Manual:	Reimbursement Policy		
Policy Title:	**Preventive Services versus Diagnostic and/or Medical Services**		
Section:	Preventive		
Subsection:	None		
Date of Origin:	1/1/2000	**Policy Number:**	RPM037
Last Updated:	10/13/2021	**Last Reviewed:**	10/13/2021

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.

Scope

This policy applies to all Commercial medical plans.

Reimbursement Guidelines

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

1. Moda Health covers 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, Moda Health also covers 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 Moda Health Medical Director and are listed below.

   NOTE: 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.

The following additional CPT codes will be 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)
- 81001 (Urinalysis, by dip stick or tablet reagent; automated, with microscopy)
- 82310 (Calcium; total)
- 83036 (Hemoglobin; glycosylated (A1C))
- 83655 (Lead)
- 84443 (Thyroid stimulating hormone (TSH))
- 85025 (Blood count; complete (CBC), automated)
- Chlamydia screening for males (87110, 87270, 87370, 87490, 87491, 87492, 87810)
  (Note: female Chlamydia screening covered under PPACA @ 100%)
- Gonorrhea (gonorrhoeae) screening for males (87590, 87591 and 87592)
  (Note: female Gonorrhea (gonorrhoeae) screening covered under PPACA @ 100%)

Effective for dates of service 12/1/2015 and forward, the following additional CPT codes will also be covered as noted above when submitted with a routine/preventive/screening diagnosis as primary on the line item:

- 82306 (Vitamin D; 25 hydroxy, includes fraction(s), if performed)
- 82607 (Cyanocobalamin (Vitamin B-12))
- 82670 (Estradiol)
- 82746 (Folic acid; serum)
- 83721 (Lipoprotein, direct measurement; LDL cholesterol)
- 85652 (Sedimentation rate, erythrocyte; automated)
- 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)
- 80076 (Hepatic function panel)
- 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)
- 82570 (Creatinine; other source)
- 84075 (Phosphatase, alkaline)
- 85027 (Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count))

3. 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.

   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.

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

<table>
<tr><th>Covered at 100%:
(if performed by in-network provider)
(mandated, “category 1”)</th><th>Covered, not necessarily at 100% level.
Deductible and usual member cost-sharing apply.
(not mandated, “category 2”)</th><th>Not covered for routine, preventive, or screening diagnosis codes:
(not covered, “category 3”)</th></tr>
<tr><td rowspan="3">List of preventive services mandated in the Patient Protection and Affordable Care Act (PPACA).</td><td>80048, 80050, 80051, 80053, 80061, 81001, 82310, 83036, 83655, 84443, 85025, 87110, 87270, 87370, 87490, 87491, 87492, 87810, 87590, 87591 and 87592.</td><td rowspan="3">All other tests.</td></tr>
<tr><td>For dates of service 12/1/2015 & forward, also covered, not necessarily at 100% level. Deductible and usual member cost-sharing apply.
(not mandated, “category 2”)</td></tr>
<tr><td>80076, 82248, 82270, 82274, 82306, 82570, 82607, 82670, 82746, 83721, 84075, 85027, 85652, 87480, 87510, and 87660.</td></tr>
</table>

B. Determining the benefit category for processing:

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

Moda Health categorizes diagnosis codes as follows:

“Personal history of…” diagnosis codes are considered **Medical**.

“Family history of…” diagnosis codes are considered **Preventive**. (Please check to verify benefits.)

“Screening” diagnosis codes are considered **Preventive.**

“Routine” diagnosis codes are considered **Preventive.**

For example:

ICD-10-CM codes Z00.121, Z00.129, Z00.00, Z00.01

“Prophylactic” diagnosis codes are considered **Preventive.**

NOTE:

<u>ICD-10 Z-codes:</u>

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 Moda Health Reimbursement Policy # RPM046, "Colorectal Cancer Screening And Related Ancillary Services" (Moda Health[B]) for detailed instructions and coding requirements.

For the remainder of PPACA-mandated preventive services, Moda Health has 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 Moda Health Reimbursement Policy # RPM046, "Colorectal Cancer Screening And Related Ancillary Services" (Moda Health[B]) for detailed instructions and coding requirements.

The following procedure codes are configured as valid to use in combination with modifier PT:

Code	Code Definition
00810	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum
45303	Proctosigmoidoscopy, rigid; with dilation (eg, balloon, guide wire, bougie)
45305	Proctosigmoidoscopy, rigid; with biopsy, single or multiple
45307	Proctosigmoidoscopy, rigid; with removal of foreign body
45308	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery
45309	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by snare technique
45315	Proctosigmoidoscopy, rigid; with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique

