



User Guide — Satisfying CPT Category II Codes

athenaOne

Certain provider actions during the encounter workflow automatically populate supported CPT Category II codes on the **Billing** tab during the **Sign-off** stage of the encounter. The codes appear in the **CPT II Codes** section.

Only the codes in this guide can be automated by athenaOne. Other CPT Category II codes must be entered manually on each claim. This automation reduces manual chart review work, and your organization may see higher reimbursement rates when claims are coded with accurate CPT Category II codes.

To request support for additional automated CPT Category II codes, submit a case to the CSC.

Understand CPT Category II Code Automation

How automated CPT Category II codes work

When a provider completes a qualifying action in the patient chart or encounter workflow, athenaOne evaluates the documented information and adds the supported CPT Category II code to the **Billing** tab during the **Sign-off** stage of the encounter.

For some measures, athenaOne uses the most recent qualifying result or documentation within the required date range. If documentation does not meet the measure criteria, the code does not automatically appear.

athenaOne generates CPT Category II codes when these conditions are met:

- The code is supported by athenaOne.
- The supported CPT Category II code is in your fee schedule.
- Information from the encounter or patient chart relates

to a supported code.

- The **Billing** tab has not yet been saved.

You see a message above each CPT Category II code that briefly explains why the patient's condition triggered athenaOne to generate the code. The message disappears after you save the **Billing** tab.

Note: If an automated code does not appear as expected, confirm that the patient meets the age and date requirements and that the qualifying document, result, screening, vital, or history item was documented in the supported location.

Important: If you are interested in using this feature, contact the CSC to enable it. In athenaOne, on the main menu, click **Support**, then click **Create Case or Call**.

What are CPT Category II codes?

CPT Category II codes track patient care. Payers use these codes to facilitate performance measurement. Category II codes are not required, but your organization may receive additional reimbursement when claims are coded with accurate CPT Category II codes.

Review and bill CPT Category II codes

Review the automatically generated CPT Category II codes before you save the **Billing** tab.

Note: If you exit the **Billing** tab without saving, athenaOne regenerates the CPT Category II codes when you reopen the tab. After you save the **Billing** tab, athenaOne does not regenerate additional CPT Category II codes when you reopen the tab.

1. After you complete the **A/P** step of the **Exam** stage of the encounter, click **Next** to proceed to the **Sign-off**

stage.

2. Click the **Billing** tab on the right side of the screen.
3. Review each code in the **CPT II Codes** section.
4. Edit the CPT Category II code as needed.
5. Enter the code's modifier if needed.
6. Edit the number of units if needed. The number of units defaults to 1.
7. Click **Apply all ICD-10 codes** to apply all diagnosis codes recorded during the **Exam** stage to each CPT Category II code, or enter ICD-10 codes manually.
8. Click **Bill these codes** to select all CPT Category II codes to bill at once, or check the box in the **Bill these codes** column to select individual codes to bill.
9. Click **Save** or **Save & Mark Reviewed**.

Important On the **Billing** tab, you must manually check the box in the **Bill these codes** column or click **Bill these codes** to ensure that the CPT Category II codes appear on the Charge Entry page. This requirement also applies if your organization uses athenaOne Medical Coding.

Important Each CPT Category II code you bill must have a corresponding ICD-10 diagnosis code. Some payers require specific ICD-10 codes for some CPT Category II codes. If you do not enter the ICD-10 code on the **Billing** tab, enter it on the Charge Entry page.

Note: You can click **Don't bill these codes** to deselect all CPT Category II codes.

Add a clinical document for supported measures

Several CPT Category II code automations depend on clinical documents and document results.

1. In the patient chart, click the menu icon and select **Add document**.
2. Click **I have a file on my computer or network** to

upload.

3. Select a **Document Class** from the menu.
4. Click **Choose File**.
5. Click **Add Document**.
6. In the **Document Label** field, select the appropriate document label.
7. Click **Save** and close the document.

