Amerigroup RealSolutions in healthcare	**Reimbursement Policy**

Subject: Preventive Medicine and Sick Visits on the Same Day		
Effective Date: **02/01/2018**	Committee Approval Obtained: **07/19/17**	Section: **Evaluation and Management**

*****The most current version of the Reimbursement Policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to https://providers.amerigroup.com. Under Quick Tools, select Reimbursement Policies > Medicaid/Medicare. Note: State-specific exemptions may apply. Please refer to the Exemptions section below for specific exemptions based on your state.*****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup 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 CPT codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current Reimbursement Policies are not followed, Amerigroup may:

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

Amerigroup reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Amerigroup strives to minimize these variations.

Amerigroup reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

Policy	Amerigroup allows reimbursement for preventive medicine (i.e., well-child visits) 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 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.
Exemptions	• Reimbursement for sick visits on the same day billed with Modifier 25 is based on 50 percent of the applicable fee schedule or contracted/negotiated rate of the sick visit for the following markets: ○ Amerigroup Community Care in Tennessee • Amerigroup Community Care in Georgia limits the reimbursement of sick visits to brief and minor problem-focused Evaluation and Management procedures. • Amerigroup Community Care in Maryland hospital-based clinic facility claims are not subject to this policy. • Amerigroup Washington, Inc. does not limit the sick visit; if preventive medicine and sick visits are billed for the same day, reimbursement is allowed for any sick visit billed with Modifier 25, in addition to the preventive medicine visit. • Federally qualified health centers (FQHCs) and rural health centers (RHCs) reimbursed other than through their respective health plan's fee schedule or state encounter rates are not subject to this policy.
History	• Policy template updated 02/01/2018 • Biennial review approved 07/19/17: Georgia exemption updated; policy template updated ○ Effective 09/01/18: Tennessee exemption added • Update due to regulatory directive : Florida exemption removed effective 01/06/16 • Effective 12/31/15: Exited Florida Medicare • Review approved 09/22/14: Policy template updated • Effective 06/01/14: Ohio exemption removed; Exited Ohio • Effective 04/28/14: Georgia exemption added • Biennial review approved 12/31/13: Disclaimer updated 08/05/13; Texas exemption removed • Review approved 05/21/12: Policy language updated; policy template updated • Review approved 11/21/11 and effective 04/01/10: Policy language updated; Policy template updated; Texas exemption added • Review approved 01/25/10 and effective 04/01/10: Limits on allowable sick visits added; South Carolina exemption removed

	due to exit from market; Maryland, FQHC and RHC exemptions added • Review approved 07/31/09: • Review approved 03/09/09: Clarification of appropriate diagnosis code requirement added; medical criteria for minor illnesses and conditions removed; South Carolina exemption updated; Policy template updated • Review approved 05/30/07: Policy language updated; South Carolina exemption added • Initial review approved and effective 09/01/05
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State Medicaid • Amerigroup state contracts
Definitions	• **Reimbursement Policy Definitions**
Related Policies	• Code and Clinical Editing Guidelines • Modifier 25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service
Related Materials	• None