DELIVERING VALUE

metrocare PHYSICIANS

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CPT Category II Codes: Important for Quality

One of the easiest ways to share your quality data across multiple payers is to report CPT II codes on your claims. These codes were created to report quality measures to CMS quality programs, but are now being recognized also by commercial payers to measure quality in their value-based contracts.

CPT II codes allow for reporting of test results or services performed that may not be billable but are a necessary part of evidence based guidelines.

Reporting CPT II codes can help you minimize the need for record abstraction and chart reviews. Think HEDIS chart audits.

CPT II codes address clinical conditions of high prevalence, high cost, and high risk. Diabetes and hypertension both require CPT II reporting. If you report no other CPT II codes, consider adding the codes for reporting blood pressure control and HbA1c test results.

CPT II Reporting: Hypertension and Diabetes

Quality reporting around controlling both hypertension and diabetes requires CPT II reporting and spans performance measures across CMS and commercial contracts.

HbA1c: Quality management of diabetes is measured thought HbA1c testing. The best way to report performance on this measure is via CPT II codes. Please note new, more specific codes 3051F and 3052F.

Controlling Hypertension: Measures involving control of hypertension necessarily involve reporting the actual blood pressure measurement. Separate codes must be reported for the diastolic and systolic measurements.

CPT II Code	HbA1c Level
3044F	< 7.0 %
3051F	≥ 7.0 % - < 8.0%
3052F	≥ 8.0% - ≤ 9.0%

CPT II Code	BP Measurement
3074F	Systolic < 130
3075F	Systolic 130 -139
3077F	Systolic ≥140
3078F	Diastolic < 80
3079F	Diastolic 80 - 89
3077F	Diastolic ≥ 90

Reporting CPT II on a Claim

If the billing and coding professionals in your practice are not familiar with reporting the CPTII codes, this will be discussed in our March lunchtime webinar on March_ at 12:15-1:00. Click here to register for the webinar

Because there is no revenue associated with these codes, many practice management systems delete them prior to sending out to the payers.

Often, a .01 charge must be charged with the code to allow it to be reported. Then, when the charge is denied by the payer because there is no payment for this code, your payment posting team will need to write off that .01 charge. A rule can often be written into your system to automatically do this.

For CMS, a denial of the .01 charge is proof that you have successfully reported the measure associated with that charge. Click here for more details.

Free CME Opportunities:

We Are Here to Assist You

A dedicated team of professionals is committed to assuring that MetroCare physicians have the tools and resources to achieve success with the changes required by transition to value-based healthcare.

T. Carter Towne, MD
Chairman
t 901.360.1360
carter.towne@metrocarephysicians.com

Taylor Bailey
Executive Director
t 901.261.7804
taylor.bailey@metrocarephysicians.com

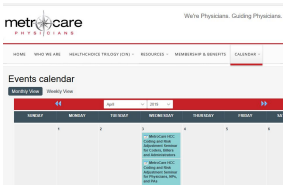
Clinical Services

Fran Parker
Quality Reporting Coordinator I
t 901.261.7791
fran.parker@metrocarephysicians.com

Wendy Hughes
Quality Reporting Coordinator II
t 901.261.7790
wendy.hughes@metrocarephysicians.com

Communications and Education Services

Donna Pendergrass, MD, CPPM, CPCO
Communications Director
t 901.261.7796
donna.pendergrass@metrocarephysicians.com



Credentialing Services

Kelly Jordan, CPMSM
Credentialing Supervisor
t 901.261.7797
kelly.jordan@metrocarephysicians.com

Teresa Stacks
Credentialing Specialist
t 901.261.7792
teresa.stacks@metrocarephysicians.com