Billing and Reimbursement Guideline:	**Preventative Medicine**

Guideline Publication Date:	**September 1, 2010**

Key coding, documentation and reimbursement points include:

- Coding includes new versus established patient ranges (Codes 99381 through 99387 and 99391 through 99397).
- Code selection is based on the patient's age on the date of service.
- A routine or preventative diagnosis code appropriate for the patient age is required.
- Routine infant and childhood checks include routine assessment of growth and development, present health status, motor abilities, coordination skills, diet, sleep, and exercise habits, history and examination appropriate to the patient's age and development status.
- Laboratory, radiology services, and immunizations are not typically included in the preventative codes and may be separately itemized on the claim.
- Only one preventative visit per day is payable.
- If a preventative exam and a sick visit are billed on the same day, notes are required to review for potential separate payment. Supportive diagnosis coding is also required on the claim.
- Modifiers 25 or 59 should be used to indicate a separately identifiable service.
- This guideline applies to both CMS-1500 and UB-92 claim submissions.

Please refer to Neighborhood's provider website at http://www.nhpri.org for specific provisions by product line.

This guideline is not a guarantee of reimbursement. Plan coverage, eligibility and claim payment edit rules may apply.

Version History

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9/1/2013	Format change, minor edits