Note: If results are not tied to the order automatically through an interface, you can add results to the order manually. If a result is received by fax or on paper, manually edit the document and tie the result back to the original order when required for numerator qualification.

Add surgical or procedural history

1. In the patient chart, click the **History** tab.
 2. Go to **Surgical/Procedural History**.
 3. Click +.
 4. Search for and add the procedure.
 5. Click **Add**.
-

Screening and Documentation Codes

3017F - Colorectal cancer screening

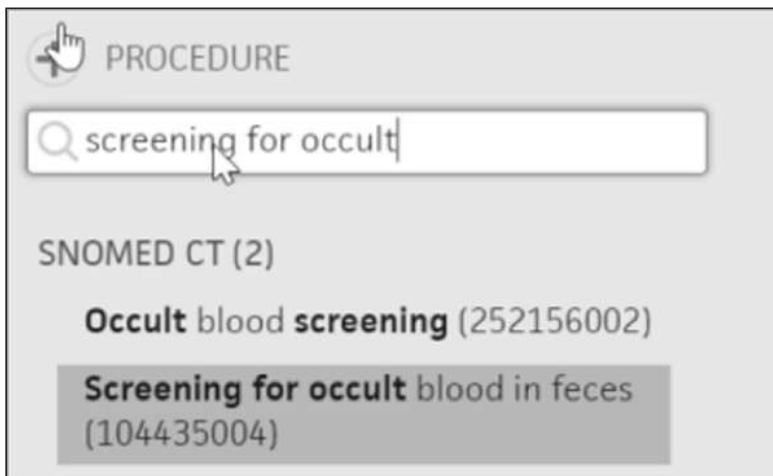
This code is automatically added when a qualifying colorectal cancer screening is documented. athenaOne uses

the most recent qualifying screening date.

- **FOBT** - Within the measurement year.
- **Flexible sigmoidoscopy** - Within 4 years.
- **Colonoscopy** - Within 9 years.
- **CT colonography** - Within 4 years.
- **FIT-DNA test** - Within 2 years.

You can document qualifying screenings in...

- **Surgical History:**



PROCEDURE

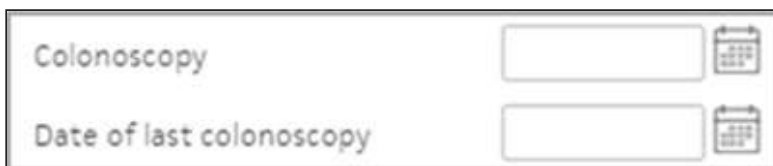
screening for occult

SNOMED CT (2)

Occult blood screening (252156002)

Screening for occult blood in feces (104435004)

- or **GYN History:**



Colonoscopy

Date of last colonoscopy

- or by adding a **Results** document:



gastrointestinal hemoglobin, QL, specimen 4, stool

Following Document Class and Subclass combination will be supported.

DocumentClass = Lab Result, Imaging Result, and
 ClinicalDocument (Sub Class =
 ClinicalDocument_Operative Note)
 Valid document labels for 3017F include:

- Colonoscopy
- Sigmoidoscopy
- FIT-DNA
- FOBT
- CT colonography

3014F - Breast cancer screening

This code is automatically added when a qualifying
 mammogram is documented within the past 27 months.
 Qualifying documentation can include:

- A mammogram noted in **Surgical History**:

The screenshot shows a medical history interface. On the left, under 'Surgical & Procedure History', there are sections for 'None recorded', 'NOTE', 'Implant History', 'None recorded', 'Past Medical History', and 'None recorded'. A 'SHOW/HIDE' link is visible. On the right, a search bar labeled 'PROCEDURE' contains the text 'mammography'. Below the search bar, a list of procedures is displayed, including 'Mammography', 'Consultation', 'Localization mammography', 'Mammography of bilateral breasts', 'Mammography of bilateral breast implants', 'Mammography extended view of bilateral breasts', 'Mammography lateral view of bilateral breasts', 'Mammography of breast implant', 'Mammography lateral view', 'Mammary ductogram', 'Mammary ductography of left breast', 'Mammary ductography of right breast', 'Mammography of left breast', and 'Mammography of left breast implant'.

