Indiana | Anthem Blue Cross and Blue Shield
Serving Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect, and Indiana PathWays for Aging

Quality Programs and Opportunities

Enhancing Provider Performance
Indiana Health Coverage Programs (IHCP) Works Provider Seminar, October 2025

Anthem

Coding Disclaimer

- The information in this presentation does not guarantee reimbursement, benefit coverage, or payment for services.
- Coding guidance in this presentation is not intended to replace official coding guidelines or professional coding expertise.
- Care providers are required to ensure documentation supports all codes submitted for conditions and services.
- If you have questions regarding claims billed and reimbursement, call Provider Services :
  - Hoosier Healthwise: 866-408-6132
  - Healthy Indiana Plan: 844-533-1995
  - Hoosier Care Connect: 844-284-1798
  - Indiana PathWays for Aging: 833-569-4739

Agenda

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Part Two: The Intersection of Healthcare Effectiveness Data and Information Set (HEDIS®) and Category II coding

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Part One — CPT Category II Codes Overview

What are CPT Category II Codes?

CPT code categories:

Category I (CPT I)	• Codes are used for tracking and billing of common procedures.
Category II (CPT II)	• Codes are supplemental tracking and performance measurement codes.
Category III (CPT III)	• Codes are temporary codes for emerging technology.

CPT II codes are:

- Alphanumeric and consist of four digits followed by the letter *F*.
- Optional and intended to be used for measuring performance on quality metrics.
- Not billing codes; they are used to track services on claims for performance measurement.

The codes listed in this presentation are for informational purposes only and are not intended to suggest or guide reimbursement.

Common Category II Codes

Commonly used CPT Category II codes that align with quality measures tied to chronic disease management, preventive care, and care coordination:

- **Diabetes management:**
  - 3044F: Most recent hemoglobin A1c level < 7.0% (controlled).
  - 3046F: Most recent hemoglobin A1c level > 9.0% (poor control).
  - 3051F: Most recent hemoglobin A1c level > 7.0% and <8.0%.
  - 3052F: Most recent hemoglobin A1c level > 8.0% and ≤9.0%.
- Immunizations:
  - 4037F: Influenza immunization ordered or administered.
  - 4040F: Pneumococcal vaccine administered or previously received.

The codes listed are for informational purposes only and are not intended to suggest or guide reimbursement.

Common Category II Codes (cont.)

- **Hypertension (blood pressure control):**
  - 3074F: Most recent systolic blood pressure < 130 mm Hg
  - 3075F: Most recent systolic blood pressure 130–139 mm Hg
  - 3077F: Most recent systolic blood pressure ≥ 140 mm Hg
  - 3078F: Most recent diastolic blood pressure < 80 mm Hg
  - 3079F: Most recent diastolic blood pressure 80–89 mm Hg
  - 3080F: Most recent diastolic blood pressure ≥ 90 mm Hg
- Screenings:
  - 3014F: Screening mammography results documented and reviewed.
  - 3015F: Cervical cancer screening results documented and reviewed.
  - 3016F: Patient screened for unhealthy alcohol use using a systematic screening method.
  - 3017F: Colorectal cancer screening results documented and reviewed.

The codes listed are for informational purposes only and are not intended to suggest or guide reimbursement.

Common Category II Codes (continued)

- Preventive care:
  - 3008F: Body mass index (BMI) documented
  - 3085F: Suicide risk assessed
  - 3725F: Screening for depression performed
- **Prenatal and postpartum care:**
  - 0500F: Initial prenatal care visit (report at first prenatal encounter with healthcare professional providing obstetrical care)
  - 0501F: Prenatal flow sheet documented in medical record by first prenatal visit
  - 0502F: Subsequent prenatal care visit
  - 0503F: Postpartum care visit

The codes listed are for informational purposes only and are not intended to suggest or guide reimbursement.

