CPT® II Codes

What are they?

Current Procedural Terminology (CPT) Category II codes are reporting codes that relay important information to the health plan. This information can close quality care gaps related to specific health outcome measures.

How to bill CPT II codes:

CPT II codes are billed in the procedure code field, just as CPT I codes are billed. CPT II codes describe clinical components usually included in evaluation and management or clinical services and are not associated with any relative value. Therefore, CPT II codes are billed with a $0.00 or $0.01 billable charge amount.

Why are they important?

CPT II codes should be submitted in conjunction with CPT I or other codes used for billing and will decrease the need for record abstraction and chart reviews, minimizing your administrative burden.

How can CPT II codes be used to close gaps in care?

CPT II codes can relay important information related to HEDIS® measures such as:

- Anti-psychotic metabolic monitoring
- Controlling blood pressure
- Comprehensive diabetes care
- Care of older Adults
- Medication reconciliation
- Prenatal and postpartum care

The following table lists the HEDIS quality measure, indicator description, and the CPT II codes recognized in the HEDIS specifications for the current 2026 Provider Quality Reports.

Quality Measure	Indicator Description	CPT II Code(s)
Controlling High Blood Pressure	Blood Pressure Readings	3074F, 3075F, 3077F, 3078F, 3079F, 3080F
Comprehensive Diabetes Care	A1C Results	3044F, 3046F, 3051F, 3052F
	Eye Exam	2022F, 2023F, 2024F, 2025F, 2026F, 2033F
Care of Older Adults	Advanced Care Planning	1123F, 1124F, 1157F, 1158F
	Functional Status Assessment	1170F
	Medication Review	1111F, 1159F, 1160F
Medication Reconciliation After Discharge	Medication Reconciliation	1111F
Prenatal and Postpartum Care	Prenatal Visit	0500F, 0501F, 0502F
	Postpartum Visit	0503F
Metabolic Monitoring for Anti-Psychotics	Cholesterol (LDL-C) Testing	3048F, 3049F, 3050F

CPT® II Code Description Guide

0500F	Initial prenatal care visit. Report at first prenatal encounter with health care professional providing obstetrical care. Report the date of the visit, and in a separate field, the date of the last menstrual period (LMP).
0501F	Prenatal flow sheet documented in medical record by first prenatal visit. Documentation includes: blood pressure, weight, urine protein, uterine size, fetal heart tones, and estimated date of delivery. Report the date of visit and in a separate field, the date of LMP. (Note: If reporting 0501F prenatal flow sheet, it is not necessary to report 0500F Initial prenatal care visit.)
0502F	Subsequent prenatal care visit. This excludes: patients who are seen for a condition unrelated to pregnancy or prenatal care (e.g., an upper respiratory infection; patients seen for consultation only, not for continuing care)
0503F	Postpartum care visit
1111F	Discharge medications reconciled with the current medication list in outpatient medical record
1123F	Advance care planning discussed and documented advance care plan or surrogate decision maker documented in the medical record
1124F	Advance care planning discussed and documented in the medical record, patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan
1157F	Advance care plan or similar legal document present in the medical record
1158F	Advance care planning discussion documented in the medical record
1159F	Medication list documented in medical record
1160F	Review of all medications by a prescribing practitioner or clinical pharmacist (e.g., prescriptions, OTCs, herbal therapies, and supplements) documented in the medical record
1170F	Functional status assessed
2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy
2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
2024F	Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy
2025F	Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
2026F	Eye imaging validated to match diagnosis from seven standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy
2033F	Eye imaging validated to match diagnosis from seven standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy
3044F	Most recent hemoglobin A1c (HbA1c) level less than 7.0%
3046F	Most recent hemoglobin A1c level greater than 9.0%
3048F	Most recent LDL-C less than 100 mg/dL
3049F	Most recent LDL-C 100-129 mg/dL
3050F	Most recent LDL-C greater than or equal to 130 mg/dL
3051F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0%
3052F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0%
3074F	Most recent systolic blood pressure less than 130 mm Hg
3075F	Most recent systolic blood pressure 130–139 mm Hg
3077F	Most recent systolic blood pressure greater than or equal to 140 mm Hg
3078F	Most recent diastolic blood pressure less than 80 mm Hg
3079F	Most recent diastolic blood pressure 80–89 mm Hg
3080F	Most recent diastolic blood pressure greater than or equal to 90 mm Hg

The information listed here is not all-inclusive and should be used as a reference only. Please refer to current ICD-10/CPT®/HCPCS coding and documentation guidelines found at cms.gov. HEDIS® measures can be found at ncqa.org.