- or, the most recent mammogram date in **GYN**

History:

Gynecological History	
Date of last Pap smear	
Most recent mammogram	

- or a mammography result added through documents:

MAMMO, diagnostic, bilateral (#23)

Following Document Class and Subclass combination will be supported.

DocumentClass = Lab Result, Imaging Result, and ClinicalDocument (Sub Class = ClinicalDocument_Operative Note)

Valid document labels for 3014F include:

- Mammography screening result document

3015F - Cervical cancer screening

This code is automatically added when a qualifying Pap or HPV screening is documented.

- **Pap test** - Ages 21-64, within 2 years.
- **HPV test** - Ages 30-64, within 4 years.
- **Co-testing** (Pap and HPV) - Ages 30-65, within 5 years.

Document the screening through a Pap/HPV order & result, or in **GYN History**, or by adding a document.

To document the date in GYN History, click the **History** tab, go to **GYN History**, expand the section, and enter the Pap smear date:



Following Document Class and Subclass combination will be supported.

DocumentClass = Lab Result, Imaging Result, and ClinicalDocument (Sub Class = ClinicalDocument_Operative Note)

Valid document labels for 3015F include:

- Pap test
- HPV test

pap test, thinprep, cervical

3511F - Chlamydia and gonorrhea screening

This code is automatically added when a qualifying chlamydia and gonorrhea screening is documented by adding a document.

Following Document Class and Subclass combination will be supported.

DocumentClass = Lab Result, Imaging Result, and ClinicalDocument (Sub Class = ClinicalDocument_Operative Note)

Valid document labels for 3511F include:

- Chlamydia trachomatis (Chlamydia)

chlamydia trachomatis, culture, cervix

3725F - Depression screening

In the **Screening** section of the **Review** step of the exam, complete a supported depression screening questionnaire with the patient.

Supported screenings include:

- PHQ-2/PHQ-9
- GDS
- EPDS
- PSC-17
- Zung SDS
- Beck Depression Inventory
- BDI - 2
- CES-D
- QIDS-SR
- PDSS
- DUKE-AD
- PHQ-A
- PHQ-9: Modified for Teens (ages 11-17) - This code only populates if the patient is 12 by the end of the appointment's calendar year:

The screenshot shows the 'Intake' section of a medical software interface. Under the 'Screening' dropdown, 'PHQ-2/PHQ-9' is selected. Below this, a 'Status' bar indicates 'PHQ-2' is the active screening. The 'Questions' tab is selected, showing a questionnaire titled 'Over the last two weeks, how often have you been bothered by any of the following:'. The first question is 'Little interest or pleasure in doing things' with radio button options: 'Not at all', 'Several days', 'More than half the days', and 'Nearly every day'. The second question is 'Feeling down, depressed, or hopeless' with the same radio button options.

Encounter Workflow Codes

1034F, 1035F, and 1036F - Tobacco use

In the **Social History** section of the **History** tab of the encounter, the following question and answer combinations result in *Tobacco Use* CPT Category II codes.

Social History question	Applicable answer	CPT II code result
Do you or have you ever smoked tobacco?	Current every day smoker; Current some days smoker; or Smoker - current/status unknown	1034F
Do you or have you ever used e-cigarettes or vape?	Current user of electronic cigarettes	1035F
Do you or have you ever used smokeless tobacco?	Current snuff user; Currently chews tobacco; or Currently uses moist/powdered tobacco	
All three Tobacco History questions	For each question, the patient's answer is a Never or Former user answer.	1036F
<i>If you skip these questions</i>	(No answers are entered for the patient.)	No <i>Tobacco Use</i> CPT II codes appear on the Billing tab.

Note: The codes only populate if the patient is 12 years old by the end of the appointment's calendar year.

Social History

This patient has legacy social history data. Open the social history chart section to view it.

