
- 3075F: 130 to 139 mmHg  
- 3077F: ≥ 140 mmHg**  

Diastolic  
- 3078F: < 80 mmHg  
- 3079F: 80 to 89 mmHg  
- 3080F: ≥ 90 mmHg**

Medication Reconciliation Post-Discharge (MRP)  
• 1111F: Discharge medications reconciled with current medication list in the outpatient medical record  
NPI required in addition to CPT II code to close care opportunity

*The last reading/result of the measurement year will be used for HEDIS reporting and performance rating.  
**Coding information presented in plum indicates results that do not meet Star measure control levels and will not fully address care opportunities. However, they should be used to verify that the test was performed and for monitoring/reporting of results.  
† When negative retinopathy results are reported for a patient, they will be compliant for the measurement year in which the testing occurred through the end of the following measurement year. 2023F, 2025F and 2033F are new CPT II codes that can be used for dates of service beginning Oct. 1, 2019.  
‡ When these codes are used for dates of service prior to Oct. 1, 2019, please report negative retinopathy results using diagnostic codes E10.9, E11.9 and E13.9.

CPT II codes provided in this document are limited to those that will address care opportunities for the measures included. For a full description of CPT II codes, please refer to the American Medical Association CPT® Professional Edition Book or coding platform.