Pain Management Coding Alert

E/M Coding: Separate New/Established Patients With These Pointers

If you only know the 3-year rule, time to go back to school.

One of the most prevalent myths in the coding world concerns patient status. In many coding circles, people still think that the "three-year rule” is all you need to know in order to determine whether a patient is new or established in your practice.

Accepting this myth will lead to confusion for everyone - coder, provider, payer, patient - and could lead to unanticipated headaches. If you know that determining a patient's status is more complex than applying the three-year rule, however, you'll be able to assign patient status with ease.

Help's here: We reached out to two of our experts to help us come up with the definitive word on how to determine a patient's status.

Determine Status After Considering 'Professional' Question

A close reading of the 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 your provider. 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 evaluation and management [E/M] CPT® 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 the Centers for Medicare and Medicaid Services [CMS] has determined that services such as EKGs [electrocardiograms], 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.

Leave 99211 Off New Patient Claims

Technically, as99211 (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 health care 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.

However, this is a myth for two very good reasons. First, "CPT® describes the 99211serviceas being for an established patient, so it cannot be used for a new patient,” explains **Donelle Holle, RN**, president of Peds Coding Inc., and a healthcare, coding, and reimbursement consultant in Fort Wayne, Indiana.

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.

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So, Why Is All This Important?

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.

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.

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 medical 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.

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