CODING FOR PERFORMANCE

CPT II CODES

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Pamela Ballou-Nelson, RN, MSPH, FMC, CMPE, PhD
Lean Six Sigma Black Belt Juran - Global Healthcare Consulting Inc.
pam@healthcareconsultinginc.com
630-294-1072

AGENDA

- CPT II code's function
- Setting up your EMR for CPT II codes
- Practice observations
- Depression
- Hypertension
- Diabetes
- **Source**

  Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) (Child Core Set) Technical Specifications and Resource Manual for 2025 Core Set Reporting January 2025 (Updated March 2025)

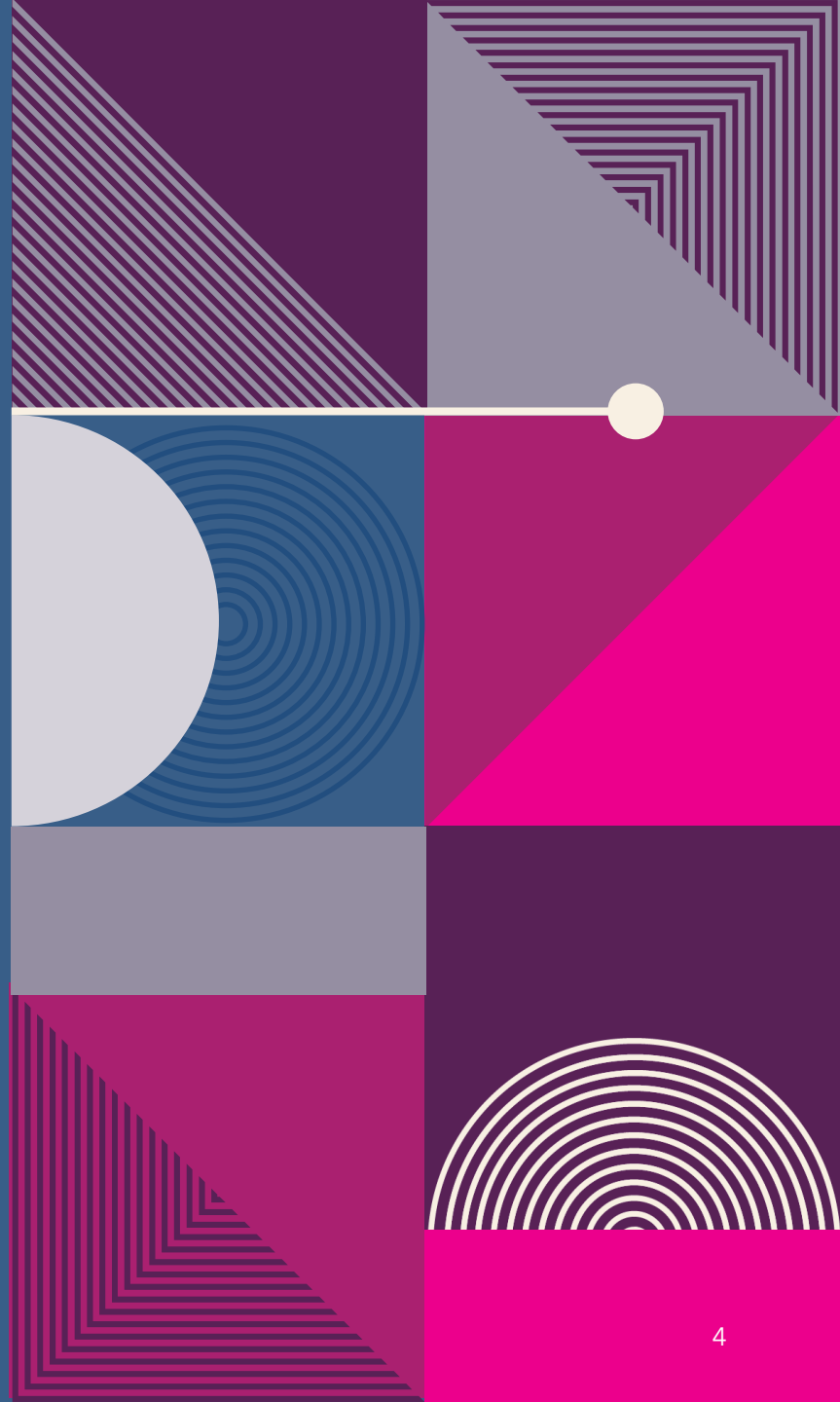
  Center for Medicaid and CHIP Services

  Centers for Medicare & Medicaid Services

CPT II CODES FUNCTION

1. Quality reporting or performance codes
2. They are Non billable codes
3. Describe clinical components ,grouped into 9 sections
4. CPT® Category II codes make it easier for you to share data with Medicaid/Medicare and commercial payers
5. Can mean fewer medical record requests When you add CPT Category II codes, payer MAY not have to request charts from your office to confirm care you've already completed.

SETTING UP YOUR EMR FOR CPT II CODES



SET UP CODES MANUALLY

- To set up **manual entry** for CPT Category II codes, you must build them into your system's quick-pick lists, billing slips, or order entry screens so providers can select them during a patient visit.
- **Step 1: Add Codes to Your Master Fee Schedule**
- Before a provider can select a code, it must exist in your EMR's database.

- **Open Settings**: Navigate to your **Admin**, **Billing Setup**, or **Fee Schedule Library** menu.
- **Create New Code**: Select the option to add a new procedural or billing code.
- **Enter the Alphanumeric Code**: Input the specific 5-digit CPT II code ending in "F" (for example, 3008F for body mass index documented). OR other required performance CPT codes such as well child visit
- **Set Price to Zero**: Assign a dollar value of **$0.00** to the code.
- **Classify as Tracking**: Check the box for **"Tracking Only," "Information Only,"** or **"Non-Billable"** to prevent the system from expecting a standard insurance payout.

SET UP CODES MANUALLY

- **Step 2: Build a Custom Quick-Pick List**
