Keystone First
Family of Health Plans

Evaluation and Management

Reimbursement Policy ID: RPC.0066.0100

Recent review date: 08/2024

Next review date: 11/2025

Keystone First 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. Keystone First 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 outlines Keystone First reimbursement criteria for Evaluation and Management (E/M) Services reported on claim form CMS-1500.

Exceptions

Evaluation and management services claims submitted to Keystone First on form CMS-1450 are excluded from this policy.

Reimbursement Guidelines

Keystone First reimbursement for Evaluation and Management (E/M) Services aligns with CPT Evaluation and Management (E/M) Services Guidelines and applicable Centers for Medicare and Medicaid Services (CMS) requirements.

New patient versus established patient
Consistent with CPT Evaluation and Management (E/M) Services Guidelines, Keystone First considers "new patient" E/M services eligible for reimbursement when the member has received no professional services from the same physician or any other health care professional with the same specialty and subspecialty in the same group practice that bills under the same Federal Tax Identification number (TIN). Evaluation and Management Services to members who have received professional service(s) from either the same provider or any same-specialty provider in the same practice during the past three years must be reported with an appropriate "established patient" E/M code.

Problem-focused visits
Per CMS and CPT, problem-oriented E/M services involve treatment, diagnosis, or assessment of an illness, symptom, or other complaint or concern, regardless of whether a definitive diagnosis is made during the patient encounter. Except in rare circumstances, Keystone First will consider one problem-focused E/M service by the same individual physician or other qualified health care professional to the same member on the same date for reimbursement.

Preventive care visits

Adults
Keystone First will reimburse one annual Preventive Medicine E/M service for adult members. Providers should report an appropriate Preventive Care E/M code is reported.

Children
Pediatric Preventive Care E/M services are a component of the Keystone First Early Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, and are eligible for reimbursement by and in accordance with applicable Keystone First EPSDT guidelines.

Multiple same-day E/M services (Modifier 25)
During the course of a problem-focused or preventive care E/M service, if the provider finds and documents a separate problem requiring significant additional work and a distinct diagnostic and treatment approach, Keystone First may consider for reimbursement one additional E/M service reported with modifier 25.

Emergency department visits
In accordance with CMS and CPT Evaluation and Management (E/M) Services Guidelines, providers of E/M services in an Emergency Department setting should select the appropriate Emergency Department E/M Service code that corresponds to the level of services provided and supported in the medical record.

Hospital inpatient and observation E/M services
CPT categorizes professional E/M services for patients in a hospital inpatient or observation status according to the length of patient stay and whether admission and discharge occur on the same or different calendar dates. Providers should select the appropriate CPT E/M code(s) using these criteria to receive accurate reimbursement from Keystone First.

Discharge day E/M services
In alignment with CMS and CPT, Keystone First discharge day E/M reimbursement includes all services performed on the day of discharge by the physician or other qualified health care professional from the same

group practice under the same specialty and same Tax Identification Number (TIN). No additional E/M service will be reimbursed.

Critical care
Consistent with CMS and CPT Evaluation and Management (E/M) Services Guidelines, Critical Care E/M services are reported based on the provider's time spent delivering direct care to a critically ill or injured patient.

Prolonged services
CPT Evaluation and Management (E/M) Services Guidelines includes add-on codes for Prolonged E/M Services, both with and without direct patient care. For accurate reimbursement, providers should report Prolonged E/M Services on the same claim as the primary E/M service. Keystone First allows no reimbursement for Prolonged E/M Services code billed without a primary E/M Services code on the same claim.

For accurate reimbursement, providers must report E/M services with the appropriate CMS Place of Service (POS) code**.**

Definitions

Established patient
An established patient is one who has received face-to-face professional services from the same individual physician or other qualified health care professional in the last three years.

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.

Modifier 25 – Significant, separately identifiable E/M
Modifier 25 indicates a significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service.

Prolonged services
Prolonged services are for additional care provided to a beneficiary after an evaluation and management (E/M) service has been performed. Physicians submit claims for prolonged services when they spend additional time beyond the time spent with a beneficiary for a usual companion E/M service

Same individual physician or other qualified health care professional
Any physician or other health care professional from the same group practice with the same specialty and subspecialty reporting under the same Federal Tax Identification number (TIN).

Edit Sources

I. Current Procedural Terminology (CPT).
II. Healthcare Common Procedure Coding System (HCPCS).
III. International Statistical Classification of Diseases and Related Health Problems (ICD-RHP), and associated publications and services.
IV. Centers for Medicare and Medicaid Services (CMS).
V. The National Correct Coding Initiative (NCCI) in Medicaid.
VI. Office of Inspector General (OIG). https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000115.asp#.
VII. Corresponding Keystone First Clinical Policies.
VIII. Applicable Keystone First manual reference.
IX. Commonwealth of Pennsylvania Medicaid Program guidance.
X. Commonwealth of Pennsylvania Medicaid Program fee schedule(s).

Attachments

N/A

Associated Policies

RPC.0008.0100 Telehealth
RPC.0009.0100 Significant, Separately Identifiable Evaluation and Management Service (Modifier 25)

Policy History

06/2025	Minor updates to formatting and syntax
04/2025	Revised preamble
08/2024	Reimbursement Policy Committee Approval
04/2024	Revised preamble
08/2023	Removal of Policy Implemented by Keystone First from Policy History section
01/2023	Template Revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section