Preventive Services

Reimbursement Policy ID: RPC.0088.FLDS

Recent review date: 09/2026

Reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. The health plan may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy addresses The health plan reimbursement criteria for preventive care services.

Exceptions

N/A

Reimbursement Guidelines

Preventive medicine evaluation and management (E/M)
The preventive medicine evaluation and management (E/M) services (i.e., Initial Preventive Physical exams and Annual Wellness Visits) include a history and examination appropriate for the patient's age and gender, provider recommendations and guidance related to personal risk factors, laboratory and other diagnostic procedures ordered, and treatment of minor problems or complaints that do not require additional work by the provider. Given the comprehensive nature of preventive medicine E/M services, few additional services are eligible for reimbursement to the same provider when performed on the same day for the same member.

Vaccine administration services
The health plan reimburses vaccinations administered during a preventive medicine visit at the allowable amount. Vaccines obtained through the Vaccines for Children (VFC) program are not eligible for reimbursement by the health plan. Providers should report each VFC vaccine product with units = 1 and billed charges = $0.00 to receive reimbursement for the corresponding vaccine administration.

Glaucoma screening services
Glaucoma screening service covered by Medicare will be considered for reimbursement when reported with an appropriate diagnosis code.

Prolonged services
Prolonged preventive services HCPCS codes are intended for use with preventive care E/M services and are reimbursed by The health plan when reported by the same provider on the same day as a preventive medicine E/M.

Preventive care for adults
The health plan considers age- and gender-appropriate preventive care services eligible for reimbursement. Examples include the following, but reimbursement may only be made for services covered by Medicare.

- Annual Well Visits (AWV);
- Initial Preventive Physical Exams (IPPE);
- Abdominal Aortic Aneurysm (AAA) screening;
- Bone density measurement;
- Cardiovascular disease screening;
- Screenings for breast, lung, cervical, prostate, and colorectal cancers;
- Screening for sexually transmitted infections (STIs);
- Glaucoma screening;
- Preventive gynecological care (e.g., pelvic exams, clinical breast exam, cervical cancer screening, Pap tests);
- Screening for hepatitis B, hepatitis C, tuberculosis;
- HIV screening and pre-exposure prophylaxis (PrEP);
- Individual risk factor assessments (e.g., cardiovascular disease, depression, diabetes, substance use disorders, depression, tobacco use, etc.);
- Diabetes management training;
- Medical nutrition therapy;
- Intensive Behavioral Therapy for cardiovascular disease and obesity;
- Vaccinations and vaccine administration.

Refer to CMS Medicare Learning Network (MLN) Educational Tool 006559: Medicare Preventive Services for covered procedure and diagnosis codes.

Preventive care for children
The health plan provides comprehensive preventive care for children. Providers should refer to Bright Futures/American Academy of Pediatrics preventive care recommendations and periodicity schedules for members aged 0 (zero) through 20 (twenty) years.

Definitions

Annual wellness visit (AWV)
An annual wellness visit is a review of an established patient's personalized prevention plan of services and includes a health risk assessment.

Evaluation and Management (E/M)
Evaluation and management (E/M) codes represent services by a physician (or other health care professional) in which the provider is either evaluating or managing a patient's health. Procedures such as diagnostic tests, radiology, surgery and other particular therapies are not considered evaluation and management services.

Initial preventive physical exam (IPPE)
An exam performed in the first 12 (twelve) months following a new patient's enrollment in Medicare that entails a review of the patient's medical and social health history and includes education about other preventive services.

Preventive services
Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare and Medicaid Services (CMS)
V. CMS Medicare Learning Network (MLN) Educational Tool 006559: *Medicare Preventive Services*.
VI. The National Correct Coding Initiative (NCCI)
VII. Bright Futures/American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care.

Attachments

N/A

Associated Policies

RPC.0009.FLDS Significant, Separately Identifiable Evaluation and Management Service (Modifier 25)
RPC.0021.FLDS New Patient Visit
RPC.0065.FLDS Vaccine
RPC.0066.FLDS Evaluation and Management
RPC.0094.FLDS Early and Periodic Screening, Diagnostics and Treatment (EPSDT)

Policy History

09/2026	Reimbursement Policy Committee Approval
07/2026	Biennial review

	• Removed the next review date • Replaced plan name with “the health plan”
06/2025	Minor updates to formatting and syntax
04/2025	Revised preamble
01/2025	Reimbursement Policy Committee Approval