Before submitting any CPT Category II code(s)…

In order for a patient to be included in the numerator for a particular performance measure, a patient must meet the denominator inclusion criteria for that measure. Prior to coding, users must review: (1) the complete description of the code in the Category II section of the CPT codebook and website; and (2) the specification documents of its associated performance measure as found on the measure developer's website. The superscripted number that follows the specific title for the performance measure directs users to the footnotes at the bottom of each page of this appendix. The footnotes identify the measure developer and the developer's Web address.

*Only modifiers 1P, 2P, 3P, and 8P can be used with Category II codes. Other modifiers may **not** be used with Category II codes. In addition, the modifiers included within the Category II code section and Appendix H are only intended to be used when parenthetical notes, guidelines, or reporting language specifically allow their use.*

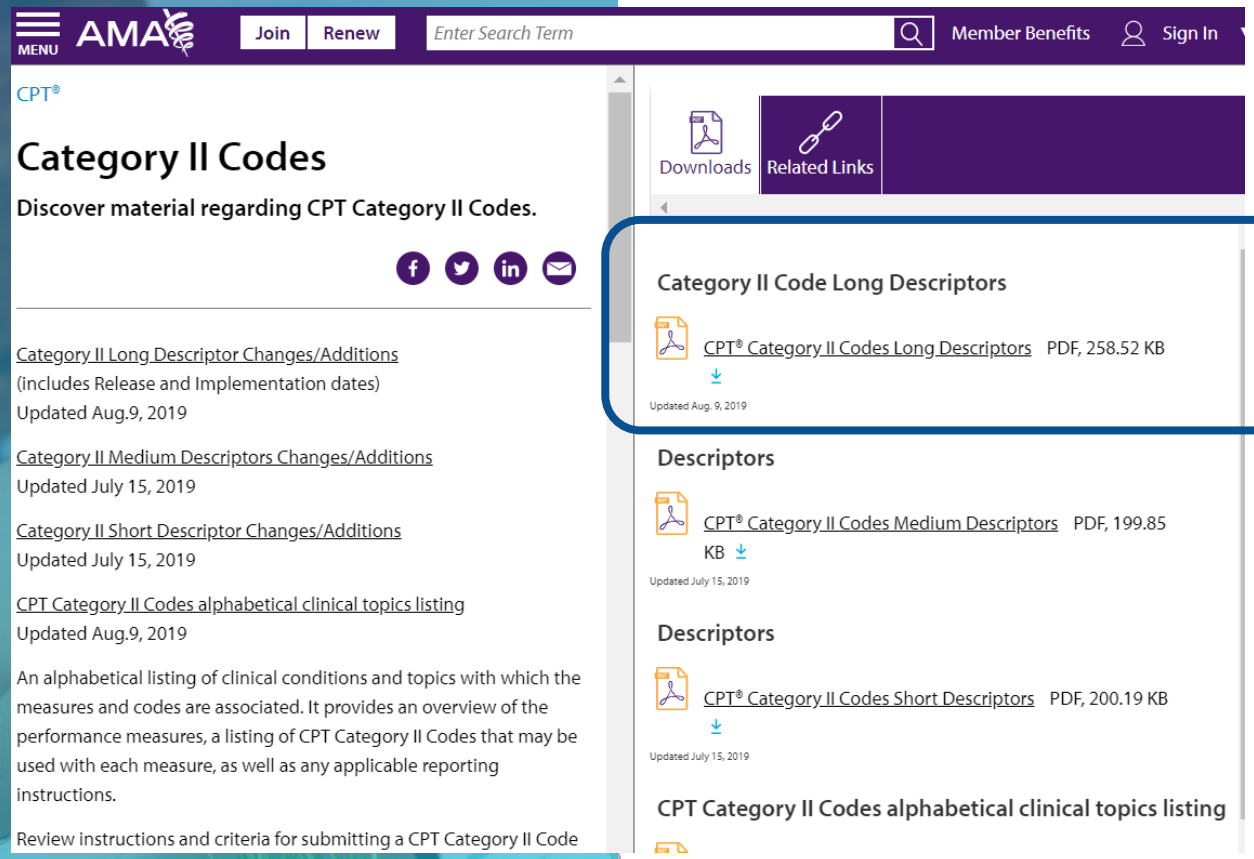
Exclusion modifiers

1P = Exclusion due to medical reasons (ex. absence of limb, drug interaction)

2P = Exclusion due to patient reasons (ex. patient declined, financial/religious)

3P = Exclusion due to system reasons (ex. resources not available, insurance issues)

CPT Category II codes may be updated more often than annually :: how will you keep up?



