CareSource

REIMBURSEMENT POLICY STATEMENT
Ohio Medicaid

Policy Name & Number	Date Effective
E/M - Preventive and Acute Care Visit on Same Date of Service-OH MCD-PY-0007	11/01/2026

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 Reimbursement policies may be superseded by federal and state laws and regulations, as applicable.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.

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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 statute through criteria based on recommendations from the US 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 exam codes are billed on the same date of service as an acute care visit code with the appropriate ICD-10 codes, CareSource will reimburse only the preventive service code at 100%. The acute care visit services codes will not be reimbursed unless billed with the appropriate modifier to identify significant, 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 physician or other qualified health care 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. Conditions of Coverage

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.

Reimbursement is dependent on, but not limited to, submitting Ohio Medicaid approved HCPCS and CPT codes along with appropriate modifiers. Please refer to the Ohio Medicaid fee schedule for appropriate codes. 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.

F. Related Policies/Rules

Modifier 25 Reimbursement policy

G. Review/Revision History

	DATE	ACTION
Date Issued	11/17/2014	
Date Revised	11/17/2015	Revision includes payment policy legal language
	08/06/2019	Updated reimbursement rate from 50% to 100% for services that are rendered on the same date of service
	09/14/2022	Annual review: removed reference to archived policies, updated codes, added reference to Modifier 25 policy
	01/17/2024	Annual Review; Approved at Committee.
	11/05/2025	Annual review: D.III. documentation requirements revised, Approved at Committee.
	03/11/2026	D. I and II combined. Approved at Committee.
	07/01/2026	Removed 'Other' codes from D.I.
Date Effective	11/01/2026	
Date Archived		

H. References

1. Healthcheck, OHIO ADMIN. CODE 5160-1-14 (2025).
2. Preventive Services, OHIO ADMIN. CODE 5160-1-16 (2017).

Approved by ODM 08/04/2026