	Johns Hopkins Health Plans Reimbursement Policies Reimbursement Policies	<i>Policy Number</i>	RPC.050
		<i>Effective Date</i>	11/15/2025
		<i>Approval Date</i>	08/14/2025
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This document applies to the following Participating Organizations:

Johns Hopkins Advantage MD

Johns Hopkins Employer Health
Programs, Inc. (EHP)

Johns Hopkins Medical Services
Corporation (USFHP)

Priority Partners Managed Care
Organization, Inc.

Keywords: Evaluation and Management, G2211, Preventive Services, Screening Services, USPSTF

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I. ABOUT OUR REIMBURSEMENT POLICIES

Providers and suppliers are responsible for reviewing the Johns Hopkins Health Plans LLC (JHHP) Reimbursement Policy Reference Guide, which is applicable to this policy. All [JHHP Reimbursement Policies](#) are publicly accessible and provide general billing and coding guidance, along with the criteria and supporting information used in certain payment determinations, as detailed in the specific policy.


II. PURPOSE

The purpose of this policy is to provide foundational guidance on billing and reimbursement for preventive and screening services submitted on a CMS-1500, UB-04, or their electronic equivalents, by both participating and non-participating providers. This policy aligns with guidance from CMS and other authoritative sources to ensure appropriate reimbursement for covered preventive and screening services, as applicable.

Providers are responsible to review the “EXCEPTIONS & EXCLUSIONS” section below for specific plan guidance, as some guidelines in this policy may not be applicable to all health plans/products.

III. GENERAL BILLING GUIDELINES

- In accordance with CMS guidelines, all services billed to JHHP must be medically necessary and accurately documented in the patient’s medical record to indicate the services that were rendered to or ordered for our member.
- JHHP will reimburse for preventive and screening services in accordance with the Affordable Care Act (ACA) and CMS guidelines, unless an exception applies. The guidelines outlined above are subject to the following criteria (this list is not all-inclusive):

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- i. Medical necessity
 - ii. Age requirements
 - iii. Sex/gender
 - iv. Diagnosis reporting requirements
 - v. Place of service (POS)
 - vi. Type of Bill (TOB)
 - vii. NCCI edits
 - viii. Medically Unlikely Edits (MUE)
 - ix. Frequency limitations (e.g., once every 90 days, annually, etc.)
 - x. Physician scope of practice
 - xi. Prior Authorization
 - xii. Preventive services that receive a Grade A or B recommendation from USPSTF
 - xiii. Other plan requirements
3. Payment for certain services and screenings performed on the same day as a Preventive Medicine visit may be bundled into the reimbursement for the visit.
 4. When applicable, HCPCS add-on code G2211 may be separately payable when reported with an Outpatient/Office Evaluation and Management (O/O E/M) visit (codes 99202–99205, 99211–99215) appended with Modifier -25, performed by the same practitioner on the same day as an "approved preventive service" (identified in CMS Transmittal [13199](#), or its superseding guidance) furnished in the office or the appropriate outpatient setting. All services must be billed on the same claim to be considered for reimbursement.

IV. IMPROPER BILLING OF SERVICES

1. JHHP will utilize CMS NCCI program edits to identify items, procedures or services that should not be reported together, or separately, by the same provider/supplier to the same member on the same day. Services that are considered part of or integral to a preventive health care service, screening, or visit will not be separately reimbursed.
 - CMS owns the NCCI program and is responsible for all decisions regarding its contents.
2. If a claim is submitted with missing or invalid information, it may be returned to the submitter as unprocessable or denied.
3. When an age- or sex/gender-specific diagnosis or service/procedure code is reported for an age or sex/gender that falls outside the parameters defined in the code description, the service may be denied.
4. When there is not an "allowed preventive service" (as identified in CMS Transmittal [13199](#) or its superseding guidance) code present on the claim, G2211 will be denied when reported with an O/O E/M visit (99202–99205, 99211–99215) appended with modifier 25, on the same date of service.
 - Consistent with CMS guidance, add-on code G2211 cannot be reported in an O/O setting that is designed to provide episodic or acute care (i.e., Ambulatory Surgical Center, Urgent Care, Emergency Room).

V. EXCLUSIONS and EXEMPTIONS


1. Maryland Waiver Providers are required to bill services in accordance with the Health Services Cost Review Commission (HSCRC) rules and regulations and will be reimbursed under the HSCRC payment methodology.
2. **AdvantageMD:** JHHP processes and reimburses claims in accordance with CMS guidance. Please consult the authoritative guidance found on the CMS website and Medicare Manuals to obtain additional specific information on policy, benefits, and coverage not addressed in this reimbursement policy.
3. **Priority Partners:** JHHP processes and reimburses claims in accordance with the Maryland Medicaid Administration Professional Services Provider Manual and COMAR guidance. Please refer to MDH and COMAR for additional guidance not addressed in this policy.

