| Priority Health | BILLING POLICY<br>No. 183 |
|---|---|
| SITE OF SERVICE | |
| **Date of origin: 03/16/2026** | **Review dates: None yet recorded** |

## APPLIES TO

- Commercial

## DEFINITION

Priority Health is advancing a site-of-care strategy to support affordability, access, and high-quality care by encouraging elective outpatient procedures to be performed in clinically appropriate, lower-acuity settings such as ambulatory surgery centers and freestanding facilities.

Delivering care in these settings often reduces total cost of care, supports provider performance in value-based arrangements, and may lower out of pocket costs for members while maintaining quality. Lower acuity settings may also improve access by reducing waiting times for certain elective procedures.

This approach promotes high-quality, safe, and cost-effective care by directing services to the most clinically appropriate and lowest-cost setting that is accessible to the member.

This policy outlines Priority Health's expectations regarding site-of-care selection and may inform future reimbursement, authorization, or review processes.

This policy applies to elective outpatient procedures. Emergency services and urgent care situations are outside the scope of this policy.

## POLICY SPECIFIC INFORMATION

Priority Health expects elective outpatient services to be performed in the most clinically appropriate and lowest-cost setting that is accessible to the member, provided that the alternative site:

- Meets quality and safety standards
- Is accessible within a reasonable geographic distance
- Aligns with where the member's physician has privileges

Lower acuity settings may include ambulatory surgery centers, physician offices, or other free-standing facilities where clinically appropriate.

Providers play an important role in helping members receive care in the most appropriate setting.

Providers should:

- Consider clinically appropriate lower-cost care settings when scheduling elective outpatient procedures
- Inform members when services may be performed in alternative settings
- Participate in care coordination efforts that support appropriate site of care selection

In the future, Priority Health may consider expanding this policy to include prior authorization requirements, retroactive review and other utilization management processes to further support site-of-care optimization.

## PROCEDURE CATEGORIES

The following categories represent examples of elective outpatient procedures that are commonly performed in lower-acuity settings when clinically appropriate:

| Category | Example procedures |
|---|---|
| Colonoscopy | 45385, 45380 and 45378 |
| Esophagogastroduodenoscopy (Egd) | 43239, 43249 |
| Pain Management - Paraspinal injections | 64635, 64493 |
| Sleep studies | 95810, 95811 |
| Pain Management - Spinal Neurostimulator | 63650, 64561 |
| Cystourethroscopy | 52000, 52287 |
| Biopsy Of Prostate | 55700 |
| Wound Debridement and Therapy | 11042 |
| Skin Lesion Removal, Benign | 11406, 11426 |
| Dialysis Circuit Imaging and Intervention | 36901, 36902 |
| Cataract procedures | 66984, 66982 |
| Arthroscopy Of Shoulder, Knee | 29827, 29828, 29881, 29880 |
| Hernia Repair, Inguinal | 49650, 49505, 49651 |
| Carpal Tunnel Surgery | 64721, 29848 |

## 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.

## 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.

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## CHANGE / REVIEW HISTORY

| Date | Revisions made |
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