Keystone First
Community HealthChoices

Preventive Services

Reimbursement Policy ID: RPC.0088.72KF

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

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 is addressed during a preventive medicine service, reimbursement may be available for the appropriate problem-oriented E/M code if it is appended with modifier 25 and reported on the same claim. The health plan will reimburse the amount allowed for a second E/M code if it is appended with modifier 25, associated to a problem-oriented diagnosis, and supported in the medical record.

Vaccine administration services
The health plan reimburses vaccinations administered during a preventive medicine visit at the allowable amount.

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.

Preventive care for adults
The health plan considers age- and gender-appropriate preventive care services included as a covered service under the health plan managed care program to be eligible for reimbursement. Examples may include some or all of the following, but reimbursement may only be made if the service is a covered service under the health plan Medicaid program:

- Annual Well Visits (AWV);
- Initial Preventive Physical Exams (IPPE);
- Abdominal Aortic Aneurysm (AAA) screening;
- Bone density measurement;
- Cardiovascular disease screening;
- Screenings for breast, lung, cervix, prostate, and colorectal cancers;
- Screening for sexually transmitted infections (STIs);
- Glaucoma screening;
- Preventive gynecological care (e.g., pelvic exams, clinical breast exam, cervical cancer screening, Pap tests);
- Screening for hepatitis B, hepatitis C, 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.

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.

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.

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)

Attachments

N/A

Associated Policies

RPC.0009.72KF Significant, Separately Identifiable Evaluation and Management Service (Modifier 25)
RPC.0021.72KF New Patient Visit
RPC.0065.72KF Vaccine
RPC.0066.72KF Evaluation and Management

Policy History

09/2026	Reimbursement Policy Committee Approval
07/2026	Biennial review • Revised preamble • Removed the next review date • Replaced the plan name with “the health plan”
07/2025	Reimbursement Policy Committee Approval