Anthem Blue Cross and Blue Shield | Serving Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect, and Indiana PathWays for Aging

Reimbursement Policy	
Subject: **Preventive Medicine and Sick Visits on the Same Day**	
Policy Number: **G-05016**	Policy Section: **Evaluation and Management**
Last Approval Date: **05/22/2024**	Effective Date: **05/22/2024**

**** Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **providers.anthem.com/in**. ****

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Anthem covered the service for the Hoosier Healthwise, Healthy Indiana Plan, or Hoosier Care Connect member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Anthem strives to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

INBCBS-CD-RP-064296-24-CPN63595 September 2024

Policy

Anthem allows reimbursement for preventive medicine and sick visits on the same day unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

Reimbursement is based on the fee schedule or contracted/negotiated rate for the preventive medicine and the allowed sick visit under the following conditions:

- Modifier 25 must be billed with the applicable evaluation and management (E/M) code for the allowed sick visit. If Modifier 25 is not billed appropriately, the sick visit will be denied.
- Appropriate diagnosis codes must be billed for respective visits.

Federally qualified health centers (FQHCs) and rural health centers (RHCs), reimbursed other than through Anthem's fee schedule or state encounter rates, are not subject to this policy.

Related Coding
Standard correct coding applies

Policy History	
05/22/2024	Review approved and effective: no changes
05/26/2022	Review approved: updated policy template
07/13/2018	Review approved: removed *example* from language
07/19/2017	Review approved: updated policy template
02/01/2015	Initial approval and effective

References and Research Materials
This policy has been developed through consideration of the following: • CMS • State contract • State Medicaid

Definitions
General Reimbursement Policy Definitions

Related Policies and Materials
Code and Clinical Editing Guidelines
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
Modifier Usage
Modifiers 25 and 57: Evaluation and Management with Global Procedures