# CPT Category II Codes: Frequently Asked Questions

**WHAT ARE CPT CATEGORY II CODES?**

- Current Procedural Terminology (CPT®) Category II codes are supplemental codes that describe clinical components, usually included in E&M or clinical services.
- They are 5-character alpha-numeric codes which always end with the character "F."
- Codes are reviewed and adopted by the Performance Measures Advisory Group (PMAG), comprised of experts from the AMA, NCQA, CMS, AHRQ and JCAHO.

**WHY DOES MEDICA 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 Medica members receive:
  - They help Medica refer members to programs appropriate for their health situation.
  - The codes help to support the provider plan of care.
  - They increase accuracy of gaps-in-care reporting, thus reducing provider burden and increasing member satisfaction. (Example: Medica can avoid sending reminders to patients to get screenings they may have already completed or may not be necessary.)
- Use of these codes helps 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 Category I codes do not. They relay 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. Opportunities for improvement can be identified and implemented throughout the year.

**HOW ARE CPT CATEGORY II CODES BILLED?**

- CPT Category II codes are billed with a $0 charge amount in the procedure code field.
- 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.

**Category II modifiers** report services that were considered but not provided because of medical reasons, patient choice or system reasons.

- Modifier 1P: Service not performed because it was not indicated or was contraindicated (e.g., service already performed, patient allergy, etc.)
- Modifier 2P: Service not performed because of a patient's religious, social or economic reason, patient declined, or other specific reason
- Modifier 3P: Service not performed because it is not covered, the service is not available or other delivery system reasons
- Modifier 8P: Used when an action described in a measure's numerator is not performed and the reason is not otherwise specified

**Advanced Illness and Frailty Criteria:** Starting in 2018, CMS allowed additional exclusions to HEDIS Star Measures for patients with advanced illness and frailty. Use of these codes is limited to patients 66 years of age and older and only apply to specific measures. Some codes apply to patients 81 years of age and older.

**WHERE CAN I FIND A COMPLETE LIST OF CPT CATEGORY II CODES?**

- CPT II codes are released annually as part of the full CPT code set and are updated semi-annually in January and July by the American Medical Association (AMA).
- AMA CPT Codes and Description book can be found on the **AMA website**.