Keystone First
Family of Health Plans

Procedure Code Guidelines

Reimbursement Policy ID: RPC.0017.0100

Recent review date: 04/2025

Next review date: 01/2027

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, 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

The Procedure Code Guidelines policy identifies rules and guidelines regarding International Classification of Diseases, 10th revision, Procedure Code System (ICD-10-PCS) and Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) coding requirements for claim submission to Keystone First.

Exceptions

N/A

Reimbursement Guidelines

The Health Insurance Portability and Accountability Act (HIPAA) required adoption of specific code sets for diagnoses and procedures to be used in all transactions. For outpatient and professional services, CPT and/or HCPCS procedure codes are required. These codes may require a two-digit modifier to further clarify the services being billed (example: an anatomical site modifier such as “RC” for right coronary artery). CPT/HCPCS books provide instruction and guidelines for CPT and HCPCS codes.

ICD-10 PCS codes are used to describe the procedure that a provider has documented in the inpatient medical record. The codes must be reported to the highest specificity of the procedure performed. The ICD-10-PCS Official Guidelines for Coding and Reporting provide instructions and guidelines for assigning procedure codes.

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS) review and update the guidelines for coding and reporting ICD-10-PCS codes annually along with the code sets. The National Center for Health Statistics releases the updated code set and guidelines.

The American Medical Association (AMA) releases CPT/HCPCS code changes and guidelines quarterly which are found on the AMA website. These changes will be added to the updated code set and guidelines annually on January 1.

The effective date of all code changes is the date the State updates the fee schedule with the changes. Fee schedules are typically updated between May and September.

The Pennsylvania Department of Medicaid may have specific coding requirements for services provided in specific settings.

Definitions

N/A

Edit Sources

I. Current Procedural Terminology (CPT).
II. Healthcare Common Procedure Coding System (HCPCS), and associated publications and services.
III. International Classification of Diseases, 10th revision, Procedure Code System (ICD-10-PCS).
IV. https://www.cms.gov/medicare/coding-billing/icd-10-codes/2024-icd-10-pcs.
V. Centers for Medicare and Medicaid Services (CMS), https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Code-Sets.
VI. American Medical Association (AMA), https://www.ama-assn.org/amaone/cpt-current-procedural-terminology.
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

N/A

Policy History

06/2025	Minor updates to formatting and syntax
04/2025	Reimbursement Policy Committee Approval
04/2025	Revised preamble
01/2025	Annual review • Updated to biennial policy
05/2024	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