CPT Category II Modifiers

Performance measure exclusion modifiers:

- 1P: Performance measure exclusion modifier due to medical reasons:
  - Not indicated (absence of organ/limb)
  - Contraindicated (patient allergic history, potential adverse drug interaction, other)
  - Other medical reasons

- 2P: Performance measure exclusion modifier due to patient reasons:
  - Patient declined for economic, social, or religious reasons.

- 3P: Performance measure exclusion modifier due to system reasons:
  - Resources to perform the services are not available (for example, equipment and supplies).
  - Insurance coverage or payer-related limitations.

Reporting modifier:

8P: Performance measure reporting modifier — action not performed, reason not otherwise specified

The codes listed are for informational purposes only and are not intended to suggest or guide reimbursement.

CPT II Coding Example

Scenario

A 10-year-old established patient is seen in the office today with complaints of shortness of breath, vomiting, coughing, and sore throat, and follow-up for moderately persistent asthma. He currently takes albuterol and steroids administered by inhaler. A medically appropriate history and physical exam was performed, with moderate-complexity medical decision-making (MDM).

The patient has an upper respiratory infection and is advised to take over-the-counter medications. His moderately persistent asthma is currently stable. Additional prescriptions are written for ProVentil and Pulmicort. A follow-up appointment for the patient is scheduled for one month. If the patient's condition worsens before the scheduled visit, they should contact the office promptly for further guidance.

Thirty-five minutes were spent with the patient today in preparation, patient care, and documentation for the visit.

CPT Category I:

- 99214: established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision-making

CPT Category II:

- 1005F: asthma symptoms evaluated
- 1038F: persistent asthma (mild, moderate, or severe)
- 4025F: inhaled bronchodilator prescribed

Part Two — The Intersection of HEDIS® and CPT Category II Coding

Importance of Healthcare Effectiveness Data and Information Set (HEDIS®)

- Healthcare Effectiveness Data and Information Set (HEDIS®) is coordinated and administered by the NCQA and used by the Centers for Medicare & Medicaid Services (CMS) for monitoring the performance of managed care organizations.
- HEDIS® allows performance comparisons of managed care plans.
- Compliance audits, along with a medical record review validation process, ensure the validity and integrity of HEDIS data.
- HEDIS® measures align with national or regional initiatives and address known gaps in care.

Healthcare

Effectiveness

Data

Information

Set

Care Providers' Role in the HEDIS® Process

Care providers can help improve the HEDIS® process by:

- Giving members the care they need within the allotted time frames.
- Carefully documenting the care provided to members in their medical records.
- Accurately coding all claims.
- Staying up to date on which documents are needed for different measures.
- Accommodating medical record requests within seven business days:
  - Using CPT Category II codes can reduce these requests during review season.
  - Using these codes on claims gives additional visit information that improves the accuracy of quality measures being reported.

HEDIS® and CPT Category II

CPT Category II codes can significantly impact HEDIS® measures by enhancing the accuracy and efficiency of data collection and reporting for quality measures.

Category II codes:

- Help capture clinical information and outcomes with more details, which provides easier reporting on specific clinical processes and outcomes required by HEDIS® measures.
- Facilitate automated data extraction directly from claims, saving time and resources versus using chart audits.
- Allow us to track compliance with evidence-based practices, which are key areas monitored by HEDIS®.
- Standardize the information being tracked, making HEDIS® data more consistent and comparable.

HEDIS® and CPT Category II (cont.)

Understanding the key components that define what to measure and how to calculate performance is essential for improving healthcare outcomes.

Measure definition	• Describes what the measure aims to assess.
Measure specifications	• Eligible population: specific population or cohort for whom the measure is applicable; this includes criteria such as age, gender, and specific conditions or risk factors. • Denominator: the total group of people from the eligible population to whom the measure applies. • Numerator: the subset of the denominator population that meets the measure's criteria. • Exclusions: situations or conditions that exclude people from the denominator or the numerator.
Data collection method	• Details how the data for the measure should be collected. HEDIS® measures can use various data sources, including administrative, hybrid, electronic clinical data systems (ECDS), and patient surveys.
Measurement period	• Specifies the time frame during which data are collected and evaluated.

