Preventive Services versus Diagnostic and/or Medical Services

Last Updated: 11/12/2025 **Last Reviewed:** 11/12/2025 **Originally Effective:** 1/1/2000
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No
If yes, Texas Last Update Effective Date: n/a
Policy #: RPM037

Scope

Companies: Moda Partners, Inc. and its subsidiaries & affiliates (All)
Claim Forms: CMS1500 & CMS1450 (paper and electronic versions)
Provider Contract Status: Any
Claim Dates: All

Purpose of Policy

This policy is intended to help clarify how and why the same test or service may process differently depending upon the primary diagnosis code with which it is billed. The focus of this policy is on the differences between the Preventive and the Medical benefit categories.

Reimbursement Guidelines

A. Categories of diagnostic tests covered and not covered as routine/preventive

1. Our plans cover the preventive services mandated in the Patient Protection and Affordable Care Act (PPACA) at 100% (no cost-sharing responsibility to the member), when the member is seeing an in-network provider.

2. In addition to the mandated PPACA preventive services, we also cover a limited list of additional tests when billed with a routine, preventive, or screening diagnosis code. The codes and tests eligible for this additional screening coverage are determined by a Medical Director and are listed below.
   a. These tests are not eligible for the 100%, no-cost-share Affordable Care Act preventive benefit because they are not on the PPACA list of mandated preventive services.
   The tests will be covered (rather than denied), but all of the following tests are subject to the member's usual cost-sharing and deductible requirements, even when billed with a preventive diagnosis.
   For another view of this concept, see also the summary table shown under #4 below.
   b. The following CPT codes are covered as noted above when submitted with a routine/preventive/screening diagnosis as primary on the line item:
      - 80048 (Basic metabolic panel)
      - 80050 (General health panel)
      - 80051(Electrolyte panel)
      - 80053 (Comprehensive metabolic panel)
      - 80061 (Lipid panel)
      - 80076 (Hepatic function panel)
      - 81001 (Urinalysis, by dip stick or tablet reagent; automated, with microscopy)
      - 82248 (Bilirubin; direct)
      - 82270 (Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was provided 3 cards or single triple card for consecutive collection))
      - 82274 (Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations)
      - 82310 (Calcium; total)

- 82570 (Creatinine; other source)
- 82607 (Cyanocobalamin (Vitamin B-12))
- 82670 (Estradiol)
- 82746 (Folic acid; serum)
- 83036 (Hemoglobin; glycosylated (A1C))
- 83655 (Lead)
- 83721 (Lipoprotein, direct measurement; LDL cholesterol)
- 84075 (Phosphatase, alkaline)
- 84443 (Thyroid stimulating hormone (TSH))
- 85025 (Blood count; complete (CBC), automated)
- 85027 (Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count))
- 85652 (Sedimentation rate, erythrocyte; automated)
- Chlamydia screening for males
  (Note: female Chlamydia screening covered under PPACA @ 100%)
  - 87110 (Culture, chlamydia, any source)
  - 87270 (Infectious agent antigen detection by immunofluorescent technique; Chlamydia trachomatis)
  - 87490 (Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, direct probe technique)
  - 87491 (Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique)
  - 87492 (Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, quantification)
- Gonorrhea (gonorrhoeae) screening for males
  (Note: female Gonorrhea (gonorrhoeae) screening covered under PPACA @ 100%)
  - 87590 (Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, direct probe technique)
  - 87591 (Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, amplified probe technique)
  - 87592 (Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, quantification)
- 87480 (Infectious agent detection by nucleic acid (DNA or RNA); Candida species, direct probe technique)
- 87510 (Infectious agent detection by nucleic acid (DNA or RNA); Gardnerella vaginalis, direct probe technique)
- 87660 (Infectious agent detection by nucleic acid (DNA or RNA); Trichomonas vaginalis, direct probe technique)

3. Our Medical Necessity Criteria policy changed for Vitamin D testing, effective for dates of service June 1, 2024 and following. [C] Please carefully review that document for coverage requirements for:
   a. 0038U *Vitamin D, 25 hydroxy D2 and D3, by LCMS/MS, serum microsample, quantitative*.
   b. 82306 *Vitamin D, 25 hydroxy, includes fraction(s), if performed*.
   c. 82652 *Vitamin D, 1,25 dihydroxy, includes fraction(s), if performed*.