A Social History Update Completed: 09-15-2021

Do you or have you ever smoked tobacco: Never smoker

How many years have you smoked tobacco: 0

Do you or have you ever used any other forms of tobacco or nicotine: No

Do you or have you ever used e-cigarettes or vape: Never used electronic cigarettes

Do you or have you ever used smokeless tobacco: Never used smokeless tobacco

How much tobacco do you chew: none

What was the date of your most recent tobacco screening?

Substance Use

Do you or have you ever smoked tobacco? Never smoker

How many years have you smoked tobacco? 0

How much tobacco do you smoke? None

Do you or have you ever used any other forms of tobacco or nicotine? Yes No

Do you or have you ever used e-cigarettes or vape? Never used electronic cigarettes

Do you or have you ever used smokeless tobacco? Never used smokeless tobacco

How much tobacco do you chew? none

What was the date of your most recent tobacco screening? 09-15-2021

Tip: Hover over the image to get a closer look.

1090F - Urinary incontinence screening

In the **Screening** section of the **Review** step of the exam, complete either the ICIQ-SF or **PISQ-IR** screening questionnaire with the patient.

Note: These screenings are not common, so your practice might need to set them up.

1125F and 1126F - Pain severity

For practices with the pain scale configured in the **Vitals** section of the **Intake** stage, a pain scale value of 1 through 10 satisfies code 1125F. A value of 0 satisfies code 1126F.

A screenshot of a software interface. At the top, there is a dark grey header bar with a progress indicator (a series of five circles, the second of which is filled) and the word "Review" with a downward arrow. Below this is a light grey section labeled "Intake". Within the "Intake" section, there is a white box containing the text "Pain Scale" followed by a dropdown arrow icon. To the right of this box is another empty dropdown menu.

1159F and 1160F - Medication list and medication review

In the **Medications** tab, add any active or historical medications for the patient and mark the section as **Reviewed**.

Note: These codes only populate if the patient will be 66 by the end of the appointment's calendar year.

1170F - Functional status assessed

In the **Screening** section of the **Review** step of the exam, complete a supported functional status screening questionnaire with the patient.

Supported screenings include:

- Katz ADL
- Barthel Index
- Lawton IADL
- PROMIS Physical Function
- HAQ-DI
- HAQ-II
- KOOS Activities of Daily Living Score
- PROMIS PF10a
- PROMIS 10 Global Physical Health Score

Intake	
Screening	
Katz ADL x	
^ Katz ADL Status	
Questions	Background
Bathing ☐ Independence: Bathes self completely or needs help in bathing only a single part of the body, such as the back, genital area, or disabled extremity. ☐ Dependence: Needs help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing. Dressing ☐ Independence: Gets clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes. ☐ Dependence: Needs help with dressing self or needs to be completely dressed.	

3008F - Body mass index documented

In the **Vitals** section during the **Review** stage of the exam, enter the patient's height and weight. athenaOne automatically calculates the BMI.

Review — HPI — ROS — PE — A/P — Sign-off

Reason for Visit (+) REASON **Next**

Intake

Vitals

HT: 5 ft 2 in Standing on 01-05-2021 (+)

Wt: 168 lbs With clothes on 01-05-2021 (+)

BMI: 30.7 on 01-05-2021

BP: 123 / 80 sitting L arm on 01-05-2021 (+)

Pulse: 68 bpm regular on 01-05-2021 (+)

RR: 14 on 12-22-2020 (+)

T: 98.1 °F temporal artery on 01-05-2021 (+)

Pain Scale: 0 Numeric on 12-22-2020 (+)

Tip: Hover over the image to get a closer look.

Note: This code only populates if the patient will be 3 years old by the end of the appointment's calendar year.

3074F, 3075F, 3077F, 3078F, 3079F, and 3080F - Blood

pressure

In the **Vitals** section during the **Review** stage of the exam, enter a blood pressure reading.