- Manual entry is fastest when common tracking codes are grouped together on a single screen.
- **Create a Quality Tab**: Open your EMR's **Superbill Builder** or **Favorites List Management** tool.
- **Group by Measure**: Create a dedicated section named **"Quality Reporting," "MIPS,"** or **"CPT II Tracking."**
- **Add Core Codes**: Insert your most frequently used codes into this section for quick point-and-click selection.

- **Step 3: Train Providers on the Entry Workflow**
- Establish a clear routine for clinicians or billing staff to record these codes before closing a chart.
- **Select at Checkout**: During the final review of the visit note, the provider opens the billing sheet or encounter form.
- **Click the Quality Tab**: Navigate to the custom CPT II group created in Step 2.
- **Match Clinical Data**: Click the code that corresponds directly to the documentation in the chart (such as selecting 2022F for a dilated eye exam performed).
- **Sign the Encounter**: Save and lock the note to push both the primary CPT codes and the CPT II tracking codes to the billing queue.

SET UP ELECTRONICALLY

- To set up your electronic medical record (EMR) for CPT Category II codes (used for quality tracking and performance data), you must enable the code set in your system settings, **map the tracking codes to specific clinical data or templates, and configure your insurance carrier profiles to accept non-billable performance codes on claims.**

- **System & Fee Schedule Setup**
- **Access CPT Maintenance:** Open your EMR admin settings and navigate to the billing or fee schedule library.
- **Import Code Set:** Add the required 5-digit alphanumeric CPT Category II
- **Mark as Non-Billable:** Designate these codes with a $0.00 fee or check the "non-billable" / "tracking" box so they do not generate patient charges

SET UP ELECTRONICALLY

- **Carrier & Claim Configuration**
- **Enable PQRS/Quality Reporting:** Go to insurance carrier setup within your EMR.
- **Select Plans:** Check the quality reporting or PQRS data fields for Medicare or private payers requiring quality data.
- **Test Transmission:** Ensure codes flow from the clinical encounter note to the final electronic claim form without triggering balance errors.