HEDIS Example: CPT Category II Code for A1c Reporting

Category II	Description: Glycemic Status Assessment for Patients with Diabetes (GSD)		
3044F	Most recent HbA1c level less than 7%	Bill using one of these outpatient visit CPT codes:	
3046F	Most recent HbA1c level greater than 9%	• 99202–99205	• 99212–99215
3051F	Most recent HbA1c level greater than or equal to 7% and less than 8%	Covered place of service codes	• 11: Office or non-facility setting • 50: Federally Qualified Health Center • 72: Rural health clinic
3052F	Most recent HbA1c greater than or equal to 8% and less than 9%		
ICD-10-CM (bill CPT Category II along with an associated diabetes code)			
E08.00–E13.9	Diabetes		

HEDIS Example: CPT Category II Code for Prenatal and Postpartum Care Reporting

Category II	Prenatal and Postpartum Care (PPC)	
0500F	Initial Prenatal Care Visit	Bill CPT Category II codes with date of service along with applicable CPT code for prenatal and/or postpartum care. • Prenatal: 59425, 59426 • Postpartum: 59430 For members with other coverage as primary, it is **important** to bill these CPT Category II codes with date of service for prenatal and postpartum visits along with global delivery codes: 59510, 59610, 59614, and 59618
0503F	Postpartum Care Visit	

Part Three — Anthem CPT Category II Codes Reimbursement Program

CPT Category II Code Reimbursement

- Anthem offers additional reimbursement to eligible providers for the use of CPT category II codes to encourage continued improvements in member care. These codes are to be used when submitting a claim.
- 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 Anthem care providers work more efficiently and effectively in the best interest of each member.
- The additional reimbursement applies to eligible physicians and qualified healthcare allied practitioners, including primary medical providers (PMPs), cardiologists, endocrinologists, pulmonologists, internal medicine physicians, nephrologists, rheumatologists, nurse practitioners, physician assistants, HIV/AIDS specialists, federally qualified health centers, urgent care centers, and hospital outpatient centers.
- Reimbursement is only provided for the following places of service:
  - 11: Office
  - 50: Federally Qualified Health Center
  - 72: Rural health clinic