Review — HPI — ROS — PE — A/P — Sign-off

Reason for Visit (+) REASON **Next**

Intake

Vitals

HT: 5 ft 2 in Standing on 01-05-2021 (+)

Wt: 168 lbs With clothes on 01-05-2021 (+)

BMI: 30.7 on 01-05-2021

BP: 123 / 80 sitting L arm on 01-05-2021 (+)

Pulse: 68 bpm regular on 01-05-2021 (+)

RR: 14 on 12-22-2020 (+)

T: 98.1 °F temporal artery on 01-05-2021 (+)

Pain Scale: 0 Numeric on 12-22-2020 (+)

athenaOne uses the lowest blood pressure reading from the encounter when more than one reading is recorded during the same encounter. The lowest systolic reading and the lowest diastolic reading can come from different blood pressure recordings during the same encounter.

CPT II code	Blood pressure result
3074F	Most recent systolic blood pressure < 130 mm Hg
3075F	Most recent systolic blood pressure 130-139 mm Hg

CPT II code	Blood pressure result
3077F	Most recent systolic blood pressure $\geq$ 140 mm Hg
3078F	Most recent diastolic blood pressure $<$ 80 mm Hg
3079F	Most recent diastolic blood pressure 80-89 mm Hg
3080F	Diastolic blood pressure $\geq$ 90 mm Hg

3288F - Falls risk assessment documented

In the **Screening** section of the **Review** step of the exam, complete a supported fall risk screening questionnaire with the patient.

Supported screenings include:

- STEADI Fall Risk
- Morse Fall Scale
- Schmid Fall Risk
- Hendrich II Fall Risk
- Berg Balance Scale
- Dynamic Gait Index
- Tinetti Balance and Gait
- Falls Efficacy Scale
- Timed Get-Up-and-Go
- Gait - Parkinsons UPDRS
- Steadi Fall Risk - 3 item
- POMA
- Short FES-I

The screenshot shows a web-based screening form titled "Intake". Under the "Screening" section, two tabs are visible: "STEADI Fall Risk" (selected) and "Morse Fall Scale". Below the tabs, the "STEADI Fall Risk" section is expanded, showing a "Status" field and a "Questions" tab. The "Questions" tab contains four questions, each with "Yes" and "No" radio button options:

- Have you fallen in the past year?
☐ Yes ☐ No
- Do you use or have you been advised to use a cane or walker?
☐ Yes ☐ No
- Do you sometimes feel unsteady while walking?
☐ Yes ☐ No
- Do you steady yourself by holding onto furniture when walking?
☐ Yes ☐ No

Result-Based Codes

2022F, 2023F, and 3072F - Diabetic retinal eye exam

In the **Clinical Document** section on the patient chart, add a document with a document result that has the result type **Diabetic retinal eye exam**.

- A value of **Positive finding** from the appointment's calendar year results in **2022F**.
- A value of **Negative finding** from the appointment's calendar year results in **2023F**.
- If there are no results from the appointment's calendar year, but the most recent result from the year before the appointment is a Negative finding, athenaOne adds **3072F**.

Document Result	Result Type	Result Value
	⊗ Diabetic retinal eye exam ▾	Positive finding ▾

Other conditions:

- If there are multiple results from a given year, athenaOne uses the most recent result.
- If a result is from the appointment's calendar year but after the appointment's date of service, athenaOne does not use it.
- The automation can occur even if the code was submitted earlier that year for the patient.
- The automation only occurs for patients ages 18-75 as of the end of the appointment's calendar year.

3044F, 3051F, 3052F, and 3046F - Hb A1c results

In the **Results** section of the patient chart, add a result associated with one of the following **Hb A1c LOINC**s:

4548-4, 17855-8, 4549-2, 17856-6, 62388-4, 96595-4, or 59261-8.

This automation should capture A1c results, including fingerstick tests. It should **not** capture results from non-A1c hemoglobin tests. Only results within the current calendar year are considered. The patient must be between ages 18 and 75 in the appointment's calendar year.

athenaOne adds the appropriate code based on the result value. If automation does not work for certain results, confirm whether the patient falls within the required age and date range and whether the results are properly tagged with one of the associated LOINC codes during results transfer.