- **Clinical Mapping & Automation**
- **Build Templates:** Create specific dropdowns or checkboxes in clinical notes for regular measures like blood pressure or HbA1c ranges.
- **Link Rules:** Set up internal clinical rules or auto-coding triggers so that selecting a specific clinical result automatically appends the matching CPT II code to the billing slip

EXAMPLES

PERFORMANCE MEASURE EXCLUSION MODIFIER

Performance measurement exclusion modifiers may be used to indicate that a service specified by a performance measure was considered, but, due to either medical, patient, or systems reason(s) documented in the medical record, the service was not provided. These modifiers serve as denominator exclusions from the performance measure. **Not all listed measures provide for exclusions. The modifiers currently available include the noted listing:**

8P Performance measure reporting modifier - action not performed, reason not otherwise specified

1P Performance measure exclusion modifier due to medical reasons Includes: not indicated (absence of organ/limb, already received/performed, other) . contraindicated (patient allergic history, potential adverse drug interaction, other) .other medical reasons

2P Performance measure exclusion modifier due to patient reasons Includes:

• Patient declined • Economic, social, or religious reasons • Other patient reasons

3P Performance measure exclusion modifier due to system reasons Includes:

• Resources to perform the services not available (eg, equipment, supplies) • Insurance coverage or payer-related limitations • Other reasons attributable to health care delivery system

SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN

[CMS CORE MEASURE]
RESPONSIBLE ENTITY PCMP RAE

- **Measure Description** Goals for both age breakouts of this measure must be met in order to achieve payment. Percentage of beneficiaries ages 12 to 17 and 18 and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the eligible encounter.
- .

- **The denominator** for this measure includes beneficiaries ages 12 to 17 and 18 and older with an outpatient visit during the measurement year.
- **The numerator** for this measure includes the following two groups: · Those beneficiaries with a positive screen for depression during an outpatient visit using a standardized tool with a follow-up plan documented. · Those beneficiaries with a negative screen for depression during an outpatient visit using a standardized tool.
- **Measure Reporting Additional Details Please see Appendix B for links to detailed measure information and value sets**

SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN

- Period Jan. 1, 2026, to Dec. 31, 2026
- Data Source All RAE claims, encounter systems, fee-for-service (FFS) claims, clinical data feeds, and pharmacy data.
- Measure Calculation **This measure will be calculated by HCPF. Measure Reporting Additional Details Please see Appendix B for links to detailed measure information and value sets**

- G8431 positive F/U plan in place
- G8510 Negative no plan needed
- G8433 Screening for depression not completed, documented patient or medical reason
- Correct diagnosis code if positive

MEASURE CDF-AD: SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN:

CENTERS FOR MEDICARE & MEDICAID SERVICES

- **Adult Screening Tools (age 18 and older) Patient Health Questionnaire** (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety- Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale for Depression in Dementia (CSDD), PRIME MD-PHQ2, Hamilton Rating Scale for Depression (HAM-D), Quick Inventory of Depressive Symptomatology Self-Report (QID-SR), Computerized Adaptive Testing Depression Inventory (CAT-DI), and Computerized Adaptive Diagnostic Screener (CAD-MDD).

- **Perinatal Screening Tools**

Edinburgh Postnatal Depression Scale, Postpartum Depression Screening Scale, Patient Health Questionnaire 9 (PHQ-9), Beck Depression Inventory, Beck Depression Inventory–II, Center for Epidemiologic Studies Depression Scale, and Zung Self-rating Depression Scale.

MEASURE CDF-AD: SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN:
CENTERS FOR MEDICARE & MEDICAID SERVICES

A follow-up plan must be documented on the date of the qualifying encounter for a positive depression screen.

Documented follow-up for a positive depression screening *must* include one or more of the following:

Referral to a provider for additional evaluation and assessment to formulate a follow-up plan for a positive depression screen.

