Payment Policy | Preventive Services for Commercial Members

EFFECTIVE DATE: 10/01/2010
POLICY LAST UPDATED: 06/17/2014

OVERVIEW

Preventive health services are primary health care 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, 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 BlueCHiP for Medicare members, see the separate policy for "Preventive Services for BlueCHiP for Medicare".

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 in the coding section.

Coverage follows recommendations by:

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

- **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 vary when preventive and non-preventive services are performed at the same time. Cost sharing will only be applied to the facility charges when the higher priced procedure is a non-preventive service. Cost sharing will not be applied to a facility fee when the higher priced procedure is considered a preventive service. For example, when a colonoscopy and endoscopy are performed at the same time there will be no cost sharing as the colonoscopy is a preventive service and is the higher priced procedure.

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)

Reimbursement Note
If a preventive evaluation and management (E&M) visit (99201-99215, 99381-99387, 99391-99397) is filed on the same date of service as one of the preventive counseling codes (99401-99404, 99411-99412), only one service will be paid.

Service limitations

- Service limitations are based on calendar/plan year depending on the member's contract.
- All limits are per calendar year, with the exception of items that are once per lifetime.

- The following evaluation and management (E&M) codes 99201-99215 with a preventive diagnosis (V70.0, V72.31, V20.0, V20.1, V20.31, V20.32) and the preventive medicine (well-child exam, well-adult exam, annual physical) codes 99381-99387, 99391-99397 are limited to 2 per year in any combination and aggregate. These codes appear in multiple categories. However, if any combination of these codes is filed more than 2 times per year, the additional visits will process under the member's standard benefit with applicable cost-sharing.

- The 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.

MEDICAL CRITERIA

None

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,
- 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.

Women's Preventive Services GuidelinesHF

~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).

~Grand fathering~

Grand fathered plans are exempt from the preventive services requirements outlined herein.

~Effective Date~

Plan years beginning on or after September 23, 2010.

Preventive health services are primary health care 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:

USPreventiveTaskFo
rceACA.pdf

– United States Preventive Services Task Force "A or B"
– 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.

BrightFutures
AmericanAcademy of

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

COVERAGE

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

CODING

Commercial products

The Commercial Preventive Services listed in following grid are in alphabetical order. The services are covered without copayment/coinsurance and deductibles. 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.

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RELATED POLICIES

Preventive Services for BlueCHiP for Medicare
Contraceptive Drugs and Devices Mandate
Prostate Specific Antigen (PSA) Screening/Testing Mandate
Newborn Metabolic, Endocrine, and Hemoglobinopathy, and the Newborn Hearing Loss Screening Programs Mandate
Visual Screening for Children Aged 0-5 Years
Colorectal Screening Mandate

PUBLISHED

Provider Update	Aug 2014
Provider Update	Sep 2012
Policy Update	Aug 2010

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 http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm
3. Health Resources and Services Administration (HRSA) Women's Preventive Services Guidelines http://www.hrsa.gov/womensguidelines/
4. American Academy of Family Physicians (AAFP) Summary of Recommendations for Clinical Preventive Services: http://www.aafp.org/dam/AAFP/documents/patient_care/clinical_recommendations/cps-recommendations.pdf
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: http://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf7. Centers for Disease Control and Prevention
7. (CDC) Advisory Committee on Immunization Practices (ACIP) http://www.cdc.gov/vaccines/acip/

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