moda HEALTH	Reimbursement Policy Manual	Policy #:	RPM078
Policy Title:	**Preventive Medicine & Problem-Oriented E/M Visits, Same Day**		
Section:	Evaluation & Management Services	Subsection:	None

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:

Companies:	☐ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates ☒ Moda Health Plan ☐ Moda Assurance Company ☐ Summit Health Plan ☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS
Types of Business:	☐ All Types ☒ Commercial Group ☒ Commercial Individual ☒ Commercial Marketplace/Exchange ☒ Commercial Self-funded ☐ Medicaid ☐ Medicare Advantage ☒ Short Term ☐ Other: _____
States:	☒ All States ☐ Alaska ☐ Idaho ☐ Oregon ☐ Texas ☐ Washington
Claim forms:	☒ CMS1500 ☒ CMS1450/UB (or the electronic equivalent or successor forms)
Date:	☒ All dates ☐ Specific date(s): _____ ☐ Date of Service; For Facilities: ☐ n/a ☐ Facility admission ☐ Facility discharge ☐ Date of processing
Provider Contract Status:	☒ Contracted directly, any/all networks ☒ Contracted with a secondary network ☒ Out of Network

Originally Effective:	5/1/2023	Initially Published:	2/8/2023
Last Updated:	1/8/2025	Last Reviewed:	1/8/2025
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No			
Last Update Effective Date for Texas: 1/8/2025			

Reimbursement Guidelines

A. General Policy Statement

When a preventive medicine visit and a problem-oriented Evaluation and Management (E/M) visit are reported on the same day for the same patient by the same provider, the reimbursement for the problem-oriented visit will be reduced.

B. Requirements for Reporting Both Visit Codes

1. A preventive medicine visit and a problem-oriented E/M visit may be reported together only when, in the process of performing the preventive medicine E/M service:
   a. An abnormality or preexisting problem is addressed, and,
   b. The problem is significant enough to require additional work to perform the key components of an E/M service. (AMA[1, 2, 3])
2. Modifier 25 needs to be added to the problem-oriented E/M visit procedure code.[1, 2, 3]
3. The medical record documentation must support that a significant, separately identifiable E/M service was provided on the same day as the preventive medicine service.
4. Note, some problem-oriented E/M visit procedure codes are not expected to be reported in combination with a preventive medicine E/M visit. This is because the nature of the two services dictate that they would not be performed together. Thus, the combination of a preventive medicine visit with these E/M codes creates a contradiction. For example:

a. Inpatient or observation E/M visits – Preventive medicine visits are routine services that would not take place in an inpatient or observation setting when the member is undergoing active care for a condition sufficiently serious to require admission to observation or inpatient care.
b. Emergency department visits -- Preventive medicine visits are routine services that would not take place in an emergency department setting.
c. Consultations – In both the outpatient or inpatient settings, specialists who perform consultations to help diagnose or treat a problem would not be expected to also perform a preventive medicine visit, which is normally performed by the member's primary physician.

C. Requirements for Reporting Both Services

A problem-oriented E/M service with modifier 25 appended may not be reported for the following situations. They do not involve significant additional time or work to perform the key components to address, and so they are considered included in the preventive medicine visit and its reimbursement:

1. An insignificant or trivial problem or abnormality encountered during the preventive E/M service.[1, 2, 3, 4]

   Example:
   During a gynecological exam, a member mentions she is having hot flashes, and the provider orders blood work to check hormone level.

2. Updating or refilling prescriptions for a preexisting condition or problem.[1, 2, 3,4]

   Example:
   A member with a history of hypertension comes in for a routine physical. The provider makes a brief mention of the hypertension and refills the patient's prescription.

D. Fee Adjustments

When a preventive medicine visit and a problem-oriented E/M visit with modifier 25 appended are billed together:

1. The preventive medicine service will be reimbursed at 100% of the allowance for the procedure code.
2. The problem-oriented E/M service (with modifier 25 appended) will be reimbursed at 50% of the allowance for the procedure code.
3. Rationale: The fee reduction on the problem-oriented visit is due to the shared resources of the overlapping services (e.g., practice expense) already being considered in the reimbursement of the preventive service.