Pharmacological interventions.

Other interventions or follow-up for the diagnosis or treatment of depression.

MEASURE CDF-AD: SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN:
CENTERS FOR MEDICARE & MEDICAID SERVICES

- **Exceptions**
- A beneficiary that does not meet the numerator criteria and meets the following exception criteria should be removed from the measure denominator.
- However, if the beneficiary meets the numerator criteria, the beneficiary would be included in the measure denominator.
- Beneficiary reason:
- Beneficiary refuses to participate.
- Medical reason: Beneficiary is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the beneficiary's health status.
- Situations where the beneficiary's cognitive, functional, or motivational limitations may impact the accuracy of results.

CORE SET OF CHILDREN'S HEALTH CARE QUALITY

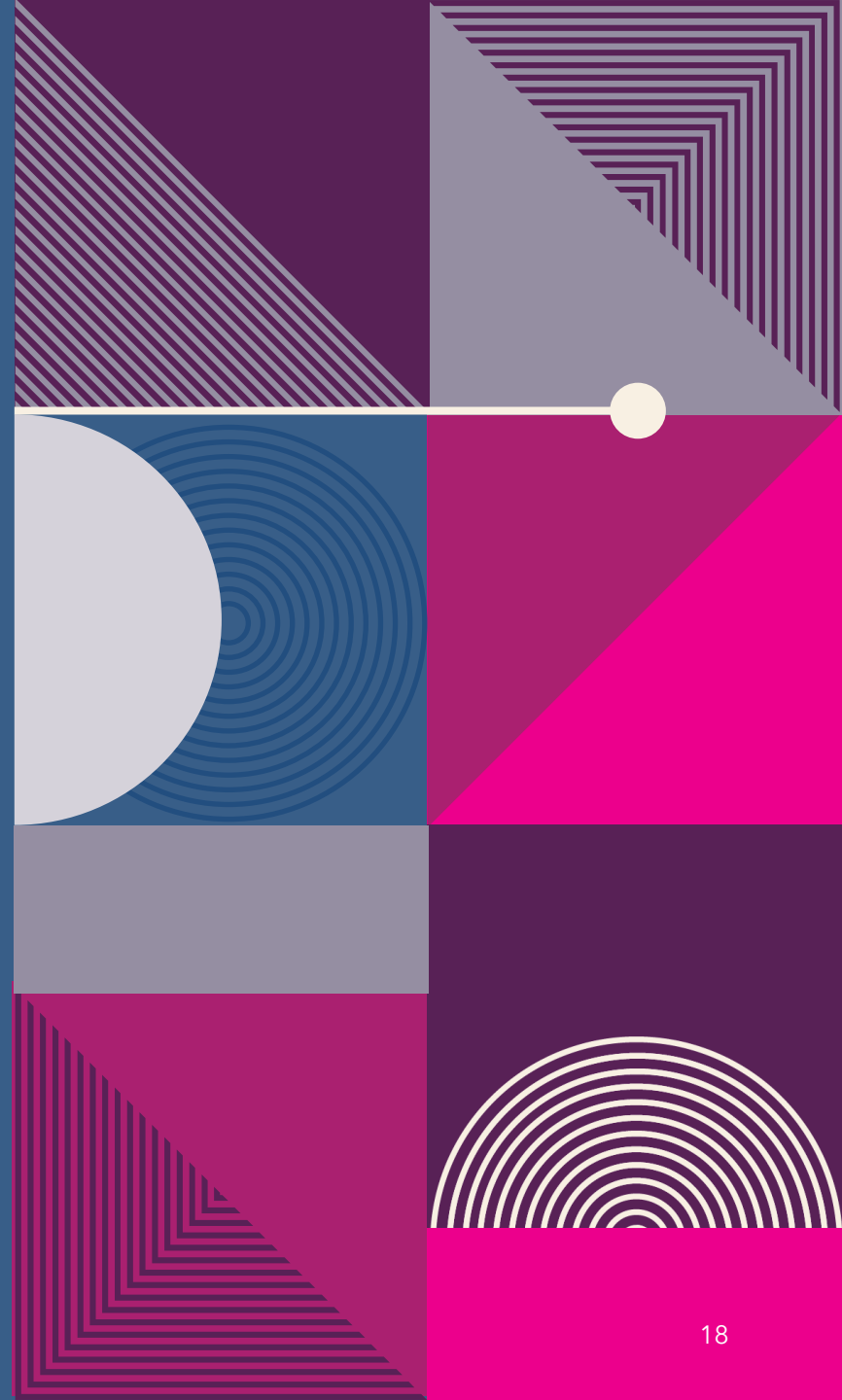
- **MEASURE CDF-CH: SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGES 12 TO 17**
- Centers for Medicare & Medicaid Services
- **A. DESCRIPTION**
- Percentage of beneficiaries ages 12 to 17 screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the qualifying encounter.
- Data Collection Method: Administrative or EHR

