Provider Bulletin
December 2021

CPT Category II code additional reimbursements

Providers can earn up to an additional $10 per member, per service on health and wellness services provided to our Healthy Blue members by documenting CPT® Category II codes in the medical record and submitting the information in your claims. The use of CPT Category II codes benefits the healthcare system by providing more specific information about healthcare encounters. This data can be used to help providers work more efficiently and effectively in the best interest of each patient.

Reimbursement for the administrative work and effort of completing and reporting CPT Category II codes can only be claimed once **per service**, **per member**, **per year**. It is earned by completing the criteria for billing the CPT Category II codes listed in *Table 1* included with this document, **including** the corresponding diagnosis codes.

CPT Category II codes eligible for reimbursement must be billed with one of the following outpatient visit codes: 99202-99215.

What is a CPT Category II code?

- A CPT Category II code provides more detailed information about the clinical service(s) performed.
- 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.

Benefits of using CPT Category II codes include:

- A reduction in the need for Healthy Blue to review your medical records by providing more detailed information through your claims submissions.
- Better tracking and management of patient care needs from the use of detailed information provided with the billing of CPT Category II codes.

Next steps you need to take:

- Review the CPT Category II code billing opportunities in *Table 1* and set up your billing system to bill us for the codes when applicable.
- Ensure that you meet the criteria for recording and billing the CPT Category II codes in *Table 1* by matching the diagnosis codes and setting up your billing system to bill appropriately.

Note: All CPT Category II codes are eligible for payment only once per service, per member, per calendar year. Continuation of payment and payment rates for billing the CPT Category II codes in *Table 1* will be evaluated annually.

If you have questions about this communication, contact your local Provider Relations representative or call Provider Services at **833-405-9086**.

BMOPEC-0814-21 December 2021

Take advantage of this great revenue opportunity by enhancing your billing processes. Thank you for delivering health and wellness care to our members.

Sincerely,

Provider Relations Department
Healthy Blue

Email is the quickest and most direct way to receive important information from Healthy Blue.

To start receiving email from us (including some sent in lieu of fax or mail), submit your information using the QR code to the right or via our online form (**https://bit.ly/3pFDnV5**).

Table 1

CPT II code to include on claim	Description	Diagnosis category code to include on claim	Criteria	2021 pay
2015F	Asthma impairment assessment	J45.20 to J45.998	• Provider conducts office evaluation for a member with asthma. • Provider performs asthma impairment assessment (for example, symptom frequency, and pulmonary function) during the visit. • Provider reports appropriate office visit, diagnosis code(s), and Category II code 2015F.	$10
3023F	Spirometry results documented and reviewed	J40 to J44.9	• Provider conducts office evaluation for a member with a chronic respiratory condition. • Provider documents and reviews spirometry results in the medical record. • Provider reports appropriate office visit, diagnosis code(s), and Category II code 3023F.	$10
3117F	For patients who have congestive heart failure: heart failure disease-specific structured assessment tool completed	I50 to I50.9	• Provider conducts office evaluation for a member with a heart condition. • Provider completes heart failure disease-specific structured assessment tool (includes lab tests, examination procedures, radiologic examination, and/or results and medical decision making). • Provider reports appropriate office visit, diagnosis code(s), and Category II code 3117F.	$10

CPT II code to include on claim	Description	Diagnosis category code to include on claim	Criteria	2021 pay
0513F	For patients who have hypertension: elevated blood pressure plan of care	I10-I16.9, N18.1-N18.9 E08.00-E13.9	• Provider conducts office evaluation for a member with hypertension or hypertensive diseases. • Provider completes and documents elevated blood pressure plan of care. • Provider reports appropriate office visit, diagnosis code(s), and Category II code 0513F.	$10
3011F	Lipid panel results documented and reviewed	I25 to I25.9	• Provider conducts office evaluation. • Provider documents and reviews lipid panel results in the medical record. • Provider reports appropriate office visit, diagnosis code(s), and Category II code 3011F.	$10
2014F	Mental status assessed (normal/ mildly impaired/ severely impaired) (CAP)1	F90.0 to F90.9	• Provider conducts office evaluation for a member with ADD or ADHD. • Provider completes and documents mental status assessment. • Provider reports appropriate office visit, diagnosis code(s), and Category II code 2014F.	$10

CPT II code to include on claim	Description	Diagnosis category code to include on claim	Criteria	2021 pay
3085F	Suicide risk assessed (MDD)1	F32.0 to F33.9	• Provider conducts office evaluation for a member with major depressive disorder. • Provider completes and documents assessment of suicide risk. • Provider reports appropriate office visit, diagnosis code(s), and Category II code 3085F.	$10
3044F	For patients who have diabetes: most recent HbA1c less than 7%	E08.00-E13.9	• Provider conducts office evaluation for a member with diabetes mellitus (any type). • Provider completes and documents hemoglobin A1C less than 7%. • Provider reports appropriate office visit, diagnosis code(s), and Category II code 3044F.	$10
3046F	For patients who have diabetes: most recent HbA1c greater than 9%	E08.00-E13.9	• Provider conducts office evaluation for a member with diabetes mellitus (any type). • Provider completes and documents hemoglobin A1C greater than 9%. • Provider reports appropriate office visit, diagnosis code(s), and Category II code 3046F.	$10
3051F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0% (DM)	E08.00-E13.9	• Provider conducts office evaluation for a member with diabetes mellitus (any type). • Provider completes and documents hemoglobin A1C greater than or equal to 7.0% and less than 8.0%. • Provider reports appropriate office visit code, diagnosis code(s), and Category II code 3051F.	$10

CPT II code to include on claim	Description	Diagnosis category code to include on claim	Criteria	2021 pay
3052F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than 9.0% (DM)2	E08.00-E13.9	• Provider conducts office evaluation for a member with diabetes mellitus (any type). • Provider completes and documents hemoglobin A1C greater than or equal to 8.0% and less than 9.0%. • Provider reports appropriate office visit code, diagnosis code(s), and Category II code 3052F.	$10
3475F	Disease prognosis for rheumatoid arthritis assessed, poor prognosis documented	M05 to M06.9	• Provider conducts office evaluation for a member with rheumatoid arthritis. • Provider completes and documents rheumatoid arthritis assessment with a poor prognosis. • Provider reports appropriate office visit, diagnosis code(s), and Category II code 3475F.	$10
3476F	Disease prognosis for rheumatoid arthritis assessed, good prognosis documented	M05 to M06.9	• Provider conducts office evaluation for a member with rheumatoid arthritis. • Provider completes and documents rheumatoid arthritis assessment with a good prognosis. • Provider reports appropriate office visit, diagnosis code(s), and Category II code 3476F.	$10

CPT II code to include on claim	Description	Diagnosis category code to include on claim	Criteria	2021 pay
3500F	CD4+ cell count or CD4+ cell percentage documented as performed (HIV)5	B20, Z21, B97.35, O98.7	• Provider conducts office evaluation for a member with HIV/AIDS-related diagnosis. • Provider completes and documents CD4+ cell count or CD4+ cell percentage in the medical record. • Provider reports appropriate office visit, diagnosis code(s), and Category II code 3500F.	$10
3066F	Documentation of treatment for nephropathy (for example, patient receiving dialysis, patient being treated for)	N04.0-N18.9; E08.00-E11.9; E13.00-E13.9	• Provider conducts office evaluation for a member with nephropathy or CKD diagnosis. • Provider completes and documents treatment for nephropathy/CKD in the medical record. • Provider reports appropriate office visit, diagnosis code(s), and Category II code 3066F.	$10