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation	Definition
AMA	American Medical Association
CCI	Correct Coding Initiative (see "NCCI")
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology

Acronym or Abbreviation	Definition
DRG	Diagnosis Related Group (also known as/see also MS DRG)
E/M E&M E & M	Evaluation and Management (Abbreviated as "E/M" in CPT book guidelines, sometimes also abbreviated as "E&M" or "E & M" in some CPT Assistant articles and by other sources.)
HCPCS	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	Health Insurance Portability and Accountability Act
MPFS	Medicare Physician Fee Schedule
MS DRG	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	National Correct Coding Initiative (aka "CCI")
RPM	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
RVU	Relative Value Unit(s)
UB	Uniform Bill

Definition of Terms

Term	Definition
Evaluation & Management (E/M) Service	A clinical service performed by an individual whose licensure includes the ability to assess a patient's health and symptoms, examine the patient, order any needed tests or procedures, review available data and information (e.g., test results), apply medical decision-making skills, establish a diagnosis, assess the status of their condition(s), select a management option, and order needed drugs, therapies, or further treatment. (Note: in general, the scope of license requirement limits this service to physicians (MD, DO, DN), Nurse Practitioner, Clinical Nurse Specialist, Physician Assistant, or a Nurse Midwife.)
Practice Expense	The costs associated with the direct and indirect practice resources associated with operating an office and furnishing medical services. Includes rent/mortgage, utilities, office supplies, clinical equipment and supplies, staffing expenses, etc. Practice expense is one component of the RVU assigned to a procedure code on the Medicare Physician Fee Schedule (MPFS). For more information about practice expense, see References & Resources[5, 6, 7, 8,9]
Preventive Medicine Visit	A preventive medicine visit is a specific category of E/M service that is an "annual physical" or routine comprehensive preventive medicine examination. The service includes an age-appropriate history and examination, family and social history, assessment of risk factors, routine maintenance of ongoing prescriptions and some existing conditions, and counseling/anticipatory guidance/risk factor reduction interventions.[2, 4]
Problem-Oriented E/M Visit	An E/M service focused on a chief complaint or current illness/problem which is addressed or resolved. The service includes a medically appropriate history and physical examination. The level of service is determined and selected based upon the extent of medical decision-making (MDM) or time spent. ("Preventive Medicine Services," CPT Assistant, Winter 1994, p.21)

Term	Definition
Relative Value Units (RVUs)	Resource-based relative value units (RVUs) comprise the core of the Medicare Physician Fee Schedule (MPFS). CMS publishes quarterly updates to the MPFS on the CMS website. For more information about RVUs, see References & Resources[5, 6, 7, 8,9]

Procedure codes (CPT & HCPCS):

Preventive Medicine Service Procedure Codes:

Code	Code Description
99381	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; infant (age younger than 1 year)
99382	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; early childhood (age 1 through 4 years)
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)
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
99391	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; infant (age younger than 1 year)

Code	Code Description
99392	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; early childhood (age 1 through 4 years)
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

Problem-Oriented E/M Visit Procedure Codes:

Code	Code Description
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

Code	Code Description
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.
G0245	Initial physician evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) which must include: (1) the diagnosis of LOPS, (2) a patient history, (3) a physical examination that consists of at least the following elements: (a) visual inspection of the forefoot, hindfoot, and toe web spaces, (b) evaluation of a protective sensation, (c) evaluation of foot structure and biomechanics, (d) evaluation of vascular status and skin integrity, and (e) evaluation and recommendation of footwear, and (4) patient education
G0246	Follow-up physician evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include at least the following: (1) a patient history, (2) a physical examination that includes: (a) visual inspection of the forefoot, hindfoot, and toe web spaces, (b) evaluation of protective sensation, (c) evaluation of foot structure and biomechanics, (d) evaluation of vascular status and skin integrity, and (e) evaluation and recommendation of footwear, and (3) patient education
G0463	Hospital outpatient clinic visit for assessment and management of a patient

Modifier Definitions:

Modifier	Modifier Description & Definition
Modifier 25	**Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service:** It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see **Evaluation and Management Services Guidelines** for instructions on determining the level of E/M service.) The E/M service may be prompted by the symptoms or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same day. The circumstances may be reported by adding modifier 25 to the appropriate level of E/M service. **Note:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

"If an abnormality/ies is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service, and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate Office/Outpatient code 99201-99215 should also be reported. Modifier -25 should be added to the Office/Outpatient code to indicate that a significant, separately identifiable Evaluation and Management service was provided by the same physician on the same day as the preventive medicine service. An insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine evaluation and management service and which does not require additional work and the performance of the key components of a problem-oriented E/M service, should not be reported." [1]

"Reporting Preventive and Problem Oriented Visits

When a problem or abnormal finding is encountered and addressed during the same visit, one should consult the preventive medicine services guidelines for instructions on how to report these services when they are provided as part of the same visit.

