Dermatology Coding Alert

E/M: New or Established? Answer Wrong and It Could Cost You

Remember, what used to be a consultation is now likely a 99201-99215 service.

Dr. Derm provides a new patient with a standard office-visit E/M. You use an established patient E/M to code the encounter.No big deal, right?

Wrong: Not only is the coding incorrect, but this mistake will cost your practice deserved reimbursement. Further, Medicare's deletion of consultation codes means that coders will have to answer the new vs. established question more often than before. For Medicare payers, and payers that follow their lead, coders will now have to "select the correct code, new or established, to bill for what used to be consults and did not have a new versus established component concept," relays **Quinten A. Buechner, M.S., M.Div., AAPC:CPC, BMSC:ACS-FP/GI/PEDS, ACMCS:PCS, PHIA:CCP, PAHCS:CMSCS,** president of ProActive Consultants in Cumberland, Wis.

Don't get Dr. Derm steamed; nail the patient's status every time by following this expert advice on new and established patients.

Leave Money on the Table if You Ignore New Patient E/Ms For dermatology practices, the main difference between new and established patient codes is the payment rate. Consider this comparison of average national payouts for new and established level-two E/M codes, respectively:

- 99202 (Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; straightforward medical decision making ...) pays about $68 per encounter (1.86 transitioned nonfacility relative value units [RVUs] multiplied by the temporary 2010 Medicare conversion rate of 36.8729)
- 99212 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a problem focused history; a problem focused examination; straightforward medical decision making ...) pays about $40 per encounter (1.08 transitioned nonfacility relative value units [RVUs] multiplied by the temporary 2010 Medicare conversion rate of 36.8729).

That's almost $30 lost if you mistakenly report 99212 instead of 99202. The main difference between a new and established patient visit, service-wise, can be minimal: it often includes simple tasks such as "setting up a new chart and quizzing the patient a little closer to get familiar with him," explains Buechner.

(Note: While there are some exceptions, non-Medicare payers generally adhere to Medicare's new/established patient rules. If you are unsure about the status rules for a private payer, check out your contract before filing a claim.)

Ask 3-Year Question 1st

If your patient has had a face-to-face service with the dermatologist (or another physician with the same specialty credentials in your group) within the last three years, then the patient is established, confirms **Kami Culb,** office coordinator at Frederick Memorial Hospital Immediate Care in Frederick, Md. So let's say a patient reports to Dr. Derm for a level-three E/M service on April 20, 2010. The patient's record indicates that she received a face-to-face E/M service from Dr. Derm on Dec. 14, 2008. This is an established patient, so you should report 99213 (... an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity ...).

Face Time a Must for Established Patients

What does a coder do when the patient has received treatment from Dr. Derm within the last three years, but the physician did not actually lay eyes on the patient? This is a different coding situation, confirms **Shelby Davidson, CPC,**

CMSCS, coding educator at OHMFS in Ohio.

Do this: "Interpret the phrase 'new patient'' to mean a patient who has not received any professional services - in other words, an E/M service or other face-to-face service - from the physician or physician group practice within the previous three years," she recommends.

This means that you might be able to report a patient as new if Dr. Derm provided services for the patient less than three years ago - provided it was not a face-to-face-service.

Example: A patient reports to Dr. Derm for an E/M service. The patient's record indicates that Dr. Derm read the pathology report of the patient's lesion excision on May 5, 2009. There was no record of a face-to-face service. You should choose a new patient E/M code for this encounter (99201-99205).

Explanation: When the physician "reads an x-ray, EKG, etc., in the absence of an E/M service or other face-to- face service with the patient, it does not affect the new patient designation," explains Davidson.

Check Specialty When Deciding Status

Coders who work in multispecialty practices will have to pay attention to one more new/established patient status rule, confirms **Cathy Satkus, CPC,** coder for Harvard Family Physicians in Tulsa, Okla.

Example: You are a coder for Dr. Derm, who is part of a multispecialty practice that also includes urologists, gastroenterologists, and otolaryngologists. A patient reports to Dr. Derm for an E/M service on March 15, 2010. The patient's medical record indicates that he received a covered screening colonoscopy from Dr. G, the practice's gastroenterologist, a year ago but has not otherwise seen Dr. Derm or any other family physicians within the practice in the past three years. You would code this as "a new patient, since the specialty is different," Satkus says.