



# CATEGORY PROCEDURAL TERMINOLOGY (CPT) CATEGORY II CODES



## What is a CPT II Code?

CPT II codes are a set of alphanumeric medical codes used to track performance measures and quality indicators. A CPT II code typically consists of four digits, followed by the letter “F”. The four digits denote the specific performance measure or clinical concept. The “F” indicates it’s a tracking code.

## Why use CPT II codes?

They provide a standardized way to measure and report health care quality. These codes help in tracking specific aspects of patient care, facilitating quality improvement initiatives.

## Using CPT II codes will help to:

- **Improve Health Outcomes** with a more comprehensive view of a member’s health status.
- More accurate information helps to identify opportunities to improve patient care. Improved patient care can help **improve HEDIS measurement scores** for your provider practice.
- **Reduce Medical Record Requests.** Adding CPT II codes improves the accuracy of the record, reducing the need for chart review.

MEASURE	CPT II CODE	DEFINITION
<b>APM: Metabolic Monitoring for Children and Adolescents on Antipsychotics</b>	<b>3044F</b>	Most recent hemoglobin A1c (HbA1c) level less than 7.0% (DM)
	<b>3046F</b>	Most recent HbA1c level greater than 9.0% (DM)
	<b>3051F</b>	Most recent HbA1c level greater than or equal to 7.0% and less than 8.0%
	<b>3052F</b>	Most recent HbA1c level greater than or equal to 8.0% and less than or equal to 9.0%
	<b>3048F</b>	Most recent LDL-C less than 100 mg/dL
LDL-C Test Result or Finding	<b>3049F</b>	Most recent LDL-C 100-129 mg/dL
	<b>3050F</b>	Most recent LDL-C greater than or equal to 130 mg/dL
	<b>1170F</b>	Functional status assessed
<b>COA: Care of Older Adults</b>	<b>1159F</b>	Medication list documented in the medical record
	<b>1160F</b>	Review of medications by prescribing practitioner or clinical pharmacist documented in the medical record
Pain Screening	<b>1125F</b>	Pain severity quantified; pain present
	<b>1126F</b>	Pain severity quantified; no pain present

MEASURE	CPT II CODE	DEFINITION
<b>CBP: Controlling High Blood Pressure</b>	Blood Pressure	<b>3074F</b> Most recent systolic blood pressure less than 130 mm Hg
		<b>3075F</b> Most recent systolic blood pressure 130 – 139 mm Hg
		<b>3077F</b> Most recent systolic blood pressure greater than or equal to 140 mm Hg
		<b>3078F</b> Most recent diastolic pressure less than 80 mm Hg
		<b>3079F</b> Most recent diastolic pressure 80 – 89 mm Hg
		<b>3080F</b> Most recent diastolic pressure greater than or equal to 90 mm Hg
<b>GSD: Glycemic Status Assessment for Patients with Diabetes</b>	HbA1c	<b>3044F</b> Most recent HbA1c level < 7.0%
		<b>3046F</b> Most recent HbA1c level > 9.0%
		<b>3051F</b> Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0%
		<b>3052F</b> Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0%
<b>BPD: Blood Pressure Control for Patients with Diabetes</b>	Blood Pressure	<b>3074F</b> Most recent systolic blood pressure less than 130 mm Hg
		<b>3075F</b> Most recent systolic blood pressure 130 – 139 mm Hg
		<b>3077F</b> Most recent systolic blood pressure greater than or equal to 140 mm Hg
		<b>3078F</b> Most recent diastolic pressure less than 80 mm Hg
		<b>3079F</b> Most recent diastolic pressure 80 – 89 mm Hg
		<b>3080F</b> Most recent diastolic pressure greater than or equal to 90 mm Hg



MEASURE		CPT II CODE	DEFINITION
<b>EED: Eye Exam for Patients with Diabetes</b>	Eye Exam by Eye Care Professional	<b>2022F</b>	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy
		<b>2023F</b>	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
		<b>2024F</b>	Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy
		<b>2025F</b>	Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
		<b>2026F</b>	Eye imaging validated to match diagnosis from seven standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy
		<b>2033F</b>	Eye imaging validated to match diagnosis from seven standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy
<b>SMD: Diabetes Monitoring for People with Diabetes and Schizophrenia</b>	HbA1c	<b>3072F</b>	Low risk for retinopathy (no evidence of retinopathy in the prior year)
		<b>3044F</b>	Most recent hemoglobin A1c level less than 7.0%
		<b>3046F</b>	Most recent hemoglobin A1c level greater than 9.0%
		<b>3051F</b>	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0%
		<b>3052F</b>	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0%
		LDL	<b>3048F</b>
<b>3049F</b>	Most recent LDL-C 100-129 mg/dL		
<b>3050F</b>	Represents the most recent LDL C level of greater than or equal to 130 mg/dL		
<b>SMC: Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia</b>	LDL	<b>3048F</b>	Most recent LDL C test level of less than 100 mg/dL
		<b>3049F</b>	Most recent LDL-C 100-129 mg/dL
		<b>3050F</b>	Represents the most recent LDL C level of greater than or equal to 130 mg/dL

MEASURE	CPT II CODE	DEFINITION
<b>TRC: Transitions of Care</b>	Medication Reconciliation Intervention	<b>1111F</b> Discharge medications are reconciled with the current medication list in outpatient medical record
<b>PPC: Prenatal and Postpartum Care</b>	Stand-Alone Prenatal Visit	<b>0500F</b> 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]) (Prenatal)
		<b>0501F</b> 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) (Prenatal)
		<b>0502F</b> Subsequent prenatal care visit (Prenatal) [Excludes: patients who are seen for a condition unrelated to pregnancy or prenatal care (eg, an upper respiratory infection; patients seen for consultation only, not for continuing care)]
	Postpartum Visit	<b>0503F</b> Postpartum care visit

For a full list of CPT II Codes, visit the [American Medical Association website](#) and select CPT.

