HIGHMARK WESTERN NEW YORK

Medicaid Managed Care
Child Health Plus

Provider Bulletin
March 2022

CPT Category II code reimbursements

Highmark Blue Cross Blue Shield of Western New York (Highmark BCBSWNY) partners with Amerigroup companies to administer certain services to Medicaid Managed Care (MMC) and Child Health Plus (CHPlus) members. Please note, this information is specific to the MMC and CHPlus programs only.

Providers can earn additional reimbursement on health and wellness services provided to our MMC and CHPlus members. Highmark BCBSWNY is offering reimbursement for the use of CPT® Category II codes to encourage continued improvements in member care. The use of CPT Category II codes benefits the healthcare system by providing more specific information about healthcare encounters, such as how data can be used to help providers work more efficiently and effectively in the best interest of each member.

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** and are earned by completing the criteria for billing the CPT Category II codes listed in *Table 1*. Please continue to bill appropriate office visits, CPT Category II codes, and diagnosis codes that are currently in production in order to receive your reimbursement listed in *Table 2*.

CPT Category II codes must be billed with one of the following outpatients visit codes: 99202-99205 or 99212-99215.

The additional reimbursement applies to physicians and qualified healthcare allied practitioners including primary care providers, cardiologists, endocrinologists, pulmonologists, internal medicine, nephrologists, rheumatologists, nurse practitioners, physician assistants, federally qualified health centers, and rural health clinics.

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What is a CPT Category II code?

- A CPT Category II code provides more detailed information about the clinical service 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 Highmark BCBSWNY to review your medical records by providing more detailed information through your claims submissions.
- Better tracking and management of member 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 *Table 2* to set up your billing system to bill us for the codes when applicable.
- Be sure that you meet the criteria for billing the CPT Category II codes in *Table 1* and *Table 2* by matching the diagnosis codes and age ranges and set up your billing system to bill appropriately.

Note: All CPT Category II codes are eligible for payment only once per member, per calendar year. Continuation of payment and payment rates for billing the CPT Category II codes in *Table 1* and *Table 2* will be evaluated annually.

If you have any questions, please contact Provider Services at **866-231-0847**.

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

Table 1

CPT II code to include on claim	Description	Diagnosis category code to include on claim	Criteria	2022 payment
3044F	Most recent hemoglobin A1c (HbA1c) level less than 7.0%.	E08.00-E13.9	• Provider conducts office evaluation for a member with diabetes mellitus (any type). • Provider completes and documents hemoglobin A1C results when less than 7. • Provider reports appropriate office visit, diagnosis code(s), and Category II code 3044F.	$20
3051F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0%.	E08.00-E13.9	• Provider conducts office evaluation for a member with diabetes mellitus (any type). • Provider completes and documents HbA1c results 7 to 8. • Provider reports appropriate office visit code, diagnosis code(s), and Category II code 3051F.	$20
2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy.	E08.00 to E13.9	• Provider reports appropriate office visit, diagnosis code(s), and Category II code 2022F.	$20
2024F	Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy.	E08.00 to E13.9	• Provider reports appropriate office visit, diagnosis code(s,) and Category II code 2024F.	$20
2026F	Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed; with evidence of retinopathy.	E08.00 to E13.9	• Provider reports appropriate office visit, diagnosis code(s), and Category II code 2026F.	$20
2025F	Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy.	E08.00 to E13.9	• Provider reports appropriate office visit, diagnosis code(s) and Category II code 2025F.	$20

CPT II code to include on claim	Description	Diagnosis category code to include on claim	Criteria	2022 payment
2033F	Eye imaging validated to match diagnosis from seven standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy.	E08.00 to E13.9	• Provider reports appropriate office visit, diagnosis code(s) and Category II code 2033F.	$20
3078F	Most recent diastolic blood pressure less than 80 mm Hg.	I10-I16.9, N18.1-N18.9	• Document blood pressure and diagnosis of hypertension in the medical record. On the claim, include diagnosis code for hypertension/hypertensive condition and report CPT II code 3078F.	$20
3079F	For patients with the most recent diastolic blood pressure 80–89 mm Hg	I10-I16.9, N18.1-N18.9	• Document blood pressure and diagnosis of hypertension in the medical record. On the claim, include diagnosis code for hypertension/hypertensive condition and report CPT II code 3079F.	$20
3074F	For patients with the most recent systolic blood pressure reading < 130 mm Hg.	I10-I16.9, N18.1-N18.9	• Document blood pressure and diagnosis of hypertension in the medical record. • On the claim, include diagnosis code for hypertension/hypertensive condition and report CPT II code 3074F.	$20
3075F	For patients with the most recent systolic blood pressure 130–139 mm Hg.	I10-I16.9, N18.1-N18.9	• Document blood pressure and diagnosis of hypertension in the medical record. • On the claim, include diagnosis code for hypertension/hypertensive condition and report CPT II code 3075F.	$20
3023F	Spirometry results documented and reviewed.	J40-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.	$20