One known case where a LOINC might not be associated with a result involves certain Point-of-Care Testing (POCT) templates on the **Office Order Type** configuration page.

LOINC codes are associated only with templates that have a **Result Type** of **Analyte Table**. If the result type is **Dropdown/Freetext List** or **Dropdown/Freetext Grid**, the appropriate LOINC is not associated and the result is not picked up for automation.

Note: athenaOne uses the Date of Service on the claim by default for these charge lines. General guidance for these codes is to use the Lab Date. Currently, you can update the charge date on Charge Entry and Claim Edit, but not on the Billing tab. athenaOne displays a warning message above each code to indicate this limitation.

Care Transition Codes

1111F - Medication reconciliation post-discharge

Code 1111F is automatically added when any of the following conditions is met:

- Supported CCDA and non-CCDA discharge-summary document is present in the patient chart (Details on valid discharge summary labels and classes are provided below).
- For CCDA discharge summaries, Medication reconciliation is completed, via the 'Legacy

Medication Reconciliation Workflow' Medication reconciliation is completed.

- All medications are reconciled or dismissed.
- A **Medication reconciliation** procedure is added through **Surgical & Procedure History**.
- The **Medication Reconciliation (1111F)** procedure template is completed through the procedure template workflow.

Note: Above medication reconciliation actions are taken on the day of inpatient discharge through 30 days post-discharge.

The discharge summary document is considered valid if it is associated with one of the following COT IDs, document labels, and class/subclass combinations.

The document can be a CCDA discharge summary or a non-CCDA discharge summary.

COT ID	Document label	Supported class/subclass combinations
274828	Hospital Discharge Summary	ADMIN / CLINICALDOCUMENT_ADMISSIONDISCHARGE; CLINICALDOCUMENT / CLINICALDOCUMENT_ADMISSION/DISCHARGE SUMMARY; HOSPITAL / CLINICALDOCUMENT_ADMISSIONISCHARGE; HOSPITAL_ADMISSIONDISCHARGE
390205	Psychiatric Hospital Discharge Note	CLINICALDOCUMENT / CLINICALDOCUMENT_ADMISSIONDISCHARGE
392039	ICU Discharge Summary	CLINICALDOCUMENT / CLINICALDOCUMENT_ADMISSIONDISCHARGE
395333	OB Delivery Discharge	CLINICALDOCUMENT / CLINICALDOCUMENT_ADMISSIONDISCHARGE; CLINICALDOCUMENT / CLINICALDOCUMENT_ADMISSIONISCHARGE
395362	Postpartum Discharge Summary	CLINICALDOCUMENT / CLINICALDOCUMENT_ADMISSIONDISCHARGE; CLINICALDOCUMENT / CLINICALDOCUMENT_ADMISSIONISCHARGE

COT ID	Document label	Supported class/subclass combinations
423198	NICU Discharge Summary	CLINICALDOCUMENT / CLINICALDOCUMENT_ADMISSIONDISCHARGE
428324	Hospital Discharge Instructions	CLINICALDOCUMENT / CLINICALDOCUMENT_ADMISSION/DISCHARGE SUMMARY; CLINICALDOCUMENT / CLINICALDOCUMENT_ADMISSIONDISCHARGE; CLINICALDOCUMENT / HOSPITAL_ADMISSIONDISCHARGE

Legacy medication reconciliation

Data Reconciliation

Documents to Reconcile

Document	Type	Received	Reconciliation Status	Actions
Continuity of Care Document #6602106	CCDA	04/07/2026	In Progress	Active

Document: Continuity of Care Document #6602106 Received: 04/07/2026

Compare and reconcile patient data in the incoming document(s) with data in the patient's chart. Review all items requiring action and select the version of the listed item you want to include in the chart.

Important: We may not be able to reconcile all the information contained in the source document(s). To ensure all incoming health data appears in this patient's chart, please review the source document(s) thoroughly and manually add any data not displayed below.

