REIMBURSEMENT POLICY STATEMENT
Marketplace

Policy Name & Number	Date Effective
Preventive Evaluation and Management Services and Acute Care Visit on Same Date of Service-MP-PY-1388	04/01/2024

Policy Type
REIMBURSEMENT

Reimbursement Policies prepared by CareSource and its affiliates are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.
CareSource and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

This policy applies to the following Marketplace(s):				
☒ **Georgia**	☒ **Indiana**	☒ **Kentucky**	☒ **Ohio**	☒ **West Virginia**

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A. Subject

Preventive Evaluation and Management Services and Acute Care Visit on Same Date of Service

B. Background

Reimbursement policies are designed to assist providers when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and office staff are encouraged to use self-service channels to verify member eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code does not imply any right to reimbursement or guarantee claims payment.

CareSource will reimburse participating providers for medically necessary and preventive screening tests as required by federal statue through criteria based on recommendations from the U.S. Preventive Services Task Force (USPSTF).

C. Definitions

- **Preventive Services** – Exams and screenings that check for health problems with the intention to prevent any problem discovered from worsening and may include, but are not limited to, physical checkups, hearing, vision, and dental checks, nutritional screenings, mental health screenings, developmental screenings, and vaccinations/immunizations. Regularly scheduled visits to a primary care provider for preventive services are encouraged at every age but are especially important for children under the age of 18 years.

D. Policy

I. When any of the following preventive health service codes are billed on the same date of service as an acute care visit with the appropriate ICD-10 codes, CareSource will reimburse only the preventive service code at 100%. The acute care visit service codes will not be reimbursed unless billed with the appropriate modifier to identify separately identifiable services that were rendered by the same physician on the same date of service.

A. Preventive Health Service Codes
1. 99381-99387
2. 99391-99397

B. Acute Care Visit Codes
1. 99202-99205
2. 99211-99215

II. CareSource reserves the right to request documentation to support billing both services for all claims received. If documentation is requested, it must clearly delineate the problem-oriented history, exam, and decision making from those of the preventive service. Documentation must include the following:
   A. Key elements that support the additional preventive health services that were rendered.
   B. A separate history paragraph describing the chronic/acute condition that clearly supports additional work needed on the same date of service.
   C. A clear list in the assessment portion of the documentation of the acute/chronic conditions being managed at the time of the encounter. If there is a portion of the physical exam that is not routinely performed at the time of the preventive service, the provider should clearly identify those exam pieces (eg, “a thorough MS and neuro exam of the left hip performed as it relates to the HPI”).

E. State-Specific Information

NA

F. Conditions of Coverage

Reimbursement is dependent on, but not limited to, submitting Centers for Medicare and Medicaid Services (CMS) approved HCPCS and CPT codes along with appropriate modifiers. Please refer to the CMS fee schedule for appropriate codes.

G. Related Policies/Rules

Modifier 25 Reimbursement policy

H. Review/Revision History

	DATE	ACTION
Date Issued	09/14/2022	
Date Revised	01/17/2024	Annual Review; Approved at Committee.
Date Effective	04/01/2024	
Date Archived		

I. References

1. Coverage of Preventive Health Services, 26 C.F.R. § 54.9815-2713 (2023).
2. Draak K. Successfully bill a preventive service with a sick visit. American Academy Professional Coders. March 1, 2022. Accessed December 20, 2023. www.aapc.com