Reporting Codes Reference Guide

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What are Reporting Codes?

Current Procedural Terminology (CPT) Category II are alphanumeric with four digits followed by the letter "F". HCPCS Level II codes are used for miscellaneous medical services or related to care coordination. They are used as supplemental tracking codes for data collection, performance measurement of quality and test results. They are informational codes only, are not reimbursable and do not have any monetary value.

Why use Reporting Codes?

These codes were created to reduce the administrative burden on physicians and other health care providers by reducing record requests and chart abstraction. By adding these codes on a claim, the quality measures can close without any further intervention. Additionally, the use of these codes enable providers to internally track performance on key metrics throughout the year.

How do you bill Reporting Codes?

These reporting codes are placed on the claim in the same section as CPT I codes. The CPT II codes listed below do not have any relative value and are for reporting purposes only. Please confirm with each payor on the CPT II code charge amount, $0.00 or $0.01.

Measure	Reporting Codes	Description
Advanced Care Planning	1123F	Advance care planning discussed and documented- advance care plan or surrogate decision-maker documented in medical record (DEM)(GER, Pall Cr)
	1124F	Advance care planning discussed and documented in medical record- patient didn't wish to or was unable to name a surrogate decision maker or provide an advance care plan (DEM) (GER, Pall Cr)
	1157F	Advance care plan or similar legal document in medical record
	1158F	Advance care planning discussion documented in medical record
Care for Older Adults (COA)	**Functional Status Assessment (FSA)**	
	1170F	Functional status assessed
	1160F	Review of medications by prescribing practitioner or clinical pharmacist documented in the medical record *NPI number required in addition to CPT II to close quality care opportunity
	Medication Review (MDR)	
	1159F	Medication list documented in medical record
	1160F	Review of medications by prescribing practitioner or clinical pharmacist documented in the medical record *NPI number required in addition to CPT II to close quality care opportunity
	Pain Screening (PNS)	
	1125F	Pain severity quantified; pain present
	1126F	Pain severity quantified; no pain present

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Measure	Reporting Codes	Description		
Controlling Blood Pressure (CBP)	**Systolic**		**Diastolic**	
	3074F	< 130mmHg	3078F	< 80mmHg
	3075F	130-139mmHg	3079F	80-89mmHg
	3077F	greater than/equal to 140mmHg	3080F	greater than/equal to 90mmHg
	MSSP			
	Systolic		**Diastolic**	
	G8752	<140 mmHg	G8754	<90 mmHg
	G8753	≥140 mmHg	G8755	≥90 mmHg
	G8756	No documentation of blood pressure measurement, reason not given		

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Measure	Reporting Codes	Description
		Eye Exam for Patients with Diabetes (EED)
	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	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy
	2025F	7 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 7 standard field stereoscopic retinal photo results documented and reviewed; with evidence of retinopathy (DM)
	2033F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photo results documented and reviewed; without evidence of retinopathy (DM)
	3072F	Diabetic eye exam without evidence of retinopathy in prior year

Blood Pressure Control for Patients with Diabetes (BPD)

Systolic		Diastolic	
3074F	< 130mmHg	3078F	< 80mmHg
3075F	130-139mmHg	3079F	80-89mmHg
3077F	greater than/equal to 140mmHg	3080F	greater than/equal to 90mmHg

Hemoglobin A1c Control for Patients with Diabetes (HBD)

3044F	HbA1c level less than 7.0%
3046F	HbA1c level greater than 9.0%
3051F	HbA1c level greater than or equal 7.0% & less than 8.0%
3052F	HbA1c level greater than or equal 8.0% & less than or equal to 9.0%

MSSP

M1371	HbA1c or GMI level <7.0%
M1372	HbA1c or GMI level ≥7.0% and <8.0%
M1373	HbA1c or GMI level ≥8.0% and ≤9.0%
M1211	HbA1c or GMI level >9.0%
M1212	HbA1c or GMI level is missing, or was not performed during the measurement period

Measure: Diabetic Care (CDC)

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Measure	Reporting Codes	Description
Screening for Breast Cancer	**MSSP**	
	G9899	Screening, diagnostic, film digital or digital breast tomosynthesis (3D) mammography results documented and reviewed
	G9900	Screening, diagnostic, film digital or digital breast tomosynthesis (3D) mammography results were not documented and reviewed, reason not specified
Screening for Depression	1220F	Patient screened for depression (SUD)
	3725F	Screening for depression performed (DEM)
	3352F	No significant depressive symptoms as categorized by using a standardized depression assessment tool (MDD)
	3353F	Mild to moderate depressive symptoms as categorized by using a standardized depression screening/assessment tool (MDD)
	3354F	Clinically significant depressive symptoms as categorized by using a standardized depression screening/assessment tool (MDD)
	MSSP	
	G8431	Screening for depression is documented as being positive and a follow-up plan is documented
	G8510	Screening for depression is documented as being negative and a follow-up plan is not required
	G8433	Screening for depression not completed, documented patient or medical reason
	G8432	Depression screening not documented; reason not given
	G8511	Screening for depression documented as positive, follow-up plan not documented, reason not given
Screening for Future Fall Risk	3288F	Falls risk assessment documented
	1100F	Patient screened for future fall risk; documentation of 2 or more falls in the past year or any fall with injury in the past year
	1101F	Patient screened for future fall risk; documentation of no falls in the past year or 1 fall without injury in the past year
Transition of Care (TRC)	**Medication Reconciliation Post-Discharge**	
	1111F	Discharge medication reconciled with current medication in outpatient record