CPT Category II code additional reimbursements

Background: Providers can earn additional payments on health and wellness services provided to Wellpoint 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.

The additional reimbursement applies to physicians and qualified healthcare 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.

CPT Category II codes eligible for reimbursement must be billed with one of the following outpatient visit codes: 99201 to 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 Wellpoint 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 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.

Table 1					
CPT® II code to include on claim	**Description**	**Diagnosis category code to include on claim**	**Age**	**Criteria**	**2022 pay**
2015F	Asthma impairment assessment	J45.20-J45.998	All	• 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
3011F	Lipid panel results documented and reviewed	I25 – I25.9	All	• 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
3023F	Spirometry results documented and reviewed	J40-J44.9	All	• 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-I50.9	All	• 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	Age	Criteria	2022 pay
0513F	For patients who have hypertension: elevated blood pressure plan of care	I10-I16.9, N18.1-N18.9, E08.00-E13.9	All	• 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
3044F	For patients who have diabetes: most recent HbA1c less than 7%	E08.00 – E13.9	All	• 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	All	• 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	All	• 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	Age	Criteria	2022 pay
3500F	CD4+ cell count or CD4+ cell percentage documented as performed (HIV)5	B20, Z21, B97.35, O98.7	All	• 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	All	• 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
G8417	For patients who are obese: body mass index (BMI) documented above normal parameters; follow-up plan documented	E66.0-E66.9	All	• Provider completes office visit and bills codes. • Provider counsels on nutrition/physical activity and documents in chart.	$10
3008F	Body mass index documented	Z68.20-Z68.45	18 and up	• Provider completes office visit and bills codes. • Provider documents weight and BMI in chart.	$5
3014F	For women over 50: screening mammogram, results documented and reviewed	N/A	50-64	• Provider orders mammography. • Member completes mammography. • Results reviewed and documented in chart.	$10

CPT II code to include on claim	Description	Diagnosis category code to include on claim	Age	Criteria	2022 pay
0503F	For patients who complete a postpartum visit between 21 and 56 days after delivery	Z39.2		• 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. • Procedure code(s): 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622.	$20
99080	For patients who have other health insurance, and Wellpoint is secondary	N/A	All	• Provider adds CPT code 99080 to COB claims. • Additional required office visit procedure code: 99241-99245.	$20
Q0091	Cervical Cancer Screening	N/A	18 and up	• Provider completes office visit and bills codes.	$10
4306F	Patient counseled regarding psychosocial and pharmacologic treatment options for opioid addiction (SUD)	F11 (opioids) F12 (cannabis) F13 (sedative, hypnotic, or anxiolytic) F14 (cocaine) F15 (other stimulants)	All	• Provider reports appropriate office visit, diagnosis code(s), and Category II code 4306F.	$10

What if I need assistance?

If you have questions about this communication or need assistance with any other item, contact your assigned Provider Experience associate or call Provider Services at **833-707-0868**.