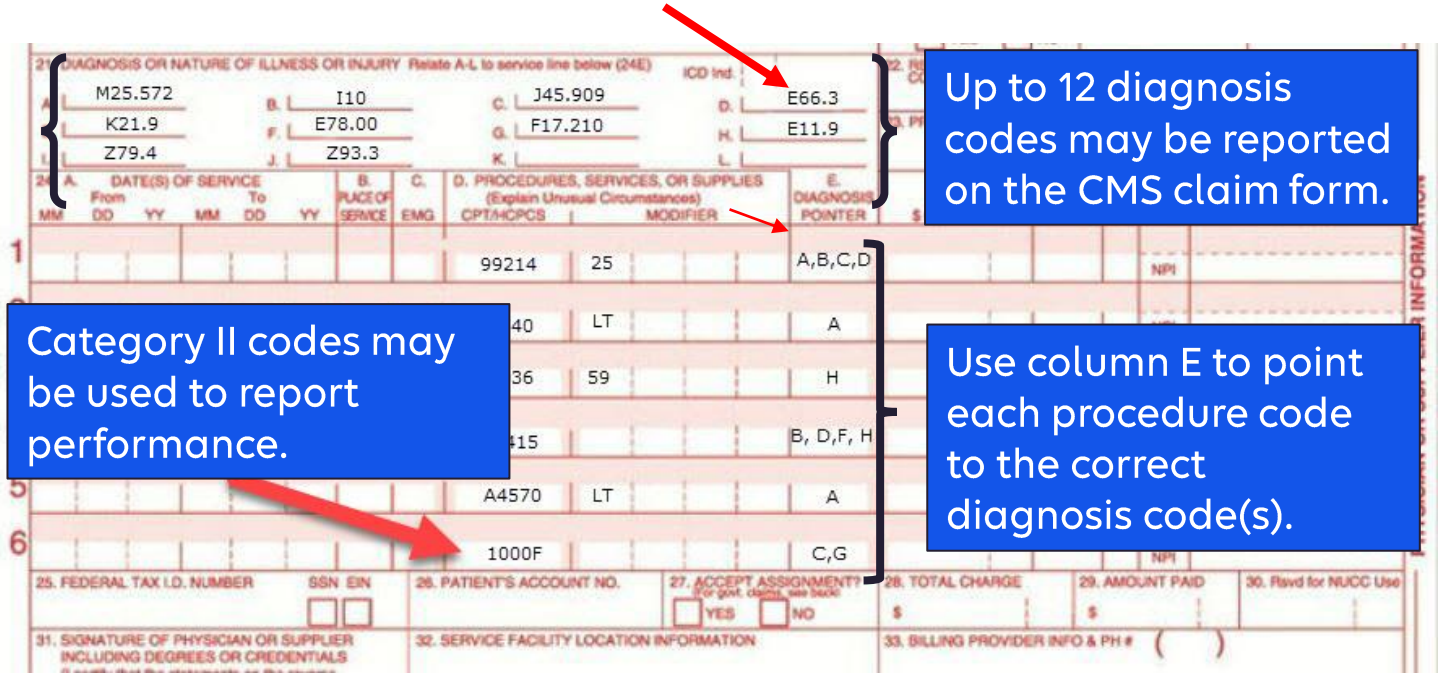
Billing and Reimbursement

Question	Answer
What do qualifying care providers need to bill to receive the reimbursement?	Submit a CPT procedure code, a CPT Category II code, and a corresponding diagnosis code on the claim to receive the additional reimbursement. The procedure code can be an office visit or other types of CPT procedure codes.
Is the reimbursement one time or every time they bill the codes?	The additional reimbursement for the administrative work and effort of completing and reporting CPT category II codes with corresponding diagnosis codes can only be claimed **once per service, per member per year**.

Billing CPT Category II Codes

CPT II Codes are:

- Billed in the procedure code field, space 24D of the CMS-1500 form.
- Billed typically with a zero-dollar amount; if billing systems require an amount, $0.01 may be billed.
- Linked to appropriate diagnosis codes listed in field 21 of the CMS-1500 form.



Category II codes **must** be billed with the appropriate diagnosis code on the claim to receive the additional administrative reimbursement.

Next Steps to Take

- Review the CPT Category II code billing opportunities in on the following slides and set up your billing system to bill us for the codes when applicable.
- Match diagnosis codes and age ranges to ensure that you meet the criteria for billing the CPT Category II Code and then set up your billing system to bill appropriately.

- If you have questions regarding claims billed and reimbursement, call Provider Services :
  - Hoosier Healthwise: [866-408-6132]
  - Healthy Indiana Plan: [844-533-1995]
  - Hoosier Care Connect: [844-284-1798]
  - Indiana PathWays for Aging: [833-569-4739]

- **Note:** Continuation of payment and payment rates for billing the CPT category II codes will be evaluated annually for qualifying providers.

Anthem CPT Category II Code Additional Reimbursements

CPT II code	Description	Diagnosis on claim	Criteria	Amount
2015F	Asthma impairment assessment	J45.20-J45.998	• Provider conducts office evaluation for a member with asthma. • Provider performs asthma impairment assessment (for example, symptom frequency, and pulmonary function) during the visit.	$$*
3023F	Spirometry results documented and reviewed	J40- J44.9	• Provider conducts office evaluation for a member with a chronic respiratory condition. • Provider documents and reviews spirometry results in the medical record.	$$*
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).	$$*

Eligible Providers must report appropriate office visit, diagnosis code(s), and Category II code.

