Priority Health	BILLING POLICY No. 091
CONCIERGE MEDICINE	
Date of origin: May 13, 2025	**Review dates: None yet recorded**

APPLIES TO

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

DEFINITION

Concierge care is when a provider or group of providers charges patients a membership fee before they will see or accept patients into their practice. Health care providers who offer concierge services often serve fewer patients than conventional practices to give patients more time during visits to ask questions and receive explanations regarding medical care. Some practices may offer additional services, such as same-day appointments, extended business hours, home visits and 24-hour emergency physician availability. After paying the membership fee, services or amenities may be provided that Priority Health doesn't cover. Priority Health doesn't cover membership fees for concierge care.

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

Providers who offer concierge care must still follow all Priority Health rules, including the following:

- Providers who accept assignment can't charge patients extra for covered services. This means the membership fee can't include additional charges for items or services that Priority Health usually covers, unless Priority Health doesn't pay for the item or service. In this situation, the provider must give the patient written notice listing the services and reasons why Priority Health may not pay.
- Providers who don't accept assignment can charge patients more than the approved amount for covered services, but there's a 15% limit called the "limiting charge."
- All providers (whether or not they accept assignment) can charge patients for items and services that Priority Health doesn't cover.

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.

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.

Resources

- Concierge Medicine Coverage (Medicare.gov)
- Concierge medicine policy (Blue Cross Blue Shield of Michigan)

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