CPT Category II code reimbursements

Amerigroup Washington, Inc. will offer additional reimbursement on health and wellness services through the use of CPT® Category II (CPT II) codes to encourage continued improvements in member care. Using CPT II codes benefits the health care system by providing more specific information about health care encounters. CPT II codes provide data that can be used to help us all work more effectively in the best interest of the member.

Reimbursement for reporting CPT II codes can only be claimed once **per service, per member, per year** and is earned by completing the criteria for billing the CPT II codes listed in Table 1.

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

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

What is a CPT II code?

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

Benefits of using CPT II codes:

- CPT II codes reduce the need for Amerigroup to review your medical records by providing more detailed information through your claims submissions.
- CPT II codes enable better tracking and management of members' health care needs from use of the detailed information provided.

Next steps to take:

- Review the CPT II code billing opportunities in Table 1.
- Set up your billing system to appropriately bill Amerigroup for the codes when applicable.
- Ensure that you meet the criteria for billing the CPT II codes in Table 1 with matching diagnosis codes and age ranges.

Table 1

Code to include on claim	Description	Diagnosis code to include on claim	Criteria	2020 payment
2015F	Asthma impairment assessment	J45.20-J45.998	• Provider conducts office evaluation for a member with asthma. • Provider performs asthma impairment assessment (e.g., symptom frequency and pulmonary function) during the visit. • Provider reports appropriate office visit, diagnosis code(s) and Category II code 2015F.	$25
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.	$25
3117F	For patients who have congestive heart failure: heart failure disease-specific structured assessment tool completed	I50.1-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.	$25
0513F	For patients who have hypertension: elevated blood pressure plan of care	I10-I16.9, N18.1-N18.9	• 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.	$25
3011F	Lipid panel results documented and reviewed	I25.10-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.	$25
2014F	Mental status assessed (normal, mildly impaired or severely impaired) (cap)	F90.0-F90.9	• Provider completes office visit for member with ADD or ADHD. • Provider completes and documents mental status assessment. • Provider reports appropriate office visit, diagnosis code(s) and CPT Category II code 2014F.	$25

3085F	Suicide risk assessed (MDD)	F32.0-F33.9	• Provider completes office visit for member with major depressive disorder. • Provider completes and documents assessment of suicide risk. • Provider reports appropriate office visit, diagnosis code(s) and CPT Category II code 3085F.	$25
3044F	For patients who have diabetes: most recent HbA1c < 7	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.	$25
3046F	For patients who have diabetes: most recent HbA1c > 9	E08.00-E13.9	• 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.	$25
3051F	Most recent HbA1c level greater than or equal to 7% and less than 8% (DM)	E08.00-E13.9	• Provider conducts office evaluation for a member with diabetes mellitus (any type). • Provider completes and documents HbA1c results 7-8. • Provider reports appropriate office visit code, diagnosis code(s) and Category II code 3051F.	$25
3052F	Most recent HbA1c level greater than or equal to 8% and less than 9% (DM)2	E08.00-E13.9	• Provider conducts office evaluation for a member with diabetes mellitus (any type). • Provider completes and documents HbA1c results when 8-9. • Provider reports appropriate office visit code, diagnosis code(s) and Category II code 3052F.	$25
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.	$25
3475F	Disease prognosis for rheumatoid arthritis assessed, poor prognosis documented	M05.00-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.	$25

3476F	Disease prognosis for rheumatoid arthritis assessed, good prognosis documented	M05.00-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.	$25
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.	$25

If you have any questions, please call Provider Services at **1-800-454-3730**. Thank you for delivering health and wellness care to our members.

Sincerely,

Amerigroup Washington, Inc.