Expand all | Collapse all

Allergies / Adverse Reactions 1 item requires action [Update Chart](#)

Medications Chart updated

Patient Chart (athenaNet)

No matching item in master chart (click to reject incoming item)

metformin 1,000 mg tablet
Sig: "Take twice a day by oral route."
Frequency: 2 times a day
Start Date: 01/08/2026

zithromax 250mg 250 mg tablet
Sig: "TAKE 2 TABLETS (250 MG) BY ORAL ROUTE ONCE DAILY FOR 1 DAY THEN 1 TABLET (250 MG) BY ORAL ROUTE ONCE DAILY FOR 4 DAYS"
Internal Note: KUQA567*45

atorvastatin 10 mg tablet
Sig: "Take 1 tablet every day by oral route with meal(s)"
Start Date: 02/01/2026

Incoming: Continuity of Care Document #6602106

amiodipine 10 mg tablet
Sig: "Take 1 tablet every day by oral route before meal(s) for 30 days."
Start Date: 04/01/2026

metformin 1,000 mg tablet
Sig: "Take 1 tablet twice a day by oral route with meal(s)"
Frequency: 2 times a day
Start Date: 01/08/2026

atorvastatin 10 mg tablet
Sig: "Take 1 tablet every day by oral route with meal(s)"
Start Date: 02/01/2026

Problems 1 item requires action [Update Chart](#)

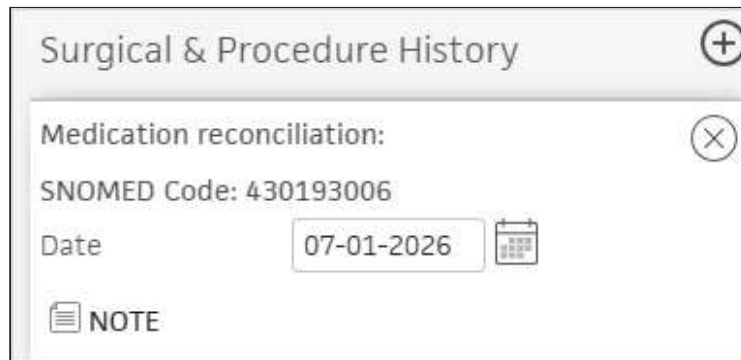
- **Match** - same information in the chart and incoming record; no action needed.
- **Conflict** - different information; choose the chart or incoming version.
- **Chart Only** or **Incoming Only** - keep or add as needed.
- Save progress as you go, then click **Update Chart** when done.

Note: Medication reconciliation can be completed either by:

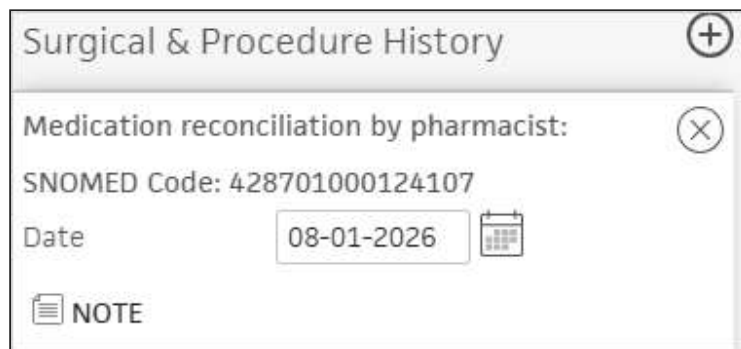
- Reconciling all medications, **or**
- Selecting **No Update Necessary** when the imported medication list requires no changes.

Add surgical and procedural history.

1. In the patient chart, click the **History** tab.
2. Click **Go To**, then select **Surgical & Procedure History**.
3. Click +.
4. Search for and add the procedure from the list.
5. Click **Add**.



