High-Level E/M with Preventive Medicine

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In a conflict, federal and state guidelines, as applicable, and the member's benefit plan document supersede the information in this policy. Also, to the extent of conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval. If there is a state exception, please refer to the state exception table listed below.

Policy Overview

Affected Codes: 99204, 99205, 99214, 99215 with 99385, 99386, 99387, 99395, 99396, 99397
This policy addresses the management of submitted codes when high-level evaluation and management (E/M) codes are submitted with preventive medicine services codes on the same day for the same patient by the same provider.

It is common for patients to have complaints and/or medical problems that need to be addressed during a preventive exam. Addressing minor problems is considered included in the payment for the preventive examination codes. If an addressed problem requires significant time and effort, an E/M code may be submitted with a preventive exam code (with a -25 modifier). If the patient's problems are of such magnitude that they require significant time and attention, the focus of the visit usually shifts from being a preventive visit to primarily a problem-focused visit. Both standard high-level evaluation and management (E/M) codes and preventive evaluation and management codes require a comprehensive history.

Submitting both services on the same day by the same provider means there is substantial overlap in time, history, examination, review of systems, and administrative services such as rooming, chart creation, and nursing services. The likelihood that minor problems managed at a preventive visit are coded at a higher level (99204/99214) than justified is greater than the likelihood that the time requirements and components were met to justify a higher-level E/M with a preventive exam code. Given the significant overlap between preventive exam code requirements and high-level E/M code requirements, if both are submitted together irrespective of modifier use, only the preventive exam code will be reimbursed.

Procedure Codes (CPT & HCPCS)

Code	Code Description
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.
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 moderate 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.
99214	Office or other outpatient visit for the evaluation and management of a 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 a established patient, which requires a medically appropriate history and/or examination and moderate 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.
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; 40-4 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
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.

Supplemental Information

State Exceptions

State	Exception

Documentation History

Type	Date	Action
Effective Date	01/01/2023	
Revised Date	08/16/2023	Verified Links
Revised Date	12/13/2023	Verified links and updated Template

References

1. AHIMA Work Group. “Taking Coding to the Next Level through Clinical Validation”. Journal of AHIMA 85, no. 1 [January

2014].

2. CMS. “Medicare Claims Processing Manual. Chapter 23 - Fee Schedule Administration and Coding Requirements.” Centers for Medicare and Medicaid Services (CMS). https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf
3. CMS. “Medicare Program Integrity Manual. Chapter 6 – Medicare Contractor Medical Review Guidelines for Specific Services.” Centers for Medicare and Medicaid Services (CMS). https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c06.pdf
4. CMS. “ICD-10-CM Official Guidelines for Coding and Reporting. FY 2021.” Centers for Medicare and Medicaid Services (CMS). https://www.cms.gov/files/document/2021-coding-guidelines-updated-12162020.pdf

***CODING DISCLAIMER**. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed*.

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