Priority Health	BILLING POLICY No. 111

HIGH-LEVEL E/M WITH PREVENTIVE EXAM

Date of origin: July 11, 2025	Review dates: 04/2026, 08/2026

POLICY OVERVIEW

This policy outlines guidelines for reporting high-level evaluation and management codes (99204/99205 and 99214/99215) on the same day as a preventive medicine service (99385, 99386, 99387, 99395, 99396, 99397) by the same provider for a member.

This policy provides guidelines for billing, coding, and documentation, ensuring claims are processed according to contractual agreements and industry standards.

POLICY SPECIFIC INFORMATION

Members may have medical complaints during preventive exams. Minor issues are covered under the preventive exam payment. However, if a problem requires substantial additional effort to manage, a problem focused on Evaluation and Management (E/M) code may be submitted in addition to the preventive exam code, using a 25 modifier.

Both problem focused and preventive E/M codes necessitate a thorough history. Billing these services on the same day, by the same provider, would allow payment for overlapping tasks. These overlapping tasks include, but are not limited to, time spent, history, examinations, system reviews, and administrative duties like rooming, chart creation, and nursing services. Because of these overlapping tasks, it is likely that problems managed during the preventive visit are coded at a higher level than is justified.

A member may have multiple medical conditions that are discussed during the preventive exam (CPE). A high-level problem focused on E/M requires a high level of medical decision making, which is generally not present when a stable member is seen for a CPE, even with a list of multiple stable medical conditions and medications. Discussing and refilling medications for stable conditions alone would not justify a high-level E/M visit.

Coding a separate high-level problem focused E/M in addition to a preventive visit based on time is unlikely to be supported. Please review the statement from February 2021 CTP Assistant: “if time is used for selection of a level of the office/outpatient E/M code, the time spent on the preventive service cannot be counted toward the time of the work of the problem assessment because time spent performing a service cannot be counted twice. The code for the problem-assessment portion of the encounter will likely be selected based on MDM”

Due to the considerable similarities between the requirements for preventive exam codes and high-level E/M codes, if both are submitted together, regardless of modifier use, only the preventive exam (CPE) code will be reimbursed. Medical records can be submitted via appeal if extenuating circumstances exist for a high-level Evaluation and Management code is supported in addition to the preventive medicine services.

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the provider. In addition, the provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

Reimbursement specifics

High-level E/M code (denied when reported with CPE)

Code	Description
99204	Office or other outpatient visits for the evaluation and management of a new patient, which require a medically appropriate history and/or examination and a 45derate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
99205	Office or other outpatient visits for the evaluation and management of a new patient, which require a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
99214	Office or other outpatient visits for the evaluation and management of an established patient, which require a medically appropriate history and/or examination and a moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99215	Office or other outpatient visits for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

Comprehensive Preventive Medicine Evaluation and Management (CPE)

Code	Description
99385	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years
99386	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-4 years
99387	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older
99395	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years
99396	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 40-64 years
99397	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 65 years and older

Modifiers

Modifier 25 is used to describe a "significant and separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service. Review our modifier 25 policy.

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Learn more about modifier use in our Provider Manual.

Place of service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information in our Provider Manual.

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. See our fee schedules (login required).

REFERENCES

- Coding and Billing for Preventive and Problem-Focused E/M Services in the Same Encounter (American Medical Association)
- CPT® Evaluation and Management (American Medical Association)

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies, and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim

payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
10/27/25	Added clarification regarding Medicare
04/23/26	Reviewed, no updates
08/24/2026	Updated references, added “Overview”