Code	Code Definition
45317	Proctosigmoidoscopy, rigid; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
45320	Proctosigmoidoscopy, rigid; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique (eg, laser)
45321	Proctosigmoidoscopy, rigid; with decompression of volvulus
45327	Proctosigmoidoscopy, rigid; with transendoscopic stent placement (includes predilation)
45331	Sigmoidoscopy, flexible; with biopsy, single or multiple
45332	Sigmoidoscopy, flexible; with removal of foreign body(s)
45333	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps
45334	Sigmoidoscopy, flexible; with control of bleeding, any method
45335	Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance
45337	Sigmoidoscopy, flexible; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed
45338	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45339	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
45340	Sigmoidoscopy, flexible; with transendoscopic balloon dilation
45341	Sigmoidoscopy, flexible; with endoscopic ultrasound examination
45342	Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)
45345	Sigmoidoscopy, flexible; with transendoscopic stent placement (includes predilation)
45346	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
45347	Sigmoidoscopy, flexible; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)
45349	Sigmoidoscopy, flexible; with endoscopic mucosal resection
45350	Sigmoidoscopy, flexible; with band ligation(s) (eg, hemorrhoids)
45355	Colonoscopy, rigid or flexible, transabdominal via colotomy, single or multiple
45355	Colonoscopy, rigid or flexible, transabdominal via colotomy, single or multiple
45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)
45379	Colonoscopy, flexible, proximal to splenic flexure; with removal of foreign body
45380	Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple
45380	Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple
45381	Colonoscopy, flexible, proximal to splenic flexure; with directed submucosal injection(s), any substance

Code	Code Definition
45382	Colonoscopy, flexible, proximal to splenic flexure; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
45383	Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique
45384	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
45385	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique
45386	Colonoscopy, flexible, proximal to splenic flexure; with dilation by balloon, 1 or more strictures
45387	Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement (includes predilation)
45387	Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement (includes predilation)
45388	Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)
45389	Colonoscopy, flexible; with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed)
45390	Colonoscopy, flexible; with endoscopic mucosal resection
45391	Colonoscopy, flexible, proximal to splenic flexure; with endoscopic ultrasound examination
45392	Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)
45393	Colonoscopy, flexible; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed
45398	Colonoscopy, flexible; with band ligation(s) (eg, hemorrhoids)
88305	Level IV - Surgical pathology, gross and microscopic examination
G0105	Colorectal cancer screening; colonoscopy on individual at high risk
G0120	Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema
G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation		**Definition**
AMA	=	American Medical Association
CBC	=	Complete Blood Count
CCI	=	Correct Coding Initiative (see “NCCI”)
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
DNA	=	Deoxyribonucleic acid
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
Hct	=	Hematocrit
Hgb	=	Hemaglobin
HIPAA	=	Health Insurance Portability and Accountability Act
LDL	=	Low-density lipoprotein
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	=	National Correct Coding Initiative (aka “CCI”)
PPACA	=	Patient Protection and Affordable Care Act
RBC	=	Red Blood Count
RNA	=	Ribonucleic acid
RPM	=	Reimbursement Policy Manual (e.g. in context of “RPM052” policy number, etc.)
TSH	=	Thyroid Stimulating Hormone
UB	=	Uniform Bill
WBC	=	White Blood Count

Summary of Synonyms:

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 of Term**
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." (CMS [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. (healthinsurance.org[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. (Mosby [2])
Prophylactic	Guarding from or preventing the spread or occurrence of disease or infection. Tending to prevent or ward off. Preventive. (Merriam Webste[5]) Synonyms: Preventive, Precautionary. (Merriam Webste[5])

Term	Definition of Term
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
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. (Optum[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. (McGraw-Hill [3])
Surveillance	Close and continuous observation or testing (Merriam Webster[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 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	Modifier Definition
Modifier GA	Waiver of liability statement issued as required by payer policy, individual case
Modifier GX	Notice of liability issued, voluntary under payer policy

Coding Guidelines

"Selection of Principle Diagnosis: The circumstances of inpatient admission always govern the selection of principle diagnosis. The principle diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."…In determining the principle diagnosis, coding conventions in the ICD-10-CM, the Tabular List and Alphabetical Index take precedence over these official [UHDDS] guidelines." (Optum[7])

"In the outpatient setting, the term first-listed diagnosis is used in lieu of principle diagnosis." (Optum[8])

"List first the ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided…In some cases the first-listed diagnosis may be a symptom when a diagnosis has not been established (confirmed) by the physician." (Optum[9])

Cross References

A. 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 .)

B. "Colorectal Cancer Screening And Related Ancillary Services." Moda Health Reimbursement Policy Manual, RPM046.

C. "Medical Records Documentation Standards." Moda Health Reimbursement Policy Manual, RPM039.

References & 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 2017.* Optum: 2016.

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.

Background Information

Sometimes, the exact same test or procedure can be covered by a member’s plan in two or more different ways, depending upon why it is being done. The primary (or first-listed) diagnosis code billed describes the chief reason why the service is being done, which can affect the processing and benefit level for the service. This is one of many reasons that it is critical to accurately select the diagnosis code when submitting claims for these services.

Member plans have different benefit levels and cost-sharing responsibilities for Preventive Services versus Medical Services. Although member plans do vary, medical services generally apply to the member’s deductible and generally have copays and/or coinsurance. Preventive services mandated by the Patient Protection and Affordable Care Act are covered at 100% (no cost-sharing).

Some lab tests and other procedures are eligible for either Preventive or Medical benefit categories, depending upon why they are done and the frequency performed. Other tests are only eligible for Medical benefits and are not covered at all under the Preventive benefit.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document Moda Health’s payment guidelines for those services covered by a member’s medical benefit plan. Healthcare providers (facilities, physicians and other professionals) are expected to exercise independent medical judgment in providing care to members. Moda Health Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Providers are expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB

Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between the Moda Health Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and Moda Health Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; Moda Health strives to minimize these variations.

***** 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 information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****