COMMON GROUND
HEALTHCARE COOPERATIVE

REIMBURSEMENT POLICY STATEMENT
Wisconsin Marketplace

Policy Name & Number	Date Effective
Preventive Evaluation and Management Services and Acute Care Visit on Same Date of Service-WI MP-PY-1491	01/01/2025

Policy Type

REIMBURSEMENT

Reimbursement Policies 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 agreements, 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 or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan 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 or Certificate of Coverage) for the service(s) referenced herein. Except as otherwise required by law, if there is a conflict between the Administrative Policy Statement and the plan contract, then the plan contract will be the controlling document used to make the determination. We may use reasonable discretion in interpreting and applying this policy to services provided in a particular case and we 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.

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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 Common Ground Healthcare Cooperative ("CGHC"). 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.

CGHC 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, CGHC 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. CGHC reserves the right to request documentation to support billing both services for all claims received. The physician or other qualified health care professional may need to indicate that in the process of performing a preventive/wellness health service, an abnormality was encountered, or a new or existing problem was addressed, and the problem or abnormal finding was significant enough to require additional work to perform the key components of a problem-focused (Acute Care) E/M service; the documentation must support the following:
   A. A separately identifiable service significant enough to require additional work to perform the key components of a problem-focused (Acute Care) E/M service.
   B. The Acute Care Service may be billed based on Time or Medical Decision Making (MDM).
      1. If billed based on time, documentation must reflect start/stop or total time spent. If time is used for selection, then the time spent on the preventive service cannot be counted toward the time of the work of the problem assessment because time spent cannot be counted twice. Please see the American Medical Association (AMA) Guidelines for Selecting Level of Service Based on Time.
      2. If billed based on MDM, documentation must support the level of service based on AMA Medical Decision-Making Guidelines.
      3. A medically appropriate history and physical exam, when performed.

E. Conditions of Coverage

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. 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.

F. Related Policies/Rules

Modifier 25 Reimbursement policy

G. Review/Revision History

	DATE	ACTION
Date Issued	08/14/2024	Approved at Committee
Date Revised		
Date Effective	01/01/2025	
Date Archived		

H. References

1. Coverage of Preventive Health Services, 26 C.F.R. § 54.9815-2713 (2023).
2. *CPT® Evaluation and Management (E/M) Code and Guideline Changes*. American Medical Association; 2023. Accessed July 14, 2024. www.ama-assn.org

The REIMBURSEMENT Policy Statement detailed above has received due consideration as defined in the REIMBURSEMENT Policy Statement Policy and is approved.

3. Evaluation and Management Services Guide. Centers for Medicare and Medicaid Services; 2023. MLN006764. Accessed July 14, 2024. www.cms.gov
4. *Evaluation and Management (E/M) Services Guideline*. Current Procedural Coding Expert. CPT®; 2023. Accessed June 28, 2024. www.encoderprofp.com