Anthem's CPT Category II Codes for additional reimbursements can vary annually but are commonly somewhere between $15-$25. Subject to terms and conditions of participation .*

CPT Category II Code Additional Reimbursements (cont.)

CPT II code	Description	Diagnosis on claim	Criteria	Amount
0513F	For patients who have hypertension: elevated blood pressure plan of care	I10 – I16--	• Provider conducts office evaluation for a member with hypertension or hypertensive diseases. • Provider completes and documents elevated blood pressure plan of care.	$$*
3011F	Lipid panel results documented and reviewed	I25.--	• Provider conducts office evaluation. • Provider documents and reviews lipid panel results in the medical record.	$$*
2014F	Mental status assessed (normal/mildly impaired/severely impaired) (CAP) 1	F90.0 – F90.9	• Provider conducts office evaluation for a member with ADD or ADHD. • Provider completes and documents mental status assessment.	$$*

Eligible Providers must report appropriate office visit, diagnosis code(s), and Category II code.

Anthem's CPT Category II Codes for additional reimbursements can vary annually but are commonly somewhere between $15-$25. Subject to terms and conditions of participation .*

CPT Category II Code Additional Reimbursements (cont.)

CPT II Code	Description	Diagnosis on claim	Criteria	Amount
3085F	Suicide risk assessed (MDD)1.	F32.0-F33.9	• Provider conducts office evaluation for a member with major depressive disorder. • Provider completes and documents assessment of suicide risk.	$$*
3044F	For patients who have diabetes: most recent HbA1c less than 7.	E08.00-E13.9	• Provider conducts office evaluation for a member with diabetes mellitus (any type). • Care provider completes and documents hemoglobin A1c results when less than 7.	$$*
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 greater than 9.	$$*

Eligible Providers must report appropriate office visit, diagnosis code(s), and Category II code.

Anthem's CPT Category II Codes for additional reimbursements can vary annually but are commonly somewhere between $15-$25. Subject to terms and conditions of participation .*

CPT Category II Code Additional Reimbursements (cont.)

CPT II code	Description	Diagnosis on claim	Criteria	Amount
3051F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0% (DM)	E08.00-E13.9	• Provider conducts office evaluation for a member with diabetes mellitus (any type). • Provider completes and documents hemoglobin A1C results 7 to 8.	$$*
3052F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0% (DM)	E08.00-E13.9	• Provider conducts office evaluation for a member with diabetes mellitus (any type). • Provider completes and documents hemoglobin A1c results when 8 to 9.	$$*
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 an HIV/AIDS-related diagnosis. • Provider completes and documents CD4+ cell count or CD4+ cell percentage in the medical record.	$$*

Eligible Providers must report appropriate office visit, diagnosis code(s), and Category II code.

Anthem's CPT Category II Codes for additional reimbursements can vary annually but are commonly somewhere between $15-$25. Subject to terms and conditions of participation .*

Q&A

Resources

Resources

1. CPT 2025, AMA
2. Alphabetical Clinical Topics Listing. AMA: [ama-assn¸org/system/files/2020-01/cpt-cat2-codes-alpha-listing-clinical-topics¸pdf]
3. ICD-10-CM 2025, Optum
4. Coding Clinic, AHA
5. NCQA, HEDIS®, and performance measurement: [ncqa¸org/hedis]

Providers who are contracted with Anthem Blue Cross and Blue Shield to serve Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect, and Indiana PathWays for Aging through an accountable care organization (ACO), participating medical group (PMG) or Independent Physician Association (IPA) are to follow guidelines and practices of the group. This includes but is not limited to authorization, covered benefits and services, and claims submittal. If you have questions, please contact your group administrator or your Anthem network representative.

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