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Dermatology Coding Alert

E/M: Navigate the New-Versus-Established-Patient Maze With Expert Tips

Different locations, same physician? Use established patient codes.

When reporting many common E/M services, you must ask yourself two questions: First, is the patient new or established? And second, what are the documented levels of history, physical exam, and medical decision-making (MDM)? We've got some quick tips on how to use this information to select the correct E/M level every time.

3 Year Rule Determines Patient Status

Generally, you should consider a patient to be established if any physician in your group (or, more precisely, any physician of the same specialty billing under the same group number) has seen that patient for a face-to-face service within the past 36 months, says **Marvel Hammer, RN, CPC, CCS-P, PCS, ASC-PM, CHCO,** owner of **MJH Consulting** in Denver, Co.

For example: A patient complaining of skin rash comes to your office. Although this is provider A's first time meeting the patient, provider B, in the same group practice, saw the patient two years ago for a similar complaint. In this case, the patient is established.

Don't let different locations lead you astray: If your practice has multiple locations, and a physician in location A sees the patient in January but a physician in location B sees the patient the following December, the patient is still established. The need to create a new chart is inconsequential, Hammer says.

Non-face-to-face encounters don't count: A primary-care physician recommends that a 60-year-old female see the ophthalmologist regarding flashes and floaters. One of the physicians in your practice interpreted some test results for the same patient the previous year but provided no face-to-face service.

In this case, you can still consider the patient to be new when selecting an initial E/M code because no physician within your practice provided the patient with a face-to-face service within the past three years.

According to section 30.6.7 of the Medicare Claims Processing Manual, "An interpretation of a diagnostic test, reading an x-ray or EKG, etc., in the absence of an E/M service or other face-to-face service with the patient does not affect the designation of a new patient."

Exceptions Could Occur for Different Specialties

The new patient rule applies when physicians in the same practice are also of the same specialty.

In a nutshell: If your practice is big enough and covers enough specialties, two physicians may see a patient for completely different reasons. This could allow you to report a new patient visit even though two physicians in the same practice saw the same patient within a three-year period if they are different specialties.

Consult Codes Don't Differentiate

The consult codes do not differentiate between new and established patients. Therefore, regardless of the patient's status, you should make your outpatient consult code choice from the 99241-99245 range.

When reporting consults and new patient E/M services, you'll need to meet the requirements of all three key components (history, exam and MDM) to report a given level of service.

Shortcut: In effect, this means that whichever key component is the -lowest- will determine the E/M service level you choose, Hammer says.

The AMA added text to CPT® in 2006 to clarify that all of the key components (history, exam and MDM) must meet or exceed the stated requirements to qualify for a particular level of service for office, new patient (99201-99205), hospital observation services (99218-99220), initial hospital care (99221-99223), office consultations (99241-99245), initial inpatient consultations (99251-99255) and others.

2 of 3 Will Do for Most Established E/M Visits

When reporting most established patient outpatient E/M services (except consults and initial observation care, which do not distinguish new from established patients), you can assign an E/M level based on just two of the key components, Hammer says.

Per CPT®, you must meet or exceed the stated requirements for two of the three key components for established patient office visits (99212-99215), subsequent hospital care (99231-99233), subsequent nursing facility care (99307-99310) and others.

Watch for Overcoding

Generally, medical necessity should determine the MDM level and, ultimately, the appropriate E/M service level. Physicians should not, for instance, report a comprehensive history and exam at every visit and expect to report 99215, regardless of medical necessity or the documented level of MDM.

Simply stated: If the presenting problem won't support a high-level E/M service, you can't get paid just because the physician documented a comprehensive history and exam.

A final note: Remember, you may report E/M services based on time rather than the key components of history, exam and MDM if the physician spends more than 50 percent of the visit on counseling and/or coordination of care AND documents total time, percent (or time) spent for counseling/coordination of care and specific detail about the counseling/coordination of care.