# Part B Insider (Multispecialty) Coding Alert

## E/M Coding: Knock Out Questions on New/Established Patient E/M

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

Suppose the physician provides a new patient with a standard office-visit E/M. You mistakenly 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 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.

Nail the patient's status every time by following this expert advice on new and established patients.

**Ignore New Patient E/M, Leave Money on the Table**

The difference between new and established patient E/M reimbursement is no small matter. Consider this comparison of average national payouts for new and established level-five E/M codes, respectively:

99205 (Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity ...) nationally allows about $194 per encounter in a physician office

99215 (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 comprehensive history; a comprehensive examination; medical decision making of high complexity ...) nationally allows about $134 per encounter in a physician office.

That's approximately $60 lost revenue if you mistakenly report 99215 instead of 99205.

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 or the carrier's website for the medical policy before filing a claim.

**Ask 3-Year Question First**

If your patient has had a face-to-face service with the physician (or another physician with the same specialty credentials in your group) within the last three years, then the patient is established. So let's say a patient reports to the doctor for a levelthree E/M service on April 20, 2010. The patient's record indicates that she received a face-to-face E/M service from the physician 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 the doctor within the last three years, but the physician did not actually lay eyes on the patient? This is a different coding situation.

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.

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

Example: A patient reports to the physician for an E/M service. The patient's record indicates that the doctor read the results of the patient's lab test 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.

**Check Specialty When Deciding Status**

Coders that work in multispecialty practices will have to pay attention to one more new/established patient status rule.

Example: You are a coder for an oncologist who is part of a multispecialty practice that also includes urologists, gastroenterologists, and otolaryngologists. A patient reports to the oncologist 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 seen the oncologist or any other oncologist within the practice in the past three years.

You would code this as a new patient because the specialty is different.

Tip: If you follow the above rule but the payer denies the new patient claim, you should investigate. Check with the third party payer that the physician's specialty, as determined by their board certification, is correctly applied to their national provider identifier (NPI) number.

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