TECHNICAL SPECIFICATIONS FOR EACH MEASURE

- **Appendix B**: CMS Core Measure Technical Specifications Important information regarding quality program measures.
- The following measures are defined using the 2025 CMS Core Measure Set Technical Specifications and Value Set Directories.
- You can find the Reporting Resources at the links below for each of the following measures: ·
- 2025 CMS Adult Core Measure Set Reporting Resources ·
- 2025 CMS Child Core Measure Set Reporting Resource

- Links found in HCPF document https://hcpf.colorado.gov/sites/hcpf/files/CY%202026%20ACC%20PhaseIII%20Quality%20Program%20Operations%20Guide_v3.pdf

HYPERTENSION CONTROL



HYPERTENSION CONTROL

The most recent BP reading during the measurement year on or after the second diagnosis of hypertension. If multiple BP measurements occur on the same date, or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. If no BP is recorded during the measurement year, assume that the beneficiary is “not controlled.”

1. Percentage of patients 18-85 years of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period, and whose most recent blood pressure was adequately controlled (<140/90 mmHg) during the measurement period

HYPERTENSION-
BLOOD PRESSURE CONTROL
CONTROLLING HIGH BLOOD PRESSURE (CBP)

Systolic less than 130 mm Hg
Code: **3074F**

Systolic between 130 to 139 mm Hg **3075F**

Systolic greater than/equal to 140 mm Hg **3077F**

1. Diastolic less than 80 mm Hg **3078F**
2. Diastolic between 80 to 89 mm Hg **3079F**
3. Diastolic greater than/equal to 90 mm Hg **3080F** provider documents a patient's most recent diastolic blood pressure reading that is 90 mm Hg or higher.

DIABETES-
GLYCEMIC STATUS ASSESSMENT FOR PATIENTS WITH DIABETES

DESCRIPTION

Percentage of beneficiaries ages 18 to 75 with diabetes (type 1 and type 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year:

Glycemic Status <8.0%.

Glycemic Status >9.0%.

Hemoglobin A1c poor control among beneficiaries ages 18 to 75 with diabetes.

3046F Most recent hemoglobin A1c (HbA1c) level > 9.0%

DIABETES-
GLYCEMIC STATUS ASSESSMENT FOR PATIENTS WITH DIABETES

HbA1c level less than 7.0% **3044F**

HbA1c level greater than 9.0% **3046F**

HbA1c level greater than/equal to 7.0% and less than 8.0% **3051F** This code represents the most recent HbA1c level is between 7.0 percent and 8.0 percent.

