Payment Policy | Preventive Services for Commercial Members

EFFECTIVE DATE: 01|01|2024
POLICY LAST REVIEWED: 09|28|2026

OVERVIEW

Preventive health services constitute primary healthcare that is aimed at the prevention of disease or disability. This includes services proven effective in avoiding the occurrence of a disease (primary prevention) and services proven effective in mitigating the consequences of an illness or condition (secondary prevention). Effective September 23, 2010 under the Patient Protection and Affordable Care Act (PPACA), coverage is provided for many preventive services without cost share to patients. This policy provides an overview of the preventive services for Commercial Products that are covered at no cost share to the member and the coding guidelines to ensure that the claim is processed at the correct member benefit.

Please Note: For Medicare Advantage members, see the separate policy for "Preventive Services for Medicare Advantage Plans."

MEDICAL CRITERIA

Not applicable

PRIOR AUTHORIZATION

Prior authorization is generally not required; exceptions are noted in this policy.

POLICY STATEMENT

Commercial Products

Preventive services as defined in this policy are covered at no cost share for members as applicable under a member's preventive health services benefits. To ensure correct claims processing, claims must be filed according to the guidelines that are found in this document:

Note: Updates to the policy requirements are made annually in June; however, all applicable CPT and HCPCS annual coding updates are reflected on the Preventive Services for Commercial grid for January.

Coverage follows recommendations by:

- United States Preventive Services Task Force (USPSTF) "A or B" Recommendations
- Advisory Committee of Immunization Practices (ACIP), Centers for Disease Control (CDC)
- Health Resources and Services Administration (HRSA) Guidelines for Preventive Care & Screenings for Infants, Children and Adolescents, including the Bright Futures/American Academy of Pediatrics recommendations.
- HRSA Women's Preventive Services Guidelines

Note: Coverage for newly recommended preventive health services is made no later than one year after the release date of the recommendation.

In some instances, plan policy may be more generous than the minimum requirement for healthcare reform.

Cost-Sharing Rules

Generally, cost-sharing may not be imposed on preventive health services. The Interim Final Regulations (IFR) issued by The Department of Health & Human Services provides cost-sharing rules for office visits, including those where both preventive health services and other services are provided. Those rules are as follows:

- **For in-network providers:** Whether plans may apply cost-sharing requirements to office visits during which preventive health services are administered depends on the way the services are billed.

- Where a preventive health service is billed separately from an office visit, a plan may impose cost-sharing on the office visit, but not on the preventive health service.

- Where a preventive health service is not billed separately from an office visit, a plan may not impose cost-sharing on the office visit. The IFR instructs plans to look to the primary intent of the visit. If the primary intent of the visit is to provide preventive health services, then cost-sharing may not be imposed. However, if the primary intent of the office visit is for services other than preventive health services, then cost-sharing may be imposed even if a preventive health service is provided during the visit (e.g., cost-sharing may be levied on an office visit for abdominal pain even if the patient receives a blood pressure screening because the primary intent was for services other than preventive health services).

- Effective January 1, 2022, Colorectal Cancer Screening will be covered as a preventive health service without cost sharing beginning at age 45. See the coding grid within the Coding Section for claims processing guidelines.

- If during a screening colonoscopy a polyp needs to be removed that service and other associated charges are paid without cost share.

- A screening colonoscopy performed after an incomplete screening colonoscopy is paid without cost share.

- For a screening *follow-up* colonoscopy, as set forth in the guidance provided by USPSTF, the follow-up colonoscopy will be considered as a preventive service when the follow-up colonoscopy is performed within six months of the initial screening colonoscopy. Once the follow-up claim is submitted and is applying member cost share you may contact the Call Center 401-274-4848 or Provider Relations at ProviderRelations@bcbsri.org to ensure the claim is identified and processed with no member cost share according to the preventive policy.

- **For out-of-network providers:** Plans may apply cost-sharing requirements to preventive health services that are delivered by an out-of-network provider; this includes cost-sharing attached to the office visit as well of the actual services provided.

- **For institutional providers:** Cost-sharing for facility charges when preventive and non-preventive services are performed at the same time: Cost-sharing will not be applied to a facility fee when one of the procedures is considered a preventive service. For example, when a screening colonoscopy and endoscopy are performed at the same time there will be no cost-sharing for the facility charges as the screening colonoscopy is a preventive service.