4. The remainder of lab procedure codes and diagnostic services are covered when billed with a medical diagnosis code (diagnosis indicating the member has symptoms or problems) but are considered non-covered and will be denied if billed with a routine/preventive diagnosis code.

5. Financial responsibility for non-covered screening lab tests:

a. **Provider Responsibility.**
Non-covered screening lab procedure codes will be denied to provider responsibility, as Moda Health believes the lack of a symptom or medical problem diagnosis code for these tests most often represents an oversight or billing error on the claim for which the member should not be financially liable.

b. **Member Responsibility.**
Effective for claims with date of service 02/01/2015 and after:
When these non-covered screening procedure codes are performed in the absence of any symptoms or problems because either you or the member believes one of these tests is needed for screening purposes, the denials may be processed *to* member responsibility when *all* of the following requirements are met:

i. The member signs and dates a waiver of liability form on or prior to the date of service.
   a) The services must be performed or initiated within 30-days of when the waiver of liability was signed.
   b) For an ongoing course of treatment and/or rental, the waiver is valid for no more than one year from the date of the member signature. A new waiver of liability would need to be obtained before billing additional services beyond one year.

ii. The procedure codes are billed with modifier GA or GX appended.
   a) Please be prepared to submit a copy of the waiver of liability form upon request should review become necessary (e.g. in case of a member appeal).
   b) If the original claim was submitted without modifier GA or GX and a corrected claim needs to be submitted, a copy of the waiver of liability form needs to accompany the corrected claim to support the change in coding from the original submitted claim.

6. To summarize categories # 1, 2, & 3 above, Moda Health covers routine/preventive testing as follows:

Covered at 100%: (if performed by in-network provider) (mandated, "category 1")	**Covered, not necessarily at 100% level. Deductible and usual member cost-sharing apply.** (not mandated, "category 2")	**Not covered for routine, preventive, or screening diagnosis codes:** (not covered, "category 3")
List of preventive services mandated in the Patient Protection and Affordable Care Act (PPACA).	80048, 80050, 80051, 80053, 80061, 80076, 81001, 82248, 82270, 82274, 82310, 82570, 82607, 82670, 82746, 83036, 83655, 83721, 84075, 84443, 85025, 85027, 85652, 87110, 87270, 87480, 87490, 87491, 87492, 87510, 87590, 87591, 87592, 87660, and 87810.	All other tests.

B. Determining the benefit category for processing:

1. Proper payment of preventive services is dependent upon claim submission using diagnosis and procedure codes which identify the services as preventive.

2. We categorize diagnosis codes as follows:
   a. "Personal history of…" diagnosis codes are considered **Medical**.
   b. "Family history of…" diagnosis codes are considered **Preventive**. (Please check to verify benefits.)
   c. "Screening" diagnosis codes are considered **Preventive.**
   d. "Routine" diagnosis codes are considered **Preventive.**
   For example: ICD-10-CM codes Z00.121, Z00.129, Z00.00, Z00.01

e. "Prophylactic" diagnosis codes are considered **Preventive**.
f. ICD-10 Z-codes:
ICD-10 diagnosis codes in chapter 21 (beginning with "Z") are not automatically considered routine/preventive; some will be considered medical diagnosis codes. The determination is based upon the code description, not merely in which section of the code set the diagnosis code is found.

C. Diagnostic Services Combined with a Preventive E/M Visit

If an abnormality is encountered or a problem existing prior to this visit is addressed in the process of performing the preventive medicine evaluation, CPT guidelines define the documentation and coding requirements for reporting an additional problem-oriented E/M service in combination with the preventive E/M service code.

Similarly, lab tests ordered at an annual preventive health visit (99381 – 99397) are not all automatically eligible for coverage at the 100%, no-cost-share Affordable Care Act preventive benefit, only those tests mandated by the PPACA. Additional tests ordered because of problems existing prior to this visit, abnormalities, or new problems encountered during the preventive visit are to be billed with the diagnosis code to describe the problem or reason the test was ordered, not the diagnosis code for the preventive visit. These additional tests are considered **Medical**, not Preventive.

