Category II Codes

The following section of *Current Procedural Terminology* (CPT) contains a set of supplemental tracking codes that can be used for performance measurement. It is anticipated that the use of Category II codes for performance measurement will decrease the need for record abstraction and chart review, and thereby minimize administrative burden on physicians, other health care professionals, hospitals, and entities seeking to measure the quality of patient care. These codes are intended to facilitate data collection about the quality of care rendered by coding certain services and test results that support nationally established performance measures and that have an evidence base as contributing to quality patient care.

The use of these codes is optional. The codes are not required for correct coding and may not be used as a substitute for Category I codes.

These codes describe clinical components that may be typically included in evaluation and management services or clinical services and, therefore, do not have a relative value associated with them. Category II codes may also describe results from clinical laboratory or radiology tests and other procedures, identified processes intended to address patient safety practices, or services reflecting compliance with state or federal law.

Category II codes described in this section make use of alphabetical characters as the 5th character in the string (ie, 4 digits followed by the letter **F**). These digits are not intended to reflect the placement of the code in the regular (Category I) part of the CPT codebook. To promote understanding of these codes and their associated measures, users are referred to the Alphabetical Clinical Topics Listing, which contains information about performance measurement exclusion modifiers, measures, and the measure's source.

Cross-references to the measures associated with each Category II code and their source are included for reference in Alphabetical Clinical Topics Listing. In addition, acronyms for the related diseases or clinical condition(s) have been added at the end of each code descriptor to identify the topic or clinical category in which that code is included. 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 Web site at www.ama-assn.org, under the Category II link. Users should review the complete measure(s) associated with each code prior to implementation.

Category II codes are reviewed by the Performance Measures Advisory Group (PMAG), an advisory body to the CPT Editorial Panel and the CPT/HCPAC Advisory Committee. The PMAG is comprised of performance measurement experts representing the Agency for Healthcare Research and Quality (AHRQ), the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS), The Joint Commission (TJC), and the Physician Consortium for Performance Improvement® (PCPI). The PMAG may seek additional expertise and/or input from other national health care organizations, as necessary, for the development of tracking codes. These may include national medical specialty societies, other national health care professional associations, accrediting bodies, and federal regulatory agencies.

The most current listing of Category II codes, including guidelines, Code Change Proposal forms, and release and implementation dates for Category II codes can be accessed at www.ama-assn.org/go/cpt.

(For blood pressure measured, use 2000F)

(For tobacco use cessation intervention, pharmacologic therapy, use 4001F)

The superscripted numbers included at the end of each code descriptor direct users to the footnotes. The following information identifies the name and web address of the measure developer that are associated with these footnotes:

Footnotes

[1] Physician Consortium for Performance Improvement® (PCPI), www.physicianconsortium.org.
[2] National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®), www.ncqa.org,
[3] Joint Commission on Accreditation of Healthcare Organizations (JCAHO), ORYX Initiative Performance Measures, www.jcaho.org/pms.
[4] National Diabetes Quality Improvement Alliance (NDQIA), www.nationaldiabetesalliance.org.
[5] Joint measure from The Physician Consortium for Performance Improvement, www.physicianconsortium.org and National Committee on Quality Assurance (NCQA), www.ncqa.org.
[6] The Society of Thoracic Surgeons at www.sts.org and National Quality Forum, www.qualityforum.org.
[7] Ingenix, www.ingenix.com.
[8] American Academy of Neurology, www.aan.com/go/practice/quality/measurements or quality@aan.com.

Modifiers

The following performance measurement modifiers may be used for Category II codes to indicate that a service specified in the associated measure(s) was considered but, due to either medical, patient, or system circumstance(s) documented in the medical record, the service was not provided. These modifiers serve as denominator exclusions from the performance measure. The user should note that not all listed measures provide for exclusions (see the Alphabetical Clinical Topics Listing for more discussion regarding exclusion criteria).

Category II modifiers should only be reported with Category II codes—they should not be reported with Category I or Category III codes. In addition, the modifiers in the Category II section should only be used where specified in the guidelines, reporting instructions, parenthetic notes, or code descriptor language listed in the Category II section (code listing and the Alphabetical Clinical Topics Listing).

1P Performance Measure Exclusion Modifier due to Medical Reasons

Reasons include:

- 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

Reasons include:

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

3P Performance Measure Exclusion Modifier due to System Reasons

Reasons include:

- Resources to perform the services not available
- Insurance coverage/payor-related limitations
- Other reasons attributable to health care delivery system

Modifier 8P is intended to be 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.

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