CareSource

REIMBURSEMENT POLICY STATEMENT
Marketplace

Policy Name & Number	Date Effective
E/M - Preventive and Acute Care Visit on Same Date of Service-MP-PY-1388	10/01/2026
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. Reimbursement Policies do not guarantee authorization or payment for services. Coverage and payment determinations are 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.

Please refer to the plan contract (e.g., Evidence of Coverage, Member Handbook) for the service(s) referenced herein. Except as otherwise required by law, if there is a conflict between the Reimbursement Policy and the plan contract and/or provider agreement, then the plan contract and/or provider agreement will be the controlling document used to make the determination. Reasonable discretion may be used in interpreting and applying this policy to services provided in a particular case and the policy may be modified at any time. Reimbursement policies may be superseded by federal and state laws and regulations, as applicable. In the case of a discrepancy between the Policy Statement's effective date and any applicable legal or regulatory requirement, the law or regulation will govern.

Coverage for mental health and substance use disorder (MH/SUD) benefits are provided at the same level as coverage for medical and surgical (M/S) benefits, as required by the Mental Health Parity and Addiction Equity Act (MHPAEA). MH/SUD benefits are not subject to limits or requirements that are more restrictive than those that apply to M/S benefits.

This policy applies to the following Marketplace(s):			
☐ **Georgia**	☐ **Indiana**	☒ **Ohio**	☒ **West Virginia**

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A. Subject
E/M Preventive and Acute Care Visit on Same Date of Service

B. Background
CareSource 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, CareSource 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. 99212-99215

II. CareSource reserves the right to request documentation to support billing both services for all claims received. The provider 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) evaluation and management (E/M) service. 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. 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. State-Specific Information

Ohio: For the purposes of this policy, "physician" and "provider" are defined as a physician or other health care provider of the same group reporting the same federal tax identification number.

F. 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.

The inclusion of a code does not imply any right to reimbursement or guarantee claims payment. 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.

G. Related Policies/Rules

Modifier 25 Reimbursement policy

H. Review/Revision History

	DATE	ACTION
Date Issued	09/14/2022	
Date Revised	01/17/2024 11/5/2025 03/11/26 07/01/26	Annual Review; Approved at Committee. Annual Review, Approved at Committee. Added D.II. and criteria under E. Approved at Committee. D.II. removed 'Other E/M' codes. Approved at Committee.
Date Effective	10/01/2026	
Date Archived		

I. References

1. Coverage of Preventive Health Services, 26 C.F.R. § 54.9815-2713 (2025).
2. *CPT® Evaluation and Management (E/M) Code and Guideline Changes*. American Medical Association; 2023. Accessed July 1, 2026. www.ama-assn.org
3. Evaluation and Management Services Guide. Centers for Medicare and Medicaid Services; 2024. MLN4824456. Accessed July 1, 2026. www.cms.gov