COMMERCIAL REIMBURSEMENT POLICY

Preventive Medicine Services

Active

Section: Evaluation and Management
Policy Number: 011
Effective Date: 06/03/24

Description

This policy addresses coding and reimbursement for preventive medicine evaluation and management services (E/M) submitted on a professional (837P) claim.

Definitions

Established Patient: An established patient is one who has received services from the provider or another provider of the same specialty who belongs to the same group practice, within the past three years.

New Patient: A new patient is one who has not received any professional services from the provider or another provider of the same specialty who belongs to the same group practice within the past three years.

Preventive E/M: A preventive visit reflects an age and gender appropriate history and examination, and includes counseling, anticipatory guidance, and risk factor reduction interventions.

Problem-oriented E/M: Per the American Medical Association (AMA), a problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.

Policy Statement

Preventive Medicine Service and Problem-Oriented Visit on the Same Date

When an abnormality or pre-existing problem is addressed on the same day as a preventive medicine visit, the appropriate office/outpatient code may be reimbursed in addition to the preventive medicine code.

If a problem or abnormality requires additional work beyond the components of a preventive visit, a problem-oriented E/M service may be billed with a -25 modifier. Appending modifier -25 indicates that a significant, separately identifiable E/M (above and beyond the preventive medicine E/M service) was provided by the same physician on the same day as a preventive medicine service or procedure.

Preventive Medicine Service and New Patient E/M Service

While the Current Procedural Terminology (CPT®) manual may not clearly state that a new patient problem-oriented E/M should not be billed with a new patient preventive exam, Blue Cross and Blue Shield of Minnesota (Blue Cross) will not reimburse two new

patient services at the same encounter. Because the patient already received professional services as part of the preventive E/M service, he or she no longer meets the "new patient" criteria. Any additional E/M service during the same visit would be considered established.

Preventive Medicine Service and Other Preventive Services on the Same Day
The preventive medicine E/M codes include counseling/anticipatory guidance/risk factor reduction interventions. Codes 99401-99412, 0403T, G0296, G0396, G0397, G0443, G0445-G0447, G0473, G2011, H0005, S0257, S0265, S9470, T1006, and T1027 will not be reimbursed when provided by the same physician or other qualified healthcare professional on the same day as a preventive medicine service.
Preventive medicine services include age and gender specific screening services represented by codes 96110, G0101, G0102, and Q0091. These services will not be reimbursed separately when provided by the same physician or other qualified healthcare professional on the same day as a preventive medicine service.

NOTE: Blue Cross, with exception of FEP, will reimburse code 99459, Pelvic examination, in addition to the preventive medicine service E/M code.

CPT instructs physicians or other qualified health care providers to use the appropriate E/M codes when providing medical nutrition therapy assessment/intervention. Codes 97802, 97803, 97804, G0270, and G0271 will not be reimbursed separately when provided by the same physician or other qualified healthcare professional on the same day as a preventive medicine service.

Auditory screening services for adults (age 22 and over) reported with codes 92551, 92567, and V5008 will not be reimbursed separately when provided by the same physician or other qualified healthcare professional on the same day as a preventive medicine service.

Visual screening services for adults (age 22 and over) reported with codes 99172 and 0333T will not be reimbursed separately when provided by the same physician or other qualified healthcare professional on the same day as a preventive medicine service.

Documentation Submission

Documentation must identify and describe the services performed. If a denial is appealed, this documentation must be submitted with the appeal.

Coverage

Eligible services will be subject to the subscriber benefits, the applicable fee schedule amount, and any coding edits.

The following applies to all claim submissions.

All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in the Provider

Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply subscriber coverage or provider reimbursement.

CPT/HCPCS Modifier: 25
ICD-10 Diagnosis: N/A
ICD-10 Procedure: N/A
CPT/HCPCS: Refer to Appendix
Revenue Codes: N/A

Resources

Current Procedural Terminology (CPT®)
Healthcare Common Procedure Coding System (HCPCS)

Policy History

10/18/2016	Initial Committee Approval
02/28/2023	Revised
11/28/2023	Revised
01/23/2024	Annual Policy Review
05/28/2024	Revised

Appendix

0333T	0403T								
92551	92567	96110	97802	97803	97804	99172	99381	99382	99383
99384	99385	99386	99387	99391	99392	99393	99394	99395	99396
99397	99401	99402	99403	99404	99406	99407	99408	99409	99411
99412	99459								
G0101	G0102	G0270	G0271	G0296	G0396	G0397	G0443	G0445	G0446
G0447	G0473	G2011							
H0005									
Q0091									
S0257	S0265	S9470							
T1006	T1027								
V5008									