If an abnormality is encountered or a preexisting problem addressed in the process of performing the preventive medicine E/M service, that is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate office/outpatient code (99201-99215) should be reported in addition to the appropriate code for the preventive E/M service. The problem or abnormality encountered must require additional work and the performance of the key components of a problem-oriented E/M service (preventive medicine and problem-oriented visit) in order for the two E/M services to be reported on the same day.

If a physician encounters an insignificant or trivial problem/abnormality, in the process of performing the preventive medicine E/M service, that does not require additional work and the performance of the key components of a problem-oriented E/M service, then this should not be reported separately." [3]

"Comprehensive History and Examination

The comprehensive history obtained as part of the preventive medicine E/M service is not problem-oriented, and does not involve a chief complaint or present illness. It does, however, include a comprehensive system review and comprehensive or interval past, family, and social history, as well as a comprehensive assessment/history of pertinent risk factors.

The comprehensive examination performed as part of the preventive medicine evaluation and management service is multisystem, but to what extent is based on the age of the patient and identified risk factors." [3]

"Preventive Medicine Services codes (99381-99397) are used to report the routine evaluation and management (E/M) of a patient, who is seeking routine preventive services. These codes report the preventive medicine E/M of infants, children, adolescents, and adults, and are a specific category of E/M codes. This category of codes includes subcategories for reporting the following:

- Initial preventive medicine E/M service for new patient visits (99381-99387)
- Periodic preventive medicine reevaluation and management services for established patient visits (99391-99397)" [4]

Cross References

A. "Moda Health Reimbursement Policy Overview." Moda Health Reimbursement Policy Manual, RPM001.

B. "Modifier 25 – Significant, Separately Identifiable E/M Service." Moda Health Reimbursement Policy Manual, RPM028.

C. "Gynecologic or Annual Women's Exam Visit & Use of Q0091 (Pap, Pelvic, & Breast Visit)." Moda Health Reimbursement Policy Manual, RPM044.

References & Resources

1. American Medical Association (AMA). "Preventive Medicine Services." *CPT Book, Professional Edition.* Chicago: AMA Press, 2023, p. 32.
2. American Medical Association (AMA). "Preventive Medicine Services." *CPT Assistant.* Winter 1994 issue, p. 21.
3. American Medical Association (AMA). "A Review of Preventive Medicine Services." *CPT Assistant.* August 1997 issue, p. 1.
4. American Medical Association (AMA). "Preventive Medicine Services." *CPT Assistant.* July 2009 issue, p. 7.
5. CMS. "Medicare Physicians Fee Schedule (MPFS)." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 20.
6. CMS. "Method for Computing Fee Schedule Amount." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 20.1.
7. CMS. "Relative Value Units (RVUs)." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 20.2.

8. RAND Corporation. "Overview of the MPFS." Improving Practice Expense Data & Methods Town Hall – June 16, 2021 Read Ahead Materials, pp. 2-3. Last updated June 16, 2021; Last accessed January 26, 2022. Improving Data and Methods Related to Indirect Practice Expense in the Medicare Physician Fee Schedule: Read-ahead materials for the virtual Town Hall (cms.gov) .
9. Burgette, Lane F., et al. "Practice Expense Data Collection and Methodology: Phase II Final Report." Santa Monica, CA: RAND Corporation, 2021. Last accessed October 4, 2022. https://www.rand.org/pubs/research_reports/RRA1181-1.html .

Background Information

After a market analysis of payment policies for preventive and problem-oriented E/M visit services performed at the same time/same visit, upper management decided to implement payment reductions for this situation, as described in this policy.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
1/8/2025	Updated Scope, States for accuracy. Updated Cross References and formatting. No policy changes.
2/14/2024	Last reviewed date updated. No changes.
5/1/2023	Original Effective Date (with or without formal documentation). Policy based on decision by upper management, including Provider Networking and Claims.
2/8/2023	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication. (future effective date of 5/1/2023)