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4. **USFHP:** JHHP will process and reimburse claims in accordance with TRICARE guidance. Please consult the authoritative guidance found in the TRICARE Manuals to obtain additional specific information on policy, benefits, and coverage not addressed in this reimbursement policy.
1. TRICARE excludes coverage and payment for:
 - FDA approved genetic tests that represent preventive services that are not recommended by U.S. Department of Health and Human Services (HHS).
 - Bone density studies for the routine screening of osteoporosis.
 - Other services as outlined in the current TRICARE Manuals.

VI. CODES, TERMS and DEFINITIONS


Term	Definition
Diagnostic Test	<p>A “Diagnostic test” is to establish the presence (or absence) of disease as a basis for treatment decisions for the individual patient.</p> <ul style="list-style-type: none"> • Usually performed after abnormal screening test • Services may begin as screening but become diagnostic • Patient is having health problems or is at high risk • Patient is symptomatic or has history of a disease/condition • Considered medical conditions, never considered preventive
Preventive Services	<p>Preventive Services is defined by CMS as routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems. Preventive care services may include, but is not limited to the following:</p> <ul style="list-style-type: none"> • Annual Wellness Visits and Physical Exams, for instance with a primary care doctor. • Health Screenings for blood pressure, cholesterol, blood sugar for diabetes, and various cancer screenings such as colonoscopies and mammograms. • Vaccinations and Immunizations for flu and pneumococcal disease. • Mental Health Screenings for conditions like depression and anxiety. • Risk Factor Assessments to identify lifestyle or genetic factors that may contribute to chronic diseases. • Counseling or lifestyle guidance on diet, exercise, managing stress, and other ways to improve overall health and well-being.

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Routine Physical Exam	As defined by CMS, a routine physical exam is an exam performed without relationship to treatment or diagnosis of a specific illness, symptom, complaint, or injury, including but not limited to, exams required by third parties (e.g., insurance companies, businesses, employer, or government agencies) and are generally not covered, unless an exception applies.
Same Group Physician and/or Other Qualified Health Care Professional	All physicians or other qualified health care professionals of the same group who report with the same Federal Tax Identification Number (TIN). Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician.
Screening Diagnosis	Screening diagnoses are typically reported for people who may not have any signs or symptoms of disease and/or when a definitive diagnosis has not been established. Refer to the ICD-10-CM Official Guidelines for the coding and reporting of a screening diagnosis.
Screening Services/Tests	Screening services/tests are used to detect an undiagnosed disease or medical condition where the patient has no signs, symptoms, laboratory evidence, radiological evidence or personal history of the disease.

CPT Code	Definition
99202-99499	Please refer to the AMA CPT book for all E/M CPT descriptors located in the Evaluation and Management section (99202-99499) as there are many code categories. Each category may have specific guidelines, or the codes may include specific details.
G2211	Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established).

Modifier	Definition
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25	Significant, separately identifiable Evaluation and Management (E/M) by the same physician or other qualified health care professional on the same day of the procedure or other service. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported.z
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VII. REFERENCES

This policy has been developed through consideration of the following:

- [ACIP Recommendations](#)
- [American Medical Association Preventive Services Coding Guides](#)
- [Bright Futures Recommendations](#)
- [CMS PFS Look-up Tool Overview](#)
- [CMS Regulations & Guidance](#)
- CMS Transmittal [R13199OTN](#)
- [COMAR- Maryland Department of Health- Maryland Medicaid Administration](#)
- CPT® Copyright American Medical Association. All rights reserved.
- [CY 2025 Physician Fee Schedule Final Rule](#),
- [JHHP Medical Policies](#)
- [JHHP Provider Manuals](#)
- [JHHP Reimbursement Policies](#)
- [ICD-10-CM Guidelines](#)
- [MDH- Transmittals \(maryland.gov\)](#)
- [Medicare Claims Processing Manual CH. 12](#)
- [Medicare Claims Processing Manual CH 18- Preventive and Screening Services](#)
- [MLN006559 – Medicare Preventive Services](#)
- [MLN Matters Number: 13473](#)
- [MLN906765 – Items & Services Not Covered Under Medicare](#)
- [NCCI Add-on Code Edits](#)
- [NCCI for Medicaid | CMS](#)
- [NCCI for Medicare | CMS](#)
- [TRICARE Manuals](#)
- [United States Preventive Services Taskforce](#)
- [Women’s Preventive Services Initiative Recommendation](#)

VIII. APPROVALS

Date	Review/Revision	Reason For Modification	Approved By
11/15/2025	New	New policy	Reimbursement, Authorization and Coding Committee (RAC)

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IX. POLICY NOTIFICATION CHART

	Yes/No	If yes in 2nd column, notify the following department of policy revisions:
Does this policy relate to NCQA?	No	Quality Improvement
Does this policy relate to Qlarant/MDH requirements?	No	Quality Improvement
Does this policy relate to DHA contractual requirements?	No	USFHP Administration