



New CPT Modifier for Preventive Services

The implementation of health care reform regulations has begun with a significant change involving preventive services. The Patient Protection and Affordable Care Act (PPACA) requires all health care insurance plans to begin covering preventive services and immunizations without any cost-sharing, ie, they must provide first-dollar-coverage for certain specified preventive services. The timing of this being implemented is dependent on when health insurance plans renew or change. The regulations specify that plans cannot impose cost-sharing requirements, such as co-pays, coinsurance, or deductibles with respect to specified preventive services in which preventive services are billed separately. When these services are part of an office visit, the office visit may not have cost-sharing if the **primary** reason for the visit is to receive preventive services. However, cost-sharing is permitted for an office visit when the office visit and covered preventive services are billed separately, and the primary purpose of the office visit is *not* delivery of the covered preventive services.

In addition, insurance plans are permitted to impose cost-sharing (*or* choose not to provide coverage) for recommended preventive services if they are provided out-of-network. Not all services that some or many clinicians consider as preventive are included in the law. For preventive services not covered in the statute and regulations, plans are permitted to require cost-sharing. The new mandate may also affect payer coverage or payment policies for services listed in the Counseling Risk Factor Reduction and Behavior Change Intervention section of CPT (99401-99429).

In response to this PPACA requirement, CPT modifier 33 has been created to allow providers to identify to insurance payers and providers that the service was preventive under applicable laws, and that patient cost-sharing does not apply. This modifier assists in the identification of preventive services in payer-processing-systems to indicate where it is appropriate to waive the deductible associated with copay or

coinsurance and may be used when a service was initiated as a preventive service, which then resulted in a conversion to a therapeutic service. The most notable example of this is screening colonoscopy (code 45378), which results in a polypectomy (code 45383).

Note that Medicare has created HCPCS II codes for some services, and effective after January 1, 2011, and should be appended to codes representing the preventive services, unless the service is inherently preventive, eg, a screening mammography or immunization advised by the Advisory Committee on Immunization Practices (ACIP). If multiple preventive medicine services are provided on the same day, the modifier is appended to the codes for each preventive service rendered for the day.

The CPT modifier's descriptor has additional non-Affordable Care Act (ACA)-specific language for states or other mandates that have similar insurance benefit requirements for other services than those covered in the federal law. For example, if a state mandates first-dollar-coverage for PSA screening, the modifier would be appropriate to use for insureds with plans affected by the mandate. It is hoped that the modifier will create less reliance on combining complex procedures and diagnosis codes without diminishing the importance of correct diagnostic coding.

Modifier 33, Preventive Service: 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 appending **modifier 33 Preventive Service**, to the service. For separately reported services specifically identified as preventive, the modifier should not be used.

CPT modifier 33 is applicable for the identification of preventive services without cost-sharing in these four categories:

1. Services rated "A" or "B" by the US Preventive Services Task Force (USPSTF) (see Table 1) as posted annually on the Agency for Healthcare Research and Quality's Web site:
www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm;

2. Immunizations for routine use in children, adolescents, and adults as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for children as recommended by Bright Futures (American Academy of Pediatrics) and Newborn Testing (American College of Medical Genetics) as supported by the Health Resources and Services Administration; and
4. Preventive care and screenings provided for women (not included in the Task Force recommendations) in the comprehensive guidelines supported by the Health Resources and Services Administration.

Services with 'A' or 'B' ratings by the USPSTF are services that are recommended to be offered or provided. Services that are graded with an 'A' rating have been judged to have a high certainty that the net benefit is substantial. Services that are graded with a 'B' rating have been judged to have a high certainty of moderate to substantial net benefit.

A complete listing of the USPSTF-rated service categories with relevant CPT and HCPCS codes and grades is listed below. HCPCS codes should be used to describe services provided for Medicare and Medicaid beneficiaries. Services for patients covered by private insurance should be reported with CPT codes, when applicable.

US Preventive Services Task Force. *USPSTF A and B Recommendations*. August 2010. Available at: www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.

The following examples illustrate common situations involving preventive services and how they are handled.

- A 45-year-old male individual receives a cholesterol-screening test, which is a recommended preventive service, during an office visit for hypertension management. The plan or issuer may impose cost-sharing requirements for the office visit because the recommended preventive service is billed as a separate charge and the office visit was not primarily for preventive services.
- An individual receives a recommended preventive service that is not billed as a separate charge. The primary purpose for the office visit is a recurring abdominal pain and not the delivery of a recommended preventive service. Therefore, the plan or issuer may impose cost-sharing requirements for the office visit.
- An individual receives a recommended preventive service that is not billed as a separate charge, ie, it is part of the office visit and the delivery of said service is the primary purpose of the office visit. Therefore, the plan or issuer may **not** impose cost-sharing requirements for the office visit.
- Treatment resulting from a preventive screening can be subject to cost-sharing requirements, if the treatment is not in itself a recommended preventive service.

For a comprehensive list of recommendations and guidelines covered by the Regulations visit, www.healthcare.gov/center/regulations/prevention/recommendations.html.

Reference

1. American Federation of State, County, and Municipal Employees, AFL-CIO. Patient Protection and Affordable Care Act of 2010: Coverage of Services. Washington, DC:2010. Available at: www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.