New Patient Visit

Reimbursement Policy ID: RPC.0021.0100

Recent review date: 05/2025

Next review date: 09/2027

Keystone First reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare & 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 describes new versus established patient visit criteria in claims processing by Keystone First.

Exceptions

N/A

Reimbursement Guidelines

Providers must submit clean claims for accurate reimbursement. A claim for a "new patient" procedure code (e.g., E/M services) will be denied if the claims history shows that the patient has already received professional services from the same provider within the past three years.

Keystone First aligns with the Centers for Medicare & Medicaid Services (CMS) with regard to new patient visit criteria:

- **Professional services** are face-to-face services rendered by a physician or other qualified health professional and reported by a specific procedure code (e.g., Evaluation and Management services).
- Any physician or other qualified health care professional from the same group practice within the same specialty and using the same Tax Identification Number (TIN) is considered the **same provider** (e.g., "same physician").
    - Any advanced practice nurse or physician assistant working with a physician (e.g., working as a physician extender) is considered as working in the exact same specialty as the physician.
- A patient who has not received any professional services from the same provider within the past three years is considered a **new patient**. Otherwise, that patient is considered an **established patient**. For example:
    - A patient who has received telehealth Evaluation and Management (E/M) services within the last three years by the same provider is considered an established patient.

Refer to CPT/HCPS manuals for complete descriptions of procedures, and state billing resources for fee schedules and billing guidelines. Only medically necessary services are reimbursable.

Definitions

New Patient
A new patient is one who has not received any professional services, [e.g., E/M service or other face-to-face service (e.g., surgical procedure)] from the physician or group practice (same physician specialty) within the previous three years.

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 & Medicaid Services (CMS) Medicare Claims Processing Manual, Chapter 12, - Physicians/Nonphysician Practitioners.
V. The National Correct Coding Initiative (NCCI).
VI. Corresponding Keystone First Clinical Policies.
VII. Applicable Keystone First manual reference.
VIII. Commonwealth of Pennsylvania Medicaid Program guidance.
IX. 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
05/2025	Reimbursement Policy Committee Approval

04/2025	Annual Review • No major changes
04/2025	Revised preamble
04/2024	Revised preamble
09/2023	Reimbursement Policy Committee Approval
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