

Reimbursement Policy

Preventive Medicine and Sick Visits on the Same Day

Policy Number: **G-05016**

Policy Section: **Evaluation and Management**

Last Approval Date: **03/25/2026**

Effective Date: **08/01/2026**

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 <https://anthembluecross.com/ny/provider>.

Policy

The health plan 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 not be eligible for reimbursement.
- Appropriate diagnosis codes must be billed for respective visits.

For members age 22 or older, reimbursement is based on the fee schedule or contracted/negotiated rate for the preventive medicine visit and 50% of the fee schedule or contracted/negotiated rate for an allowed sick visit if the sick visit code is CPT® code 99214 or 99215.

To learn more about applying for health insurance, including Medicaid, Child Health Plus, Essential Plan, and Qualified Health Plans through the NY State of Health, The Official Health Plan Marketplace, visit nystateofhealth.ny.gov or call 855-355-5777.

Medicaid coverage provided by Anthem Blue Cross and Blue Shield HP, trade name of Anthem HP, LLC. Independent licensee of the Blue Cross Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

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

Related Coding

Standard correct coding applies.

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

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- State contract
- State Medicaid

Policy History

- **03/25/2026** - Review approved 03/25/2026 and 08/01/2026: updated policy to reimburse CPT® codes 99214 and 99215 on the same day as preventive medicine at 50% for members aged 22 or over
- **05/22/2024** - Review approved and effective: no changes
- **05/26/2022** - Review approved: updated policy template
- **05/22/2020** – Review approved
- **07/13/2018** - Review approved
- **09/22/2014** - Review approved: updated background section and policy template
- **12/31/2013** - Review approved: updated disclaimer 08/05/2013
- **05/21/2012** - Review approved: removed *allowable sick visits* language; updated policy template
- **11/21/2011** - Review approved: updated policy template, added state encounter rate language
- **01/25/2010** - Review approved 01/25/2010 and effective 04/01/2010: added limits on allowable sick visits; added FQHC and RHC language
- **03/09/2009** - Review approved: added clarification of appropriate diagnosis code requirement; removed medical criteria for minor illnesses and conditions; updated background section and policy template
- **05/30/2007** - Review approved: clarified claim denial without modifier 25

- **09/01/2005** - Initial approval and effective

Disclaimer

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

Ensure that you use proper billing and submission guidelines, including industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedural 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, we may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive 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.