Priority Health	BILLING POLICY No. 094
PREVENTIVE SERVICES	
Date of origin: June 19, 2025	**Review dates: None yet recorded**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise specified
- Medicaid follows MDHHS unless otherwise specified

DEFINITION

Preventive services include routine health care such as screenings, check-ups and patient counseling to prevent illnesses, disease or other health problems, when the member has no symptoms.

MEDICAL POLICY

- Bone Density Studies (#91494)
- Breast Related Procedures (#91545)
- Colorectal Cancer Screening (#91547)

Find a listing of Priority Health medical policies in our Provider Manual.

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

See our Provider Manual for exceptions, age range criteria, frequencies and specific codes.

Billing and coding specifics

- Some preventive services are time-based. Consult the CPT rules and CPT lay description.
- Add-on codes should be reported with an appropriate primary code. Claims will be denied when the primary code is not reported.
- Some CPT codes are labeled as "separate procedures" in their CPT code description and should not be reported separately with a related procedure.
- Preventive medicine evaluations may be reported with a problem visit. The problem necessitates additional work of performing the key components of a problem-oriented visit outside of the requirements for the preventive medicine evaluation. A modifier indicating significant and separately identifiable will be required. Documentation must support significant, separately identifiable services, and medical records may be requested.
- Failure to accurately code preventive services with appropriate CPT, HCPCS, ICD-10 and modifiers may result in service processing outside of preventive guidelines. Review our preventive guidelines to accurately code for these preventive services.
- Certain preventive services may result in a diagnostic service being performed based on procedural findings, such as a colonoscopy or mammogram. In these instances, code according to preventive guidelines with applicable modifiers to represent services were initiated as preventive.

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.

Modifiers
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.

- **25**: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service
- **26**: Professional Component
- **33**: Preventive Services. Applies to Commercial plans only. Used on services that were performed for indications described under the Priority Health Preventative Care Guidelines.
- **52**: Reduced Services
- **59**: Distinct Procedural Service
- **TC**: Technical component
- **PT**: Colorectal cancer screening test; converted to diagnostic test or other procedure

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).

Resources

- Medicare NCCI policy manual (CMS)
- Preventive services coding guides (American Medical Association)
- 8 Tips Give You Straight Facts on Modifier 33 (AAPC Knowledge Center)
- Modifier PT fact sheet (WPS)

Related policies and Provider Manual pages

- Preventive care
- Coding for preventive services
- Advance care planning billing policy
- General coding billing policy
- Lab and pathology billing policy
- Medicare Annual Wellness Visit / Preventive Care Visits billing policy

DISCLAIMER
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, HCPCPS, 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 for 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 to 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