Humana.

Medicare Advantage frequently used CPT II codes for HEDIS measures

What are CPT II codes?

Current Procedural Terminology (CPT®) Category 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?

- Reduce patient chart requests from health plan
- Identify and address care opportunities more quickly, which drives Healthcare Effectiveness Data and Information Set (HEDIS®) measures and Star Rating improvements
- Provide access to more accurate medical data, supporting your care plan through more targeted case management services
- Support a proactive approach to 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 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 nonpayable and will be processed accordingly.

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

Measure	Common CPT II codes
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.	
Care for Older Adults (COA)	**Functional Status Assessment (FSA)** • 1170F: Functional status assessed
	Medication Review (MDR) • 1159F: Medication list documented in the medical record • 1160F: Review of medications by prescribing practitioner or clinical pharmacist documented in the medical record (National Provider Identifier [NPI] number required in addition to CPT II code to close care opportunity)
	Pain Screening (PNS) • 1125F: Pain severity quantified; pain present • 1126F: Pain severity quantified; no pain present

<table>
<tr><td rowspan="5">Diabetes Care</td><td colspan="3">Glycemic Status Assessment (GSD)
• 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%</td></tr>
<tr><td colspan="3">Eye Exam for Patients With Diabetes (EED)
(NPI required in addition to CPT II code to close care opportunity)</td></tr>
<tr><td>Description</td><td>Without evidence of retinopathy**</td><td>With evidence of retinopathy</td></tr>
<tr><td>• Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed
• Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed
• Eye imaging validated to match diagnosis from seven standard field stereoscopic retinal photos results documented and reviewed
• Low risk for retinopathy (no evidence of retinopathy in the prior year)</td><td>• 2023F
• 2025F
• 2033F
• 3072F</td><td>• 2022F
• 2024F
• 2026F
• N/A</td></tr>
<tr><td>Controlling Blood Pressure (CBP)*</td><td colspan="2">Systolic
• 3074F: < 130 mmHg
• 3075F: 130–139 mmHg
• 3077F: ≥ 140 mmHg</td><td>Diastolic
• 3078F: < 80 mmHg
• 3079F: 80–89 mmHg
• 3080F: ≥ 90 mmHg</td></tr>
<tr><td>Medication Reconciliation Post-Discharge (MRP)</td><td colspan="3">• 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)</td></tr>
</table>

* The last reading/result of the measurement year will be used for HEDIS reporting and performance rating.

** When negative retinopathy results are reported for a patient, he or she will be compliant for the measurement year in which the testing occurred through the end of the following measurement year.

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. The coding information in this document is subject to changing requirements and should not be relied on as official coding or legal advice. All coding should be considered on a case-by-case basis and supported by medical necessity and appropriate documentation in the medical record.