Current Procedural Terminology (CPT) Category II Codes: Pay-for-Performance Measures

Category II *Current Procedural Terminology (CPT®)* codes were developed to simplify reporting of performance measures and eliminate the need for chart abstraction. These supplemental tracking codes are used by physicians and hospitals to report specific services that contribute to positive outcomes and high-quality care. The performance measures used to establish Category II *CPT* codes are developed by national organizations including the National Committee for Quality Assurance (NCQA) and the American Medical Association (AMA) Physician Consortium for Performance Improvement (PCPI) based on quality measures currently accepted and used in the health care industry.

The Centers for Medicare & Medicaid Services (CMS) led the way for pay-for-performance programs by establishing a voluntary reporting program in January 2006. As part of this program, CMS is collecting data on evidence-based quality measures for the Medicare population through the use and reporting of Healthcare Common Procedure Coding System (HCPCS) Level II codes **G8006–G8186.** For reporting performance measures to Medicare, either the appropriate Category II *CPT* code or HCPCS Level II G code is used.

Category II *CPT* codes are used for reporting purposes only and therefore do not have values assigned on the Medicare physician fee schedule (Resource-Based Relative Value Scale or RBRVS). The reporting of Category II *CPT* codes is optional, and these codes are not used in place of Category I *CPT* codes. However, they may be very beneficial to a practice, because they allow internal monitoring of performance, patient compliance, and outcomes.

Performance Measurement Codes

Category II *CPT* codes have been developed for 9 clinical conditions (including complete performance measurements sets) and 5 screening measures. The treatment of asthma is the only performance measure that currently applies to the pediatric population. If a pediatric practice cares for patients 18 years or older, it may report Category II *CPT* testing and treatment codes for hypertension, diabetes mellitus, and community-acquired bacterial pneumonia and screening codes for tobacco use and cessation. The American Academy of Pediatrics (AAP) served as a leading organization in the development of performance measures for pediatric acute gastroenteritis, otitis media with effusion, and acute otitis externa through the AMA PCPI measure development process. The AAP also is participating in the development of measures for outpatient parenteral antibiotic therapy and adolescent major depressive disorder.

Each Category II *CPT* code describes the performance of a clinical service that is typically included in an evaluation and management (E/M) code or a test result that is part of a laboratory procedure. This is an additional reason that there are no relative value units assigned to Category II *CPT* codes.

These codes are grouped within categories based on established clinical documentation methods (eg, history, physical findings, assessment, plan). Each code identifies the specific clinical condition and performance measured. The categories are defined as follows:

Composite measures: 0001F–0012F

Several measures are grouped to facilitate reporting of a clinical

condition when *all* included components are met.

Patient management: 0500F–0509F

These codes are used to describe utilization measures or measures of patient care provided for specific clinical purposes (eg, prenatal care, pre- and postsurgical care, referrals).

Patient history: 1000F–1111F

Patient history codes are used to describe measures for aspects of patient history and review of systems.

Physical examination: 2000F–2031F

These codes describe aspects of the physical examination or clinical assessment.

Diagnostic screening processes or results: 3006F–3210F

These codes are used to report results of clinical laboratory tests and radiologic or other procedural examinations.

Therapeutic, preventive, or other interventions: 4000F–4124F

Codes in the **4000F** range describe pharmacologic, procedural, or behavioral therapies, including preventive services such as patient education and counseling.

Follow-up or other outcomes: 5005F-5015F

These codes are used to describe the review and communication of test results to patients, patient satisfaction or experience with care, and patient functional status.

Patient safety: 6005F-6020F

Code **6005F** is used to report the rationale (eg, severity of illness and safety) for the recommended level of care (eg, home, hospital) for a patient. It identifies whether an assessment was made to determine the level of care required for patients with community-acquired pneumonia (CAP).

Category II Modifiers

Four Category II modifiers **(1P, 2P, 3P, and 8P)** are used to report services that were considered but not provided because of medical reason(s), patient choice, or system reasons. Modifier **1P** (performance measure exclusion modifier due to medical reasons) is used to report that one of the performance measures was not performed, because it was not indicated (eg, already performed) or was contraindicated (eg, because of a patient's allergy).

Modifier **2P** (performance measure exclusion modifier due to patient choice) is used to report that the performance measure was not performed because of a patient's religious, social, or economic reasons; the patient declined (ie, noncompliance with treatment); or other specific reasons.

Modifier **3P** (performance measure exclusion modifier due to system reasons) is used to report that the performance measure was not performed because the payer does not cover the service, the resources to perform the service are not available, or other reasons attributable to the health care delivery system. These modifiers are only used with Category II codes and only when allowed based on the specific reporting instructions for each performance measure.

