

UTMB COMPLIANCE STANDARD

UTMB OFFICE OF INSTITUTIONAL COMPLIANCE	11/01/2003	-Effective
Documentation, Billing, and Coding Standard	08/28/07	-Revised

Outpatient New and Established Patient Classification

Purpose	To clarify how new and established patient classification is made for coding and billing at UTMB.
Audience	UTMB Physicians, Non-Physician Providers, Department Administrators, Billing Managers, Billing and Coding Staff
Policy CPT & Medicare Professional	<p>Current Procedural Terminology (CPT) defines a new patient as “one who has not received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.” They further define “professional services” as “face-to-face services rendered by a physician and reported by a specific CPT code”. The classification of new or established impacts the selection of the appropriate CPT code for certain Evaluation and Management (E/M) services and can affect billing and coding issues. Many payers, including Medicare use the CPT definition to classify new or established patients.</p> <p>CPT also clarifies the status of patients seen “on call”. If “a physician is on call for or covering for another physician, the patient’s encounter will be classified as it would have been by the physician who is not available.”</p>
Policy Medicare Facility (Hospital)	Medicare currently uses CPT E/M codes for billing outpatient facility charges. The CPT codes differentiate between new and established patients. However, the definition of a new patient is different for the facility than for the provider. For the facility, a new patient is one who does not have a medical record.
Policy Medicaid	For Texas Medicaid patients, <i>“a new patient visit is limited to one every 3 years, per patient, per provider. A new patient visit in the office... is reimbursed as an established patient visit if history shows that the same physician has furnished a medical service (TOS 1) (excluding routine newborn care and lab handling fee), a surgical service (TOS 2), or a consult (TOS 3) within 3 years.”</i>

<p>Procedure Professional CPT and Medicare</p>	<p>The definition of a “group” applies to all UTMB/MSRDP physicians or Non-Physician Providers in the same specialty, regardless of their location. Therefore, if a patient is seen by a physician of a specific specialty/group as a new patient in any setting, i.e., the Community Based Clinics (CBCs), the Urgent Care Clinic, UTMB Clinic or the Emergency Department, then the next time the patient is seen by the same specialty they are not a new patient.</p> <p>Example- Mr. Smith is seen in the Urgent Care Clinic by a Family Medicine physician, who recommends follow up. Mr. Smith makes an appointment in the UTMB Family Medicine Clinic for the first time. At this clinic visit, Mr. Smith is an established patient because he has already been treated by a UTMB Family Medicine physician.</p> <p>However, if Mr. Smith was seen by a Family Medicine physician in the Urgent Care Clinic, then went to the UTMB Internal Medicine clinic for the first time, Mr. Smith would be a new patient to Internal Medicine (different specialties).</p> <p>If a patient is seen by a Resident only, and there is no professional charge generated, then the next visit might still be a new patient service, if the new patient criteria are met.</p> <p>In a multi-specialty clinic; if the patient is seen by a physician of one specialty who is “on call” for that patient’s physician (who is a different specialty), the service is billed as if that patient was the patient of their regular doctor and it is an established patient service.</p> <p>Example- Mr. Smith is a patient of Dr. Jones, a Family Medicine physician. Dr. Roberts, an Internal Medicine physician, is covering for Dr. Jones and sees Mr. Smith. Mr. