Priority Health	BILLING POLICY No. 134
PREOPERATIVE SERVICE	
Date of origin: Aug. 2025	**Review dates: 7/2026**

DEFINITION

Evaluation and management (E/M), diagnostic testing, and risk assessment services performed before a scheduled surgery to determine a patient's fitness for the procedure. Our billing policy includes global surgical packages as well as other preoperative services for which separate billing is allowed. Priority Health aligns billing guidelines to CMS regarding preoperative services coverage.

FOR MEDICARE

For indications that do not meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Click here for additional details on PSOD.

POLICY SPECIFIC INFORMATION

Preoperative services coverage is determined by whether the services are reasonable and necessary for the diagnosis and treatment of the injury or illness. Routine preoperative care is a part of global surgical package and not separately covered.

Reimbursement specifics

Do not bill separately for preoperative evaluations performed by the operating surgeon within the global period unless the visit is unrelated.

Preoperative testing coverage

The preoperative examination is *payable* when:

- The services rendered are medically necessary and not performed solely for surgical clearance. The preoperative services are payable when patients have co-morbidities or other diagnoses that require additional evaluation by a professional
- When a pre-service determination from Priority Health, if necessary, finds the services covered

Not payable:

- When exam is "routine" vs. medically necessary
- When billed with codes that do not support medical necessity, such as Z01.810, Z01.811, Z01.812, Z01.818 (encounters for pre-procedural exams)

Preoperative testing coverage

Certain routine preoperative tests often do not meet the definition of "reasonable and necessary." Examples include:

- Electrocardiograms or radiological tests, when there is no medical indication for them
- Partial thromboplastin time (PTT) or prothrombin time (PT), when there are no signs or symptoms of bleeding or thrombotic abnormality or personal history of bleeding, thrombosis conditions associated with coagulopathy
- Serum iron studies, when there is no indication of anemia or recent autologous blood collections prior to surgery.

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 for 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. Please see our provider manual page for modifier use here.

The following modifiers can be used to support the preoperative examination services.
Modifier 57 to indicate that an E/M service resulted in the decision for surgery
Modifier 25 indicates that a separately identifiable E/M service is on the same day as a procedure.
Modifier 24 indicates an unrelated E/M service by the same physician during a post-operative period.

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. Click here for additional information.

Reimbursement rates
Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. Go to the fee schedules (login required).

REFERENCES

- Preoperative services, Medicare | Priority Health
- CMS Fee schedule for Physician's services**1707-B3.PDF**

DISCLAIMER
CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. 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 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 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
7/2026	No updates