D. Modifier 33 (Preventive Services)

Pre-procedural consultations prior to screening colonoscopies must be submitted with modifier 33 appended to ensure the member's PPACA no-cost-share benefits are accessed. Please refer to Reimbursement Policy # RPM046, "Colorectal Cancer Screening And Related Ancillary Services" [D] for detailed instructions and coding requirements.

For the remainder of PPACA-mandated preventive services, we have configured our system to properly apply the PPACA benefit for mandated tests regardless of the presence or absence of modifier 33.

E. Modifier PT (Colorectal cancer screening test; converted to diagnostic test or other procedure)

Certain ancillary services connected with colorectal cancer screening must be submitted with modifier PT appended to ensure the member's PPACA no-cost-share benefits are accessed. Please refer to Reimbursement Policy # RPM046, "Colorectal Cancer Screening And Related Ancillary Services" [D] for detailed instructions, coding requirements, and the list of procedure codes considered valid to use in combination with modifier PT.

Definitions

Acronyms/Abbreviations

Acronym	Definition
CBC	Complete Blood Count
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
DNA	Deoxyribonucleic acid
Hct	Hematocrit
Hgb	Hemaglobin
LDL	Low-density lipoprotein
PPACA	Patient Protection and Affordable Care Act
RBC	Red Blood Count
RNA	Ribonucleic acid

Acronym	Definition
RPM	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
TSH	Thyroid Stimulating Hormone
WBC	White Blood Count

Summary of Synonyms

Synonymous Term	Lay Description
Preventive = Screening = Routine benefits	*(no symptoms or problems)*
Prophylactic = Preventive	*(no symptoms or problems)*
Medical = Diagnostic or Therapeutic	*(symptoms or problems exist)*

Definition of Terms

Term	Definition
Diagnostic	The member is having symptoms or health problems. Tests and/or procedures are ordered to assist in determining the cause of the symptoms or health problems. Diagnostic tests are considered under the **Medical** benefit category. They are never considered Preventive Care. A problem already exists. Diagnostic services are performed "to obtain information to aid in the assessment of a medical condition or the identification of a disease…to determine the nature and severity of an ailment or injury." [4]
Medical	*Medical* services are those which are recommended by a doctor in order to diagnose symptoms, or treat or monitor a known medical condition, health problem, or disease. If it's testing that's being done, it might be called *diagnostic* testing.
Preventive Care Preventive Services	*Preventive,* in insurance terms, is synonymous with *routine* or *screening. Preventive,* in medical terms, is also synonymous with *prophylactic.* *Preventive* service(s) are provided to help [the member] avoid becoming sick in the first place. [1] *Preventive* tests and services are performed when the member has no signs or symptoms, no indications that they are not healthy. [*Preventive* Care is] a pattern of nursing and medical care that focuses on disease prevention and health maintenance. It includes early diagnosis of disease, discovery and identification of people at risk of development of specific problems, counseling, and other necessary intervention to avert a health problem. Screening tests, health education, and immunization programs are common examples of preventive care. [2]
Prophylactic	Guarding from or preventing the spread or occurrence of disease or infection. Tending to prevent or ward off. Preventive.[5] Synonyms: Preventive, Precautionary.[5]
Routine	*Routine,* in insurance terms, is synonymous with *screening* or *preventative.* Routine services are those things that doctors recommend to ordinary people, who are healthy as far as they know, in order to screen them for things that may not be causing symptoms yet. There are no known health problems, symptoms, chronic conditions, or injuries. Synonyms: Preventive, Screening