Go visit: https://www.ama-assn.org/practice-management/cpt/category-ii-codes

CPT® Category II Codes

AMA AMERICAN MEDICAL ASSOCIATION

The following codes are an excerpt of the Current Procedural Terminology (CPT®) Category II codes set that were most recently approved by the CPT Editorial Panel. These codes are provided to identify and distinguish those codes that were added to the Category II code set since the latest printing of the CPT codebook (CPT 2019). Therefore, the codes noted within this Web listing will include only those codes that are not listed in the latest edition of the CPT codebook. For a complete list of all of the existing Category II codes, this list should be appended to the codes in the latest edition of the CPT code set.

Sample from the AMA Category II Clinical Topics Listing :: Diabetes and A1C measurement

Diabetes (DM)		
Brief Description of Performance Measure & Source and Reporting Instructions	**CPT Category II Code(s)**	**Code Descriptor(s)**
A1c Management [4] Whether or not patient received one or more A1c test(s) **Numerator:** Patients who received one or more A1c test(s) **Denominator:** Patients with diagnosed diabetes 18-75 years of age **Percentage** of patients with diagnosed diabetes aged 18-75 years with one or more A1c test(s). **Exclusion(s):** NONE **Reporting Instructions:** In order to meet this measure, the date of test, when it was performed, and the corresponding result are required. For this reason, report one of the three Category II codes listed and use the date of service as the date of the test, not the date of the reporting of the Category II code. The measure may also be met by reporting the Category I code, 83036 Hemoglobin; glycosylated (A1C), when performed. ►To report most recent hemoglobin A1c level ≤9.0%, see codes 3044F, 3051F, 3052F.◄	*3044F* ►3051F◄ ►3052F◄ *3046F*	*Most recent hemoglobin A1c (HbA1c) level < 7.0%* ►Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0%◄ ►Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0%◄ *Most recent hemoglobin A1c (HbA1c) level > 9.0%*

Refer to the CPT 2020 code updates per AMA!

23	Cat II-Diabetes Care	●304XF●305XF **D**3045F	**Accepted addition** of codes 304XF, 305XF to allow ~~reporting~~ for different levels of HbA1c; **deletion** of 3045F	January 1, 2020

CPT Cat. II codes for Hypertension and description of Performance Measure

Hypertension		
Brief Description of Performance Measure and Source	**CPT Category II Code(s)**	**Code Descriptor(s)**
Blood Pressure Control[1] Whether or not the patient aged 18 years and older with a diagnosis of hypertension has a blood pressure reading less than 140 mm Hg systolic and less than 90 mm Hg diastolic OR a blood pressure reading greater than or equal to 140 mm Hg systolic and less than 90 mm Hg diastolic and prescribed 2 or more anti-hypertensive agents during the most recent visit		
For complete measure language with definitions, please reference the measure worksheets at www.physicianconsortium.org	3074F	Most recent systolic blood pressure < 130 mm Hg
Numerator:	3075F	Most recent systolic blood pressure 130 to 139 mm Hg
Patients with a blood pressure < 140/90 mm Hg	3077F	Most recent systolic blood pressure ≥ 140 mm Hg
OR Patients with a blood pressure ≥ 140/90 mm Hg and prescribed 2 or more anti-hypertensive medications during the most recent office visit	3078F	Most recent diastolic blood pressure < 80 mm Hg
Denominator: All patients aged 18 years and older with a diagnosis of hypertension	3079F	Most recent diastolic blood pressure 80 – 89 mm Hg
Exclusion(s): Documentation of medical (eg, allergy, intolerant, postural hypotension, other medical reason(s)), patient (eg, patient declined, other patient reason(s)), or system (eg, financial reasons, other system reason(s)) reason(s) for not prescribing 2 or more anti-hypertensive medications	3080F	Most recent diastolic blood pressure ≥ 90 mm Hg
Reporting Instructions: For the systolic blood pressure value, report one of the three systolic codes; for the diastolic blood pressure value, report one of the three diastolic codes. If 3077F or 3080F are reported AND two or more anti-hypertensive agents are prescribed or currently taking, also report 4145F. For patient with appropriate exclusion criteria report 4145F with modifier 1P, 2P, or 3P.	4145F	Two or more anti-hypertensive agents prescribed or currently being taken

