Empire BlueCross BlueShield
An Anthem Company

Medicaid

Provider Bulletin
April 2023

CPT Category II code reimbursements

Providers can earn additional reimbursement on health and wellness services provided to Empire BlueCross BlueShield HealthPlus (Empire) members. Empire 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 Empire 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** (excluding prenatal and postpartum care measures; one per pregnancy) 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 these outpatient visit codes: 99202 through 99215.

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

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 Empire 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.

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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, contact Provider Services at **800-450-8753**.

Table 1

CPT II code	Description	Diagnosis category code	Criteria	2023 pay
0500F	Report at the first prenatal encounter with healthcare 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: o 99202-99205, 99211-99215.	$25
0501F	Prenatal flow sheet documented in the medical record by the first prenatal visit.	N/A	• Bill with the appropriate evaluation and management code within 30 days of the visit that confirmed the pregnancy: o 99202-99205, 99211-99215 • 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.	$25
0503F	For patients who complete a postpartum visit between 7 and 84 days after delivery.	Z39.2	• Complete a postpartum visit between 7 and 84 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 7 and 84 days after delivery: o 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622	$25

Table 2

CPT II code	Description	Diagnosis category code	Criteria	2023 pay
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
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
2023F	Dilated retinal eye exam 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 2023F.	$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
3078F	For patients with the most recent diastolic blood pressure < 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

CPT II code	Description	Diagnosis category code	Criteria	2023 pay
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.	$20
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.	$20
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.	$20
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 results when less than 7. • Provider reports appropriate office visit, diagnosis code(s), and Category II code 3044F.	$20
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 results when greater than 9. • Provider reports appropriate office visit, diagnosis code(s), and Category II code 3046F.	$20
3051F	Most recent HbA1c level greater than or equal to 7% and less than 8%	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.	$20

CPT II code	Description	Diagnosis category code	Criteria	2023 pay
			• Provider reports appropriate office visit code, diagnosis code(s), and Category II code 3051F.	
3052F	Most recent HbA1c level greater than or equal to 8% and less than 9%	E08.00-E13.9	• Provider conducts office evaluation for a member with diabetes mellitus (any type). • Provider completes and documents HbA1c results when 8 to 9. • Provider reports appropriate office visit code, diagnosis code(s), and Category II code 3052F.	$20
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.	$20
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.	$20
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.	$20