Where a plan provides coverage for preventive services in excess of those contained in the sources listed above, the plan may impose cost-sharing requirements on such services. Additionally, plans may impose cost-sharing on any treatment given as a result of the preventive health service (e.g., cholesterol medication when a cholesterol screening indicated high cholesterol). (45 C.F.R. § 147.130(a)(2)

Coding and Reimbursement Notes

- For local participating providers, some codes within this policy are covered services but providers will not be separately reimbursed for the services.
- Append modifier 33 (Preventive Services) to pathology services for a preventive colonoscopy and an injection filed with a contraceptive.
- Preventive Evaluation and Management office visit codes should not be filed on the same date of service as one of the preventive medicine counseling codes (99401- 99404). According to CPT instructions, preventive codes 99381 - 99397 include counseling, anticipatory guidance, and risk factor reduction interventions that are provided at the time of the initial or periodic comprehensive preventive medicine examination. Preventive Medicine counseling and risk factor reduction services (99401-99404) are separate face-to-face encounters for the purpose of promoting health and preventing illness or injury. Preventive medicine counseling and risk factor reduction interventions will vary with age and should address such issues as family issues, appropriate diet and exercise, substance use, high-risk behavior, avoidance of injury, and discussion of available and/or diagnostic results.

Service Limitations

- Service limitations are based on calendar/plan year depending on the member's contract.
- Two preventive visits per year for adults are allowed in the event the member changes PCPs during the year or to allow for a woman to have a preventive visit with her PCP and her GYN.

COVERAGE

Benefits may vary between groups/contracts. Please refer to the Subscriber Agreement for applicable preventive health services coverage/benefits.

BACKGROUND

Federal Healthcare Reform: Patient Protection and Affordable Care Act Preventive Health Services

On Tuesday, March 23, 2010, President Obama signed into law the "Patient Protection and Affordable Care Act" ("PPACA"), which had been passed by the House just days earlier. A reconciliation bill was signed by the President on March 30, 2010. The PPACA as amended by the reconciliation bill is collectively referred to as the "Act" in this summary. The Departments of Health & Human Services, Treasury, and Labor issued Interim Final Regulations ("IFR") implementing preventive health services on July 14, 2010. This summary provides an overview of the preventive health services provisions of the Act as clarified by the IFR.

Summary

For plan years beginning on or after September 23, 2010, individual and group health plans must provide coverage for preventive health services. Such coverage may not include any cost-sharing requirement if provided by in-network providers. Plans may, however, impose cost-sharing requirements on preventive health services administered by out-of-network providers. Cost-sharing includes copayments, deductibles, and coinsurance. (§ 1001 of PPACA; § 2713 of PHSA; 45 C.F.R. § 147.130)

Scope

Applicable to all individual health plans and group health plans, whether insured or self-funded. (§ 1001 of PPACA; § 2713(a) of PHSA; 45 C.F.R. § 147.130(a)

Preventive Health Services

The IFR defines preventive health services using the following resources as reference:

- Services that have an A or B rating in the current recommendations of the U.S. Preventative Services Task Force (USPSTF);
- Immunization recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

- Preventive care and screenings for infants, children, and adolescents as outlined in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- Preventive care and screenings for women as outlined in the comprehensive guidelines supported by the HRSA. (45 C.F.R. § 147.130(a))

Section V of the Preamble to the IFR includes lists of preventive health services that must be covered without cost-sharing when delivered by an in-network provider.

HHS will maintain a website containing the most current list of preventive health services, available at: http://www.HealthCare.gov/center/regulations/prevention.html

Nothing contained in the IFR prevents a plan from providing coverage for preventive services in addition to those set forth in the above-cited sources. In addition, plans may deny coverage for preventive services not contained in the four sources listed above. (45 C.F.R. § 147.130(a))

Changes to Preventive Health Services
Plans must provide coverage for newly recommended preventive health services no later than one year after the recommendation is made. Where a service is no longer recommended by one of the four sources referenced above, plans are not required to provide coverage for such service. However, pursuant to other PPACA provisions, plans must provide 60 days' notice to a member before ceasing to provide coverage for that item. (45 C.F.R. § 147.130(b)(2); see also § 2715(d)(4) of the PHSA)

Women's Health
On August 1, 2011, the Department of Health and Human Services (HHS) adopted additional *Guidelines for Women's Preventive Services* including

- Well-woman visits,
- Support for breast-feeding equipment and replacement supplies,
- Human papilloma virus screening,
- Contraception, and
- Domestic violence screening
- All Preventive health services for women-are covered without cost-sharing-effective August 2012.

The guidelines were recommended by the independent Institute of Medicine (IOM) and based on scientific evidence. Refer to the following document for a full list of services covered:

HRSA Women's Health

Interval of Preventive Health Services
If the recommendation or guideline listed above contains details as to the frequency, method, treatment, or setting for the provision of a service, coverage for that preventive health service must reflect such recommendations. If, however, the recommendation or guideline is silent as to the frequency and other details, the plan may use "reasonable medical management techniques to determine any coverage limitations." (IFR, Preamble § II; 45 C.F.R. § 147.130(a)(4))

Impact on State Mandates
To the extent that State law is more generous than the preventive services requirement, such mandates control. (§ 2724 of PHSA).

