

Preventive Services

Reimbursement Policy ID: RPC.0088.2400

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

The health plan follows the South Carolina Department of Health and Human Services (SCDHHS) Medicaid guidelines for preventive medicine. SCDHHS uses the Bright Futures/American Academy of Pediatrics

preventive care recommendations and periodicity schedules for members aged 0 (zero) through 20 (twenty) years.

Preventive medicine evaluation and management (E/M)

The preventive medicine evaluation and management (E/M) services, (CPT codes 99381-99397; HCPCS codes G0438-G0439) 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.

Significant separately identifiable E/M

If a preexisting condition or abnormality that requires additional work beyond the components of a preventive visit (i.e., "well visit") is addressed during a preventive medicine service, reimbursement may be available for the appropriate problem-oriented E/M (i.e., "sick visit") reported on the same claim. The health plan will reimburse a sick visit on the same date of service as a preventive care service if it is associated to a problem-oriented diagnosis supported in the medical record.

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.

Visual function and acuity screening services

Visual function and acuity screening service (99172, 99173, 0333T) provided to the same member by the same provider on the same date of service as a preventive medicine E/M will be considered eligible for separate reimbursement.

Prolonged services

Prolonged services codes (CPT 99415-99418) are intended for use with problem-oriented E/M services and are not eligible for separate reimbursement by The health plan when reported by the same provider on the same day as a preventive medicine E/M.

Oral Health

Application of topical fluoride varnish by a physician or other qualified health care professional will be considered eligible for separate reimbursement.

Preventive services for adults

Preventive services are defined as any routine services or procedures performed in the absence of an illness or complaint(s). Examples may include some or all of the following, but reimbursement may only be made for services is a covered service by SCDHHS:

- Breast Cancer Screens (mammography) for women ages 40 to 74 years with a recommended frequency of one screening every 2 years;
- Abdominal Aortic Aneurysm (AAA) screenings for men aged 65 to 75 years with a history of smoking.
- Colorectal Cancer screening for adults between the ages of 50 and 75 years:
 - The mt-sDNA test (Cologuard) will be considered for reimbursement once every three years for asymptomatic, low average risk members, aged 45 to 75 years who:
 - Have not had any colorectal screening in the past, or

- Have had a negative colonoscopy at least seven years prior.
- The mt-sDNA test **is not reimbursable** for high-risk individuals who:
 - Have a personal history of colorectal cancer or adenomas.
 - Have ever had a positive result from another colorectal cancer screening .
 - Have been diagnosed with a condition associated with high risk for colorectal cancer such as IBD, chronic ulcerative colitis, or Crohn's disease; or
 - Have a family history of colorectal cancer, or certain hereditary syndromes.
- Lung Cancer screening for adults between the ages of 55 and 80 years who meet at least one of the following criteria:
 - Current smokers;
 - Past smokers with a smoking history of 30 or more packs per year;
 - Past smokers that have quit smoking within the last 15 years.
- Bone density measurement;
- Cardiovascular disease screening;
- Screenings for prostate cancers;
- Screening for sexually transmitted infections (STIs);
- Glaucoma screening;
- Preventive gynecological care (e.g., pelvic exams, clinical breast exam, cervical cancer screening, Pap tests);
- Screenings for hepatitis B, hepatitis C, and tuberculosis;
- HIV screening and pre-exposure prophylaxis (PrEP);
- Individual risk factor assessments (e.g., cardiovascular disease, depression, diabetes, substance use disorders, depression, etc.);
- Vaccinations and vaccine administration.
 - Providers must follow the Advisory Committee on Immunization Practices (ACIP) recommendations on vaccines for both children and adults.
 - For Family Planning Limited benefit members, refer to the Family Planning section of the DHHS Physician Services Provider Manual for immunization coverage information.

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.

Early and periodic screening, diagnostic, and treatment (EPSDT)

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under 21 (twenty-one) years of age who are enrolled in Medicaid. This program ensures that children and adolescents receive appropriate preventive, hearing, vision, dental, behavioral health, developmental, laboratory, and specialty services. Refer to South Carolina Medicaid guidelines for applicable procedure codes and requirements. (See RPC.0094.2400 Early and Periodic Screening, Diagnostics and Treatment (EPSDT) for additional information.)

Definitions

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.

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. The National Correct Coding Initiative (NCCI).
- VI. Applicable Department of Health and Human Services (SCDHHS).
- VII. Bright Futures/American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care

Attachments

N/A

Associated Policies

RPC.0021.2400 New Patient Visit

RPC.0065.2400 Vaccine

RPC.0066.2400 Evaluation and Management

RPC.0094.2400 Early and Periodic Screening, Diagnostics and Treatment (EPSDT)

Policy History

09/2026	Reimbursement Policy Committee Approval
07/2026	Biennial review <ul style="list-style-type: none">• Revised preamble• Replaced the plan name with “the health plan”
10/2025	Reimbursement Policy Committee Approval