Term	Definition
Routine Monitoring	Routine monitoring of an existing health condition (such as diabetes or high cholesterol) is ***not*** a routine preventive service. In this case, the word "routine" does not refer to the health insurance benefit category, but rather it means that the testing or care is considered a medical standard of care for the patient's known problem or condition. Anytime a known condition or problem exists, the testing and care for that condition is never considered preventive; instead it is covered under the benefit category for that condition (e.g. Medical, Substance Use Disorder, Maternity, Infertility, etc.).
Screening Services	*Screening,* in insurance terms, is synonymous with *routine* or *preventative.* *Screening* is the testing for disease or disease precursors *in seemingly well individuals* so that early detection and treatment can be provided for those who test positive for the disease.[6] (emphasis added) Tests or procedures performed for a patient who does not have symptoms, abnormal findings, or any past history of the disease; used to detect an undiagnosed disease so that medical treatment can begin.[3]
Surveillance	Close and continuous observation or testing[5] Surveillance testing is considered **Medical** if it is being done to observe or monitor a known symptom or problem. The diagnosis code needs to indicate the problem or symptom which is being observed or monitored. Surveillance testing is considered **Preventive** if the patient is being observed because of risk factors (e.g., work environment) or due to family history.

Modifier Definitions

Modifier	Modifier Description & Definition
Modifier 33	**Preventive Services:** When the primary purpose of the service is the delivery of an evidence based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.
Modifier PT	Colorectal cancer screening test; converted to diagnostic test or other procedure
Modifier GA	Waiver of liability statement issued as required by payer policy, individual case
Modifier GX	Notice of liability issued, voluntary under payer policy

Related Policies

A. "Moda Health Reimbursement Policy Overview." Moda Health Reimbursement Policy Manual, RPM001.
B. Moda Health Plan Adult and Child Preventive Services summaries. To locate, go to www.modahealth.com and search for keyword "preventive."
(See: https://www.modahealth.com/reform/prev_svcs.shtml .)
C. "Vitamin D Testing." Moda Health Medical Necessity Criteria.
D. "Colorectal Cancer Screening And Related Ancillary Services." Moda Health Reimbursement Policy Manual, RPM046.
E. "Medical Records Documentation Standards." Moda Health Reimbursement Policy Manual, RPM039.
F. "Modifiers GA, GX, GY, and GZ." Moda Health Reimbursement Policy Manual, RPM036.

Resources

1. healthinsurance.org. http://www.medicareresources.org/glossary/, last accessed 10/31/2013.
2. Mosby's Medical Dictionary, 8th edition. © 2009, Elsevier. http://medical-dictionary.thefreedictionary.com/preventive+care, last accessed 10/31/2013.
3. http://highered.mcgraw-hill.com/sites/0073521914/student_view0/glossary.html#top, last accessed 10/31/2013.
4. CMS. "Diagnostic Services Defined." *Medicare Benefit Policy Manual* (Pub. 100-2). Chapter 6, § 20.4.1.
5. Merriam Webster. Online Medical Dictionary. http://www.merriam-webster.com .
6. Official ICD-10-CM Guidelines for Coding and Reporting, §I, C, 21, c, 5). *ICD-10-CM 2023.* Optum: 2022.
7. Official ICD-10-CM Guidelines for Coding and Reporting, §II. *ICD-10-CM 2017.* Optum: 2016.
8. Official ICD-10-CM Guidelines for Coding and Reporting, §IV, A. *ICD-10-CM 2017.* Optum: 2016.
9. Official ICD-10-CM Guidelines for Coding and Reporting, §IV, G. *ICD-10-CM 2017.* Optum: 2016.
10. Rodriguez, Denis, CPC. "Keep up with ASC Colonoscopy Clarifications." *AAPC Cutting Edge,* May 2013: pp. 22-25.

Policy History

Reminder: The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the current information by going to: https://www.modahealth.com/medical/policies_reimburse.shtml

Date	Summary of Update
11/12/2025	Coding Guidelines & Sources section retired; see Resources for information. Background Information section retired. History section info added to 9/14/2022 entry. Important Statement section retired; info in Related Policy RPM001. Acronyms updated. Minor rewording. No policy changes.
11/13/2024	Updated Vitamin D testing information. Related Policies updated. No policy changes.
9/11/2024	Formatting updates. No policy changes.
7/12/2023	Formatting updates. No policy changes.
9/14/2022	Policy History section added; entries prior to 2022 omitted (in archive storage). Related Policies updated. Formatting updates. No policy changes.
4/1/2014	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
1/1/2000	Original Effective Date (with or without formal documentation). Policy based on ICD-10-CM guidelines, healthcare industry definitions of key terminology.