Grandfathering
Grandfathered plans are exempt from the preventive services requirements outlined herein.

Effective Date
Plan years beginning on or after September 23, 2010.

Preventive health services constitute primary healthcare that is aimed at the prevention of disease or disability. This includes services proven effective in avoiding the occurrence of a disease (primary prevention) and services proven effective in mitigating the consequences of an illness or condition (secondary prevention).

Coverage must follow recommendations by:

- United States Preventive Services Task Force "A or B" Recommendations:
  USPSTF A and B Recommendations
- Advisory Committee of Immunization Practices, Centers for Disease Control (CDC)
- HRSA Guidelines for Preventive Care & Screenings for Infants, Children and Adolescents, including the Bright Futures/American Academy of Pediatrics recommendations.

American Academy of Pediatrics Bright Futures periodicity schedule.pdf

Coverage for newly recommended preventive health services is made no later than one year after the release date of the recommendation.

CODING

Commercial Products

The Commercial Preventive Services listed in the following grid are in alphabetical order. The services are covered without copayment/coinsurance and deductibles. To ensure correct claims processing of these preventive services, claims must be filed as noted on the attached grid with any diagnosis noted on the grid in the primary position on the claim. This attached code grid reflects the most recent changes or new recommendations. Additional details for the services listed here can be found by accessing the documents contained in this policy. In some instances, plan policy may be more generous than the minimum requirement for healthcare reform.

Preventive Services for Commercial Code Grid

Please Note: Services not identified by the PPACA as preventive health services are covered in accordance with the applicable benefit section of the member's Subscriber Agreement. Cost share such as copayments, deductibles and coinsurance may apply.

Additional coding notes:

- Append modifier 33 (Preventive Services) to pathology services for a preventive colonoscopy and an injection filed with a contraceptive.
- Updates to the policy requirements are made annually in June; however, all applicable CPT and HCPCS annual coding updates are reflected on the Preventive Services for Commercial grid for January.
- Append modifier 33 (Preventive Services) to counseling services and ICD-10 Code Z30.09 to the claim when contraceptive counseling is the ONLY service performed during the encounter.
- Contraceptive Fertility Tracking Application: Member Claim Submission Form please click here.

RELATED POLICIES

Bone Mineral Density Studies
Breast Pumps
Colorectal Screening Mandate
Contraceptive Drugs and Devices Mandate
COVID-19 Vaccinations
Diabetes Self-Management Education Mandate
Intensive Behavioral Therapy (IBT) for Obesity
Lactation Consultations
Mammograms and Pap Smears Mandate
Maximum Units

Non-Reimbursable Health Service Codes
Nutritional Counseling/Medical Nutritional Therapy
Newborn Metabolic, Endocrine, and Hemoglobinopathy, and the Newborn Hearing Loss Screening Programs Mandate
Prostate Specific Antigen (PSA) Screening/Testing Mandate
Preventive Services for Medicare Advantage Plans
Smoking Cessation Mandate
Visual Screening for Children Aged 0-5 Years

PUBLISHED

Provider Update, August 2025
Provider Update, July 2024
Provider Update, December 2023
Provider Update, September 2023
Provider Update, July 2023
Provider Update, February 2023
Provider Update, August 2022
Provider Update, June 2022
Provider Update, October 2021
Provider Update, July 2021
Provider Update, August 2020

REFERENCES

1. Preventive Health Services, HealthCare.gov What are my preventive care benefits? http://www.HealthCare.gov/center/regulations/prevention.html.
2. U.S. Preventive Services Task Force USPSTF A and B Recommendations
3. Health Resources and Services Administration (HRSA) Women's Preventive Services Guidelines
4. American Academy of Family Physicians (AAFP) Summary of Recommendations for Clinical Preventive Services
5. American Academy of Pediatrics http://www.aap.org/en-us/Pages/Default.aspx
6. American Academy of Pediatrics, Bright Futures Recommendations for Preventive Pediatric Health Care
7. Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP):
https://www.cdc.gov/vaccines/hcp/acip-recs/index.html
8. Recommendation: Colorectal Cancer: Screening | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)

CLICK THE ENVELOPE ICON BELOW TO SUBMIT COMMENTS

This medical policy is made available to you for informational purposes only. It is not a guarantee of payment or a substitute for your medical judgment in the treatment of your patients. Benefits and eligibility are determined by the member's subscriber agreement or member certificate and/or the employer agreement, and those documents will supersede the provisions of this medical policy. For information on member-specific benefits, call the provider call center. If you provide services to a member which are determined to not be medically necessary (or in some cases medically necessary services which are non-covered benefits), you may not charge the member for the services unless you have informed the member and they have agreed in writing in advance to continue with the treatment at their own expense. Please refer to your participation agreement(s) for the applicable provisions. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. BCBSRI reserves the right to review and revise this policy for any reason and at any time, with or without notice. Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.