Modifier **8P** (performance measure reporting modifier—action not performed, not otherwise specified) is used as a reporting modifier to allow the reporting of circumstances when an action described in a measure's numerator is not performed and the reason is not otherwise specified.

***Tip:* Make sure that the medical record includes written documentation of patient noncompliance or other reason for nonperformance of the measure.**

Reporting the Codes

When reporting Category II *CPT* codes, Appendix H (located in the back of the *CPT* manual) should be used in coordination with the Category II section in *CPT*. Appendix H includes an alphabetic index of performance measures by clinical condition or topic and includes the measure developer (eg, PCPI), the performance measure, description of the measure, and the associated code. It also directs the reader to the measure developer's Web site to access the complete description of the measure.

Users should always review the description of the Category II *CPT* code in the *CPT* manual and access the measure developer's Web site for the specification documents of the performance measure. For example, specifications and requirements for reporting performance measures for asthma are located at www.physicianconsortium.org.

Each performance measure outlined in Appendix H includes a symptom or activity assessment, numerator, denominator, percentage, and reporting instructions. A patient must meet the criteria specified in the denominator *(International Classification of Diseases, Ninth Revision, Clinical Modification [ICD-9-CM]* code) to be included in the numerator (Category II code) for a particular performance measure.

Let's see how this works when using Category II *CPT* codes for patients with asthma.

Your practice elects to report Category II *CPT* codes for your asthmatic patients who meet the patient selection criteria. This performance measure will apply to all patients 5 to 40 years of age with a documented diagnosis of asthma who were evaluated during at least one office visit during the reporting year for the frequency of daytime and nocturnal asthma symptoms. You meet all the criteria in the asthma measurement set as specified by the developer of the performance measurement.

You review the applicable codes as identified under the Category II *CPT* code section and Appendix H, and because there are constant updates to the Category II *CPT* codes, you refer to the AMA Web site to access the latest information on these codes (www.ama-assn.org/go/cpt).

Code **1005F** is used to report that asthma symptoms were evaluated in the patient who meets the criteria for the asthma performance measure. There are 2 codes to report patient history assessments for asthma. Code **1038F** is reported for assessment of patients with persistent asthma (mild, moderate, or severe) and code **1039F** is reported for assessment of patients with intermittent asthma. If a patient with persistent asthma is on prescribed preferred long-term control medication or an acceptable alternative treatment, code **4015F** is reported in addition to code **1038F.** Modifier **2P** (patient noncompliance) may be reported with code **4015F.** Modifier **1P** (measure not performed due to patient allergy) may not be reported with **4015F.**

Reporting the measures to a payer (electronically or with a CMS-1500 claim form) is done the same way as reporting any *CPT* code. Report the appropriate E/M code (eg, **99201–99215)** based on the level of service performed and documented with all the appropriate *ICD-9-CM* codes that were addressed during the course of the visit. Report the Category II *CPT* code that relates to the performance measure with any applicable Category II modifier. In this case, only the *ICD-9-CM* code for asthma **(493.00,**

493.02) will be linked to the Category II *CPT* codes.

Example

An 8-year-old established patient is seen with complaints of an upper respiratory infection (URI) and follow-up for moderate, persistent asthma. He is currently on albuterol and steroids administered by a metered-dose inhaler. His last exacerbation was a month ago. A brief history of present illness with review of the respiratory; ear, nose, and throat (ENT); and constitutional systems and past history is performed. Physical examination of the respiratory, ENT, and cardiovascular systems is performed. He is advised to take over-the-counter medications for his URI; his asthma is currently stable; prescriptions are renewed; and the physician discusses the criteria for an urgent follow-up visit.

This visit would be reported as follows:

99213 Established patient; expanded history and physical examination with low-complexity medical decision-making; *ICD-9-CM* **465.9** (URI), **493.00** (asthma, unspecified)

1005F Asthma symptoms evaluated; *ICD-9-CM* **493.00**

1038F Persistent asthma; *ICD-9-CM* **493.00**

4015F Persistent asthma, long-term control medication prescribed; *ICD-9-CM* **493.00**

The appropriate *ICD-9-CM* code(s) is reported and linked to the procedure(s) based on the diagnosis (es) that is addressed during the course of the visit. Only the codes for asthma **(493.00, 493.02)** would be linked to the Category II *CPT* codes.

The reporting of Category II *CPT* codes is optional at this time, and the information is used for reporting purposes only.

Quality Improvement & Management

By the Committee on Child Health Financing and the Steering Committee on Quality Improvement and Management

Current Procedural Terminology (CPT) Category II Codes: Pay-for-Performance Measures