CPT Cat. II codes for Lipid Control/Cholesterol

Chronic Stable Coronary Artery Disease (CAD)
Diabetes (DM)
Chronic Kidney Disease (CKD)

These measures for high/low cholesterol levels are found in several disease categories and use similar measures. Be sure to check for a full listing of exclusions, documentation requirements, and reporting instructions! Below is just a sample from a few areas in the ~387 pages – use the Search feature!

Lipid Control[1]		
Whether or not the patient aged 18 years and older with a diagnosis of CAD has an LDL-C result less than ` 100 mg/dL OR has an LDL-C result greater than or equal to 100 mg/dL and a plan of care is documented to achieve LDL-C less than 100 mg/dL, which includes prescription of a statin, at a minimum	3048F	Most recent LDL-C < 100 mg/dL
For complete measure language with definitions, please reference the measure worksheets at www.physicianconsortium.org	3049F	Most recent LDL-C 100 - 129 mg/dL
Numerator:	3050F	Most recent LDL-C greater than or equal to 130 mg/dL

IN SUMMARY :: Performance Measurement Using CPT Category II Codes

- In addition to being a “superuser” of you EHRs -- it is likely that your quality review staff/nurses will need basic and intermediate training on clinical documentation, professional coding, and even billing for various insurers in order to locate and interpret our quality compliance needs and requirements.

- Though previously considered voluntary, supplemental, and optional codes – many managed care carriers are “asking” for these codes to be submitted on a periodic basis for specified disease categories or for specific segments of your patient population.

- Carriers have widely varying policies on how/when to submit these codes and if they are payable or are just used to measure performance against the “requirements” of the insurance plan(s) that you participate with.

- Some carriers allow these codes to be submitted on the same date of service as other traditional visits, but some want it on a separate claim with $.01 on the claim line – others want a “claim” to be submitted as informational-only using either a CMS1450 or CMS1500 form equivalent.

QUALITY & CARE MANAGEMENT: What do we need?

Quality/Care Management Category	Use CPT	Use HCPCS-II	Use ICD-10-CM	Impact on RHC Revenue
Care Management Services	✓	✓		HIGH
CPT Category II Performance Measures	✓			MEDIUM
Preventive Medicine Services	✓	✓	✓	HIGH
Hierarchal Conditions Categories (HCC)			✓	LOW
HEDIS measures	✓	✓	✓	LOW
Population Health Prevention via Social Determinants of Care			✓	**n/a**
Primary Care & Behavioral Health Integration (ex. SUD/OUD/MAT)	✓	✓	✓	HIGH

WHO SHOULD BE INVOLVED?

Managers

Who offers financial incentives for reporting Performance Measures using CPT Category II codes?

Prepare electronic or paper tools to trigger the rooming nurse to communicate with the provider when it is necessary to meet UDS, CPT-II, or other quality measures.

Coordinate closely with the Chief Medical Officer (CMO)!

Quality Reporting/Nurses

Work together to develop an effective method where your clinical providers know how to report potentially billable services DIFFERENTLY than quality measures.

Have we documented any Care Management Services in between visits like TCM or VCS? Will we be updating a Care Plan?

Clinical Providers

We recognize that this new Value-based world makes it feel as though you do not have full control over the scope of care you provide and that some quality measurement issues take valuable time away from your day – thanks for helping!

NRHA

NATIONAL RURAL HEALTH ASSOCIATION

Thanks for your attention - Now is our time to shine!

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