PAYMENT POLICY STATEMENT

Original Effective Date	Next Annual Review Date	Last Review / Revision Date
11/17/2014	11/17/2016	11/17/2015

Policy Name	Policy Number
Preventive Services and Sick Visit on Same Date of Service	**PY-0007**

Payment Policies prepared by CSMG Co. and its affiliates (including CareSource) 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 Payment Policies.

In addition to this Policy, payment of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CSMG Co. and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

A. SUBJECT

Preventive Services and Sick Visit on Same Date of Service

B. BACKGROUND

CareSource will reimburse participating providers as outlined in this policy when a preventive services visit or exam and a sick visit are performed on the same date of service for a CareSource member.

C. DEFINITIONS

- **Current Procedural Terminology ("CPT")** codes are numbers assigned to every task, medical procedure, and service a medical practitioner may provide to a patient. CPT codes are developed, maintained and updated annually, and copyrighted by the American Medical Association
- **Preventive Services** are exams and screenings to check for health problems, with the intention to prevent any problem discovered from becoming worse. Preventive services 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 21

D. POLICY

Preventive medicine exam codes 99381-99387 and 99391-99397 should be billed with the appropriate ICD-9 diagnosis codes (if before 10/1/2015) or ICD-10 diagnosis codes (after 10/1/2015). When a provider conducts a preventive medicine service or exam at the time of an acute care visit, Evaluation & Management CPT codes 99201-99205 or 99212-99215 may be submitted along with the appropriate ICD-9 or ICD-10 code, indicating the reason for the acute care visit, as a secondary diagnosis.

CareSource will reimburse the provider for the preventive medicine CPT code at 100% of the allowed amount, and will reimburse the provider for the acute care CPT code at 50% of the allowed amount. Please see the examples provided below.

Correct Billing Example (this example is pre-10/1/2015, using ICD-9)

Date of Service	Procedure	Diagnosis Code	Billed Amount	Allowed Amount
01/15/2014	99392	V20.0	$150.00	$52.97 (100%)
01/15/2014	99213	462	$100.00	$20.19 (50%)

Incorrect Billing Example (this example is pre-10/1/2015, using ICD-9)

Date of Service	Procedure	Diagnosis Code	Billed Amount	Allowed Amount
01/15/2014	99392	V20.0	$150.00	$52.97 (100%)
01/15/2014	99213	V20.0	$100.00	$0.00

For Medicare Plan members, reference the Applicable National Coverage Descriptions (NCD) and Local Coverage Descriptions (LCD).

CONDITIONS OF COVERAGE

HCPCS
CPT

AUTHORIZATION PERIOD

E. RELATED POLICIES/RULES

F. REVIEW/REVISION HISTORY

Date Issued: 11/17/2014
Date Reviewed: 11/17/2014, 11/17/2015
Date Revised: 11/17/2015 – Revision includes payment policy legal language.

G. REFERENCES

The Payment Policy Statement detailed above has received due consideration as defined in the Payment Policy Statement Policy and is approved.