Codify
BY AAPC

Internal Medicine Coding Alert

READER QUESTIONS: Apply Universal New Patient Definition

Question: An internist in our group provides an E/M service to a hospital inpatient. If the patient then comes to our office for follow-up care, should I charge a new or established patient visit? Should I code the scenario differently based on CPT versus Medicare guidelines?

Texas Subscriber

Answer: You should report an established patient office visit (99212-99215, Office or other outpatient visit for the evaluation and management of an established patient ...) if an internist performs the follow-up care within three years from the hospital encounter (such as 99231-99233, Subsequent hospital care, per day, for the evaluation and management of a patient ...). Specialty and time, not location or insurer, affect a patient's status. CPT and CMS guidelines do not vary on the definition of a new or established patient.

Rule: To determine a patient's status, you should use CPT's established patient definition: "An established patient is one who received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years."

Medicare defines "professional services" as an E/M service. Therefore, when an internist provides services to a patient, and another internist in the same group furnishes services before three years have elapsed, you should consider the patient established. "If no evaluation and management service is performed, the patient may continue to be treated as a new patient," according to the Medicare Carriers Manual section 30.6.7 "Payment for Office/Outpatient Visits (Codes 99201-99215)."

If your group includes multi-specialties, an office visit following a hospital encounter could qualify as a new patient service. For instance, a gastroenterologist may have seen the patient in the hospital and recommended that the patient follow up with your office. The patient sees an internist within the same group for follow-up care.

In this case, you could code a new patient code (such as 99201-99205, Office or other outpatient visit for the evaluation and management of a new patient ...), instead of an established patient code.

"Physicians in the same group practice but who are in different specialties may bill and be paid without regard to their membership in the same group," states CMS in the MCM section 30.6.5 "Physicians in Group Practice."

Each carrier and payer may vary on what counts as "different specialties." Best bet: Obtain written confirmation from the payer as to its specific requirements.

Public-relations consideration: Although you can technically count the patient as "new" in these scenarios, good patient relations may dictate that you bill the encounters as established. Patients may question why you're charging them as new when they've been patients in the practice. This is especially true if the patient's coinsurance is a percentage of the allowed amount. Insurers usually pay new patient codes at a higher allowance than established patient codes.

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