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Current Procedural Terminology (CPT®) II Category Codes Closing Gaps in Care

Current Procedural Terminology (CPT) II codes are supplemental tracking codes that can be used for performance measurement and to track the delivery of quality of care. The codes also simplify how performance measures are reported and reduce the need for chart abstraction. Providers can use these codes to report specific services that contribute to positive outcomes and high-quality care.

Aetna Better Health of Virginia will offer reimbursement for the utilization of CPT category II codes. **Providers will have the opportunity to earn an additional $25 by adding specific CPT II codes to their claims.**

The incentive program takes place from January 1 to December 31, 2024, with claims run out accepted until February 1, 2025. Payment will be made as codes are received via claims.

Benefits and features to using CPT codes

Benefits	Features
Identifies gaps in care such as poorly controlled diabetes and uncontrolled blood pressure	Alphanumeric codes consisting of four digits followed by letter "F"
Generates high risk adjusted payments for members	Developed by the American Medical Association (AMA)
Improves member quality of care	Record abstraction and chart review is decreased
Identifies interventions to proactively enhance overall health	Data collection aligns with HEDIS® performance measures
Used to track services on claims for performance in patient care	Not associated with a relative value
Lessens burden on healthcare providers measuring quality of patient care	Supplemental performance tracking to Category I and III

CPT® Category II Codes and Ranges

Category	Code Range	Category	Code Range
Composite measures	0001F – 0015F	**Therapeutic, prevention or other invention**	4000F – 4306F
Patient management	0500F – 0575F	**Follow-up or other outcomes**	5005F – 5100F
Patient history	1000F – 1220F	**Patient safety**	6005F – 6045F
Physical examination	2000F – 2050F	**Structural measures**	7010F – 7025F
Diagnostic/screening processes or results	3006F – 3773F		

CPT® II Coding Incentive Program Pilot Revision

HEDIS Measure	Description	CPT II Codes
Comprehensive Diabetes Care (CDC) Consists of blood pressure, eye exam, hemoglobin A1C control, and kidney health evaluation for patients with diabetes The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following: • Hemoglobin A1c (HbA1c) testing (one CPT 2 per one member) • HbA1c poor control (>9.0%) • HbA1c control (<8.0%) • Eye exam (retinal) performed • Medical attention for nephropathy • BP control (<140/90 mm Hg) • **Note: Both codes must be present for the incentive to be paid.** • **Examples:** • Claim with diastolic and systolic BP is paid $25. • Claim with only diastolic BP is paid $0. • Claim with only systolic BP is paid $0.	No evidence of diabetic retinopathy	2023F (New), 2025F (New), 3072F (No evidence of retinopathy in the prior year exam)
	Evidence of diabetic retinopathy	2022F (Revised), 2024F (Revised)
	HbA1c Level <7%	3044F
	HbA1c Level 7%<x>8%	3051F
	HbA1c Level >9%	3046F
	HbA1c Level 8%<x>9%	3052F
	Note: 3045F has been removed by the American Medical Association (AMA) and replaced by 3051F, 3052F	
	Systolic <140	3074F, 3075F
	Systolic ≥ 140	3077F
	Diastolic <80	3078F
	Diastolic 80-89	3079F
	Diastolic ≥ 90	3080F
Controlling High Blood Pressure (CBP) The percentage of members 18–85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year • **Note: both codes must be present for the incentive to be paid.** • Examples: • Claim with diastolic and systolic BP is paid $25. • Claim with only diastolic BP is paid $0. • Claim with only systolic BP is paid $0.	Systolic <140	3074F, 3075F
	Systolic ≥ 140	3077F
	Diastolic <80	3078F
	Diastolic 80-89	3079F
	Diastolic ≥ 90	3080F

Prenatal and Postpartum Care (PPC) The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year For these women, the measure assesses the following facets of prenatal and postpartum care: • **Timeliness of Prenatal Care:** The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. • • **Postpartum Care:** The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.	Standalone prenatal visits	0500F, 0501F, 0502F
	Postpartum visits	0503F

Note: The table limits the specific CPT II codes to be reimbursed from January 1, 2024, through December 31, 2024. For claims with date of service from September 1, 2022, to December 31, 2023, the entire list of AMA CPT II codes is eligible for reimbursement.

For more information, contact Provider Relations at **1-800-279-1878**.

CPT Category II Codes: Frequently Asked Questions

What are CPT codes?
Current Procedural Terminology (CPT) category II codes are supplemental codes that describe clinical components, usually included in evaluation and management or clinical services. They are five-character alpha-numeric codes which always end with the character "F." Codes are reviewed and adopted by the Performance Measures Advisory Group, comprised of experts from the AMA, NCQA, CMS, AHRQ and JCAHO.

Why does Aetna Better Health encourage the use of CPT category II codes?

- To facilitate data collection related to quality and performance measurement
- To reduce administrative burden for providers by decreasing the need for record abstraction and chart review
- To improve quality of care and services that Aetna Better Health members receive:
    - Helping Aetna Better Health refer members to appropriate programs
    - Supporting the provider's plan of care
    - Increasing accuracy of gaps-in-care reporting, thus reducing provider burden and increasing member satisfaction
- To monitor members and ensure they receive continuous and appropriate care throughout the continuum of care

What are the benefits of using CPT category II codes?

- To help ease the burden of chart review for many NCQA HEDIS performance measures
- To enable more effective monitoring of quality and service delivery within a physician practice
- To allow providers to report services and/or values based on nationally recognized, evidence-based guidelines for improving the quality of patient care
- **To capture data that ICD 10 codes and CPT** c**ategory I codes do not**, **relay**ing **important information related to health outcome measures**
- **To enable organizations to monitor internal performance for key measures throughout the year, rather than once per year**

How are CPT category II codes billed?
CPT II codes are NOT billing codes; they are used to track services on claims for performance measurement. Category II codes are not to be used as a substitute for category I codes. CPT category II codes cannot be used in place of category I CPT codes or category III CPT codes.

How are CPT category II codes grouped?
Codes are grouped into the following 12 categories: Composite Measures, Patient Management, Patient History, Physical Examination, Diagnostic/Screening, Therapeutic, Preventive, Intervention, Follow up/Outcomes, Patient Safety, Structural Measures, Non-Measure Code Listing.