January 2019

Subject: CPT Category II code reimbursements

Dear Provider:

Beginning January 1, 2019, you can earn additional reimbursement on health and wellness services provided to Anthem Blue Cross and Blue Shield Medicaid (Anthem) members. Anthem is offering reimbursement for the use of CPT Category II codes starting this year in 2019 to encourage continued improvements in member care. The use of CPT Category II codes benefits the health care system by providing more specific information about health care encounters. These CPT Category II codes provide data that can be used to help us all work more efficiently and effectively in the best interest of the member. Take advantage of this great revenue opportunity by enhancing your billing processes now.

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 below in Table 1.

The CPT Category II code must be billed with one of these outpatient visit codes: 99201 through 99215.

The additional reimbursement applies to physicians and qualified health care allied practitioners (for example, PCPs, cardiologists, endocrinologists, pulmonologists, internal medicine, nephrologists, rheumatologists, nurse practitioners, physician assistants, HIV/AID specialists), FQHCs and RHCs.

What is a CPT Category II code?

- CPT II codes provide more detailed information about clinical services performed.
- These codes are billed similar to the way that your office bills regular CPT codes and are placed in the same location on the claim form.

Benefits of using CPT Category II codes include:

- Reduction in the need for Anthem to review your medical records by providing more detailed information through your claims submissions.
- Better tracking and management of members' care needs from the use of the 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.
- Be sure that you meet the criteria for billing the CPT Category II codes in Table 1 with matching diagnosis codes and age ranges, and set up your billing system to bill appropriately.
- You can retroactively bill for the CPT Category II codes in Table 1 that meet the criteria.

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 will be evaluated annually.

If you have questions, please call Provider Services at **1-855-661-2028**. Thank you for delivering health and wellness care to our members. We appreciate all that you do for our members.

Sincerely,

Provider Relations Department
Anthem Blue Cross and Blue Shield Medicaid

Table 1

CPT II code to include on claim	Description	Diagnosis category code to include on claim	Criteria	2019 pay
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

CPT II code to include on claim	Description	Diagnosis category code to include on claim	Criteria	2019 pay
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 report appropriate office visit, diagnosis code(s), and category II code 0513F.	$20
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 report 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

CPT II code to include on claim	Description	Diagnosis category code to include on claim	Criteria	2019 pay
3044F	For patients who have diabetes: most recent HbA1c < 7	E08, E09, E10, E11, E13	• Provider conducts office evaluation for a member with diabetes mellitus (any type). • Provider completes and documents hemoglobin A1C results when less than 7. • Provider report appropriate office visit, diagnosis code(s) and category II code 3044F.	$20
3045F	For patients who have diabetes: most recent HbA1c 7 to 9	E08, E09, E10, E11, E13	• Provider conducts office evaluation for a member with diabetes mellitus (any type). • Provider completes and documents hemoglobin A1C results when 7 to 9. • Report appropriate office visit, diagnosis code(s) and category II code 3045F.	$20
3046F	For patients who have diabetes: most recent HbA1c > 9	E08, E09, E10, E11, E13	• Provider conducts office evaluation for a member with diabetes mellitus (any type). • Provider completes and documents hemoglobin A1C results when greater than 9. • Provider reports appropriate office visit, diagnosis code(s) and category II code 3046F.	$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

CPT II code to include on claim	Description	Diagnosis category code to include on claim	Criteria	2019 pay
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
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