CPT II code to include on claim	Description	Diagnosis category code to include on claim	Criteria	2022 payment
3066F	Documentation of treatment for nephropathy (for example, patient receiving dialysis, patient being treated for).	N04, N05, N06, N07, N08, N10, N11, N12, N14, N15, N17, N18, N19 & Z99.2	• 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.	$20
4010F	Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) therapy prescribed or currently being taken.	E08.00-E13.9 I25.10-I25.9	• Provider reports appropriate office visit, diagnosis code(s), and Category II code 4010F.	$20
3060F	Positive microalbuminuria test result documented and reviewed.	E08.00-E13.9	• Provider reports appropriate office visit, diagnosis code(s) and Category II code 3060F.	$20
3061F	Negative microalbuminuria test result documented and reviewed.	E08.00-E13.9	• Provider reports appropriate office visit, diagnosis code(s) and Category II code 3061F.	$20
3062F	Positive macroalbuminuria test result documented and reviewed.	E08.00-E13.9	• Provider reports appropriate office visit, diagnosis code(s) and Category II code 3062F.	$20
0503F	For patients who complete a postpartum visit between 21 and 56 days after delivery.	N/A	• Complete a postpartum visit between 21 and 56 days after delivery. • Bill using the appropriate delivery code and the date of delivery. • Submit claim with CPT category code 0503F and diagnosis code. • Submit required procedure code and complete a postpartum visit between 21 and 56 days after delivery: o 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622	$20

CPT II code to include on claim	Description	Diagnosis category code to include on claim	Criteria	2022 payment
0500F	Report at the first prenatal encounter with health care professionals providing obstetrical care. In a separate field, report the date of the last menstrual period (LMP).	N/A	• Bill with the appropriate evaluation and management code within 30 days of the visit that confirmed the pregnancy (99201-99205, 99211-99215).	$20
0501F	Prenatal flow sheet documented in the medical record by the first prenatal visit.	N/A	• Documentation must include blood pressure, weight, urine protein, uterine size, fetal heart tones and estimated date of delivery. In a separate field, report the date of the LMP.	$20
0502F	Subsequent prenatal care visit (excludes patients seen for a condition unrelated to pregnancy or prenatal care).	N/A	• Bill CPT II with one of the following global codes: 59400, 59510, 59610, 59618.	$20

Table 2

CPT II code to include on claim	Description	Diagnosis category code to include on claim	Criteria	2022 payment
2015F	Asthma impairment assessment	J45	• 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.	$20
3023F	Spirometry results documented and reviewed	J40 to J44	• 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.	$20
3117F	For patients who have congestive heart failure: heart failure disease-specific structured assessment tool completed	I50	• 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.	$20
0513F	For patients who have hypertension: elevated blood pressure plan of care	I10 to I16	• 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.	$20

CPT II code to include on claim	Description	Diagnosis category code to include on claim	Criteria	2022 payment
3011F	Lipid panel results documented and reviewed	I25	• 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.	$20
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.	$20
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. • Report appropriate office visit, diagnosis code(s), and Category II code 3085F.	$20
3475F	Disease prognosis for rheumatoid arthritis assessed, poor prognosis documented	M05 to M06	• 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.	$20
3476F	Disease prognosis for rheumatoid arthritis assessed, good prognosis documented	M05 to M06	• 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.	$20

CPT II code to include on claim	Description	Diagnosis category code to include on claim	Criteria	2022 payment
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.	$20
3066F	Documentation of treatment for nephropathy (for example, patient receiving dialysis, patient being treated for)	N04, N05, N06, N07, N08, N10, N11, N12, N14, N15, N17, N18, N19 & Z99.2	• 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.	$20

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