

CPT II Code Reimbursement Guidelines – Effective October 1, 2024

AmeriHealth Caritas Pennsylvania (PA) and AmeriHealth Caritas PA Community HealthChoices continue our commitment to improving outcomes in several key HEDIS® measures. To encourage your engagement in meeting this goal, reimbursement will be made for the CPT II codes outlined in the chart below when submitted with the appropriate required diagnosis.

Reportable CPT II codes for Medication Reconciliation Post-Discharge	Description	Rate	Age Limit	Frequency
1111F	Discharge medications reconciled with the current medication list in outpatient medical record	\$25	18 and over	Payable within 30 days after every inpatient hospitalization discharge
<b>A diabetes related diagnosis is required for the following:</b>				
Reportable CPT II codes for HbA1c test	Description	Rate	Age Limit	Frequency
3044F	Most recent HbA1c level less than 7.0%	\$25	18 and over	Once per 90 days
3044F-U9	Most recent HbA1c level less than 7.0%	\$75	18 and over	Payable at this rate only in the 4 <sup>th</sup> Quarter
3046F	Most recent HbA1c level greater than 9.0%	\$10	18 and over	Once per 90 days
3051F	Most recent HbA1c level greater than or equal to 7.0% and less than 8.0%	\$25	18 and over	Once per 90 days
3051F-U9	Most recent HbA1c level greater than or equal to 7.0% and less than 8.0%	\$75	18 and over	Payable at this rate only in the 4 <sup>th</sup> Quarter
3052F	Most recent HbA1c level greater than or equal to 8.0% and less than or equal to 9.0%	\$25	18 and over	Once per 90 days
3025F-U9	Most recent HbA1c level greater than or equal to 8.0% and less than or equal to 9.0%	\$75	18 and over	Payable at this rate only in the 4 <sup>th</sup> Quarter
<b>A diabetes or hypertension related diagnosis is required for the following:</b>				
Reportable CPT II codes for Controlling High Blood Pressure <140/90 mm Hg	Description	Rate	Age limit	Frequency

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3074F	Most recent systolic blood pressure <130 mm Hg	\$25	18 and over	Once every 90 days
3074F-U9	Most recent systolic blood pressure <130 mm Hg	\$75	18 and over	Payable at this rate only in the 4th Quarter
3075F	Most recent systolic blood pressure 130-139 mm Hg	\$25	18 and over	Once every 90 days
3075F-U9	Most recent systolic blood pressure 130-139 mm Hg	\$75	18 and over	Payable at this rate only in the 4th Quarter
3077F	Most recent systolic blood pressure >=140 mm Hg	\$10	18 and over	Once every 90 days
3078F	Most recent diastolic blood pressure <80 mm Hg	\$25	18 and over	Once every 90 days
3078F-U9	Most recent diastolic blood pressure <80 mm Hg	\$75	18 and over	Payable at this rate only in the 4th Quarter
3079F	Most recent diastolic blood pressure 80-89 mm Hg	\$25	18 and over	Once every 90 days
3079F-U9	Most recent diastolic blood pressure 80-89 mm Hg	\$75	18 and over	Payable at this rate only in the 4th Quarter
3080F	Most recent diastolic blood pressure >=90 mm Hg	\$10	18 and over	Once every 90 days
<b>Reportable CPT II codes for members with diabetes for screening or retinopathy diagnosis</b>	<b>Description</b>	<b>Rate</b>	<b>Age Limit</b>	<b>Frequency</b>
3072F	Low risk for retinopathy (no evidence of retinopathy in prior year)	\$25	18 and over	Once per year
2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy	\$25	18 and over	Once per year
2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy	\$25	18 and over	Once per year
2024F	7 standard field stereoscopic photos	\$25	18 and over	Once per year
2025F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or	\$25	18 and over	Once per year

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	optometrist documented and reviewed; without evidence of retinopathy			
<b>2026F</b>	Eye imaging validated to match diagnosis from 7 standard field stereoscopic photos results documented and reviewed; with evidence of retinopathy	\$25	18 and over	Once per year
<b>2033F</b>	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy	\$25	18 and over	Once per year
<b>A pregnancy related diagnosis is required for the following:</b>				
<b>Reportable CPT II codes</b>	<b>Description</b>	<b>Rate</b>	<b>Age Limit</b>	<b>Frequency</b>
<b>0500F</b>	Initial prenatal care visit (report at first prenatal encounter with health care professional providing obstetrical care. Report also date of visit and, in a separate field, the date of the last menstrual period [LMP]) (Prenatal)	\$10	None	Once per pregnancy
<b>0502F</b>	Subsequent prenatal care visit (Prenatal) [Excludes: patients who are seen for a condition unrelated to pregnancy or prenatal care (e.g., an upper respiratory infection; patients seen for consultation only, not for continuing care)]	\$10	None	None
<b>0503F</b>	Postpartum care visit	\$10	None	Once per pregnancy, payable when date of service is between 7-84 days from the date of delivery
<b>3725F</b>	Screening for depression performed	\$10	None	Once per pregnancy

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