Part B Insider (Multispecialty) Coding Alert

Compliance: Boost 3-Year Rule Knowledge with This Primer

Tip: Review CPT® guidelines for best results.

Choosing the right E/M code is daunting, but first steps must always include determining whether a patient is new or established. To do this, you'll likely use the "three-year rule," but there's more to the popular guideline than meets the eye.

A key element in determining whether a patient is new or established is time. Plus, you need to consider other factors, such as the kind of services a patient has already received, and what kind of exceptions may come into play, before you make that determination.

Pocket this guidance for the next time the issue comes up in your practice.

Focus on this Basic CPT® Guidance

An in-depth study of CPT® guidelines reveals much more than the simple definition that a new patient is one that has not received services from your practice in three years prior to seeing a provider. Remember, CPT® also requires that:

1. The services need to be professional. "'Professional' here means services following the CPT® definition of being performed by a physician or other qualified healthcare professional [QHP] and being reported by an E/M code," says **Mary I. Falbo, MBA, CPC,** CEO of Millennium Healthcare Consulting Inc. in Lansdale, Pennsylvania.

2. The services need to be face-to-face. "This is also key, as CMS has determined that services such as EKGs, diagnostic tests, or X-ray interpretations do not affect a patient's status unless they are accompanied by an E/M or other face-to-face service," Falbo continues.

3. The services need to be in the same specialty or subspecialty. This part of the definition can be significant for large practices that may employ subspecialists, as patients that may be regarded as established in one specialty may be classified as new when they are seen for the first time by a specialist in a different field.

Don't Forget About Exceptions

Consider the scenario of a patient coming in for a vaccine, such as a flu immunization. As often happens, the patient is vaccinated by a nurse, and the visit is coded using an administration code such as 90471 (Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)), but there is no E/M service reported.

"If the patient then sees a provider at some point during the next three years, the patient is considered new," explains **Donelle Holle, RN,** president of Peds Coding Inc., and a healthcare, coding, and reimbursement consultant in Fort Wayne, Indiana. "Many parents do not understand why their child is considered new when their child is seen by a physician or QHP for the first time in three years. They assume if they have been in and had a vaccine, that established them as a patient," Holle further elaborates.

Skip 99211 for New Patients

This is a very common myth when the issue of a patient's status comes up. Technically, as 99211 (Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified healthcare professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services) does not require the presence of a physician and requires no history,

it appears as if you could use the code for a new patient.

Here's why: This is a myth for two very good reasons. First, "CPT® describes the 99211 service as being for an established patient, so it cannot be used for a new patient," Holle explains.

Second, the code can only be for established patients because the service is performed incident-to, meaning that any service, "even one as simple as a weight check, has to be reviewed by the provider. But without any type of history it will be difficult for the provider to give any advice," Holle recommends.

Simply put, "If a patient comes in, it is best practice to have the patient seen by the provider who will initiate a care plan," Holle concludes.

Why Does this Matter?

Defining a patient as new or established is significant for two more reasons. Misidentifying a new patient as established "poses a billing risk, as the reimbursement is higher for a new patient," due to the extra work involved in taking the patient's history and diagnosing new conditions, explains Falbo.

Money matters: Currently, for example, CMS values a level-four nonfacility established patient visit (99214) at $110.28, while reimbursement for a level-four visit for a new patient (99204) is valued at $166.86, a sizeable difference.

Assignment risk: But just as important, if you fail to assign new or established status to a patient correctly, "you could be facing compliance issues," warns Falbo.

"As the criteria for the sick visits are distinctly different between new and established, the coder could give the wrong information to the payer," Holle agrees. So, while new and established level-four visits both require the provider to document moderate-complexity decision making (MDM), new visits require you to document three components, including a comprehensive history and exam, while you only have to document two elements, which can include a lower-level detailed history and detailed exam, for established visits.