HbA1c level greater than/equal to 8.0% and less than/equal to 9.0% **3052F**

PREVENTION SCREENING

- Cervical Cancer Screening Code Description Date of Service **3015F** Cervical cancer screening results documented and reviewed Date of screening
- ***Screening criteria vary by age and test type. See Appendix B for detailed measure information and value sets***.
- Mammogram for Breast Cancer Screening Code Description Date of Service **3014F** Screening mammography results documented and reviewed Date of screening

CHLAMYDIA

- For **HEDIS® Chlamydia Screening in Women (CHL)**, the accepted **CPT®/CPT II** codes for chlamydia testing are:
- **87110** – *Chlamydia screening, urine test*
  87270 – *Chlamydia screening, swab specimen*
  87320 – *Chlamydia screening, other method*
  87490–87492 – *Chlamydia screening, other method (specify type)*
  87810 – *Chlamydia screening, other method*
- These codes are used to report a valid chlamydia screening test for women aged 16–24 who are identified as sexually active, or for older women with risk factors. They are essential for meeting HEDIS numerator requirements and ensuring proper reimbursement.
- **Key points for accurate coding:**
- **Document the method** (e.g., urine, swab, other) to match the correct CPT code .

DEVELOPMENTAL SCREENING [CMS CORE MEASURE]

Developmental, behavioral, and social delay screening for children using a standardized tool.

Children who were screened for risk of developmental, behavioral and social delays using a standardized tool with interpretation and report (G9966)

Children who were not screened for risk of developmental, behavioral and social delays using a standardized tool with interpretation and report (G9967)

FINAL TIPS & TAKEAWAYS

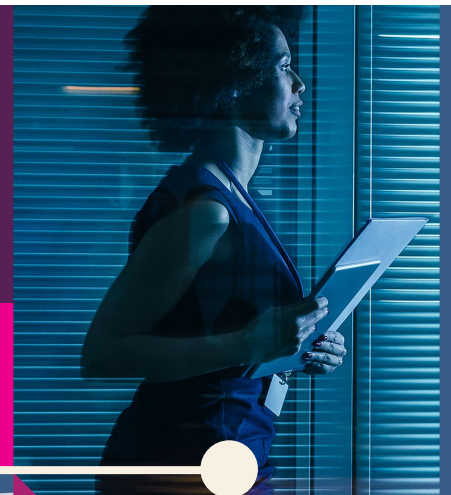
Work with your system vendor to add these codes into your EMR and Practice Management System. Inquire about automation. Some systems can automatically translate clinical data elements into the CPT II code.

CPT Category II codes are billed similar to the way your office bills for regular CPT codes and are placed in the same location on the claim form.

CPT Category II codes can be reported alone on a claim with $0.00 value (or $0.01 value if your system requires it in order for the codes to populate on a claim).

List CPT II codes on the claim after your CPT 1 codes

www.cms.gov › list-cpt-hcpcs-codesList of CPT/HCPCS Codes | CMS



RESOURCES

- A complete listing of the diseases/clinical conditions, and their acronyms are provided in alphabetical order in the Alphabetical Clinical Topics Listing. The Alphabetical Clinical Topics Listing can be accessed on the website at https://www.amaassn.org/system/files/2020-01/cpt-cat2-codes-alpha-listing-clinical-topics.pdf. Users should review the complete measure(s) associated with each code prior to implementation.
- Specifics of the measure can be found in HCPF Quality Operations Guide Appendix B:
- https://hcpf.colorado.gov/sites/hcpf/files/CY%202026%20ACC%20PhaseIII%20Quality%20Program%20Operations%20Guide_v3.pdf
- Which refers you to CMS Core Measure Sets: https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf?t=1786527721
- **Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)** Technical Specifications and Resource Manual for 2025 Core Set Reporting –
- **January 2025 (Updated March 2025)** Center for Medicaid and CHIP Services Centers for Medicare & Medicaid Services
- Accountable Care Collaborative Phase III Quality Operations Guide Effective Date: July 1, 2025 CY 2026 ACC Phase III Quality Program Operations Guide

THANK YOU

Pamela Ballou-Nelson, RN, MSPH, FMC, CMPE, PhD

Lean Six Sigma Black Belt Juran - Global

Healthcare Consulting Inc.

pam@healthcareconsultinginc.com

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Managing The Human Side of Change