The screenshot shows a window titled "Surgical & Procedure History" with a close button (X) in the top right. Inside the window, there is a section labeled "Medication reconciliation:" with a close button (X) in the top right. Below this label, the "SNOMED Code" is 430193006. The "Date" field is set to 07-01-2026, with a calendar icon to its right. At the bottom left, there is a "NOTE" icon and the word "NOTE".

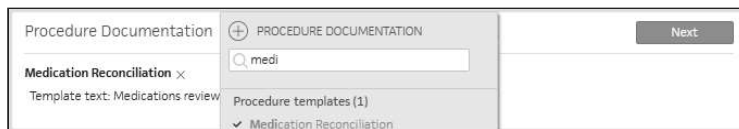


The screenshot shows a window titled "Surgical & Procedure History" with a close button (X) in the top right. Inside the window, there is a section labeled "Medication reconciliation by pharmacist:" with a close button (X) in the top right. Below this label, the "SNOMED Code" is 428701000124107. The "Date" field is set to 08-01-2026, with a calendar icon to its right. At the bottom left, there is a "NOTE" icon and the word "NOTE".

Document a medication reconciliation procedure during an

encounter

1. In the Exam stage of an encounter, click the **PE** step indicator.
2. Under **Procedure Documentation**, click the plus icon  and select the **Medication Reconciliation (1111F)** procedure template.
3. Complete the template and click **Next** . If the template is mapped to a procedure code, the code is prepopulated on the Billing tab in the **Sign-off** stage and on the claim's billing tab in the **Checkout** stage.


Note:

- Use the **Medication Reconciliation (1111F)** procedure template. You can create or add local procedure templates on the Procedure Templates page. You can create local procedure code mappings for accelerated billing on the Order Type & Procedure Template Mapping page.
- You do not have to manually link 1111F code to this template, in order for this automation to work.

Note: For CCDA documents, athenaOne uses the **Document Created Date** to determine whether the discharge document falls within the required timeframe. For non-CCDA documents, athenaOne uses the observation date and time associated with the document.

List of supported CPT II codes — change history.

CPT II procedure code	Change made	Release window
• 1111F (Medication Reconciliation Post-Discharge) • 3014F (Breast Cancer Screening) • 3015F (Cervical Cancer Screening) • 3017F (Colorectal Cancer Screening) • 3511F (Chlamydia and Gonorrhea Screening for HIV-positive patients)	Added these CPT II codes to the list of supported codes.	July 2026
3044F, 3051F, 3052F, and 3046F - Hb A1c codes	Added these CPT II codes to the list of supported codes.	August 2025
2022F, 2023F, and 3072F - Diabetic eye exam codes	Added these CPT II codes to the list of supported codes.	August 2025
1170F - Functional status assessed	Updated the list of applicable screeners.	May 2025
3288F - Falls risk assessment documented	Updated the list of applicable screeners.	May 2025
3725F - Depression screening performed	Updated the list of applicable screeners.	May 2025

CPT II procedure code	Change made	Release window
3725F - Depression screening performed	Updated the logic so the code automatically populates only for patients who will be 12 by the end of the appointment's calendar year.	August 2024
3008F - BMI documented	Updated the logic so the code automatically populates only for patients who will be 3 by the end of the appointment's calendar year.	May 2024
1159F and 1160F - Medication list and medication review	Updated the logic so the codes automatically populate only for patients who will be 66 by the end of the appointment's calendar year.	February 2024

CPT II procedure code	Change made	Release window
1034F and 1036F - Tobacco use codes	Non-answers, such as Patient Refused, result in no Tobacco Use CPT II codes appearing on the Billing tab. Previously, a Non-User code could appear.	March 2022
1034F, 1035F, and 1036F - Tobacco use codes	Uses the new Social History questions. Added 1034F and 1035F.	October 2021
3074F, 3075F, 3077F, 3078F, 3079F, and 3080F - Blood pressure codes	Updated the logic so the lowest blood pressure reading from the encounter is used, not necessarily the most recent reading.	August 2021
1159F - Medication list documented	Added this CPT II code to the list of supported procedure codes.	August 2021

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