Payment Policy: Problem Oriented Visits Billed with Preventative Visits (7 years old and older)

Reference Number: MO.PP.057
Product Types: ALL
Effective Date: 11/1/2017
Last Review Date:

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
Under modifier -25 correct coding principles, a patient may be seen by the physician for both a preventative evaluation and management (E&M) service and a problem-oriented E&M service during the same patient encounter. Duplicate payments occur when a provider is reimbursed for resources not directly consumed during the provision of a service.

The purpose of this policy is to define payment criteria for problem-oriented visits when billed with preventative visits in making payment decisions and administering benefits.

Application
Physicians and other qualified health professionals.

Policy Description
Modifier -25 represents a significant and separately identifiable E&M service by the same physician on the same day of the procedure or other service.

A physician or other qualified health professional may submit both a preventative E&M CPT® code and a problem oriented E&M CPT® code on the same date of service for the same patient. Once clinically validated (see ***CC.PP.013 "Clinical Validation of Modifier -25"***), if the problem-oriented E&M represents a significant and separately identifiable E&M procedure or service, the problem-oriented procedure code will be reimbursed at a reduced rate.

Reimbursement
Providers do not incur duplicate indirect expenses with the original E&M (preventative service) when there is a problem-oriented visit on the same date of service. For example, obtaining vital signs, scheduling the visits, staffing, lighting, and supplying the examination room costs are not incurred twice by the provider. Reimbursement should not be duplicated for these services.

The health plan conducts a clinical claims review of E&M coding combinations when a problem-oriented visit is billed with a preventative visit regardless if modifier -25 is present.

If the problem-oriented visit is appended with modifier -25 or without modifier -25 and clinical claims review supports a significant and separately identifiable E&M service; the health plan will reimburse the preventative medicine code plus 50 percent of the problem-oriented E&M code.

The applicable reimbursement methodology does to apply to children 6 years of age and younger.

Documentation Requirements
The following guidelines will be used to determine whether or not a significant and separately identifiable E&M service was used appropriately. If any one of the following conditions is met then reimbursement for the E/M service is recommended:

- If the E/M service is the first time the provider has seen the patient or evaluated a major condition
- A diagnosis on the claim indicates that a separate medical condition was treated in addition to the procedure that was performed
- The patient's condition is worsening as evidenced by diagnostic procedures being performed on or around the date of services
- If a provider bills supplies or equipment, on or around the same date, that are unrelated to the procedure performed but would have required an E/M service to determine the patient's need

Coding and Modifier Information
This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2016, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current 2017 manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT/HCPCS Code	Descriptor
99383	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years
99384	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)

CPT/HCPCS Code	Descriptor
99385	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years
99386	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years
99387	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older
99393	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years)
99394	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)
99395	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years
99396	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 40-64 years
99397	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 65 years and older
G0402	Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment

CPT/HCPCS Code	Descriptor
99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: - A problem focused history; - A problem focused examination; - Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: - An expanded problem focused history; - An expanded problem focused examination; - Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: - A detailed history; - A detailed examination; - Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: - A comprehensive history; - A comprehensive examination; - Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: - A comprehensive history; - A comprehensive examination; - Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.

CPT/HCPCS Code	Descriptor
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: - A problem focused history; - A problem focused examination; - Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: - An expanded problem focused history; - An expanded problem focused examination; - Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: - A detailed history; - A detailed examination; - Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: - A comprehensive history; - A comprehensive examination; - Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family
G0463	Hospital outpatient clinic visit for assessment and management of a patient

Modifier	Descriptor
25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service

Definitions

Preventative E&M Services

A preventative medicine E&M service is comprehensive in nature and includes a medical history and examination. These codes include counseling, anticipatory guidance, a discussion with the patient about risk factor reduction and provision or referral for immunizations and screening tests.

Problem-Oriented Evaluation and Management Service

An abnormality or a preexisting condition that is encountered during the process of a patient's preventative E&M service that is significant enough to require additional work by the physician to perform the key components of a problem-oriented E&M service.

Related Policies

Policy Name	Policy Number
Clinical Validation of Modifier 25	CC.PP.013

References

1. *Current Procedural Terminology (CPT)*®, 2017
2. *HCPCS Level II*, 2017

Revision History	
08/09/2017	Original Policy Draft
09/12/2017	MO version created to account for age limitation of 7years old and older
10/5/2017	Updated the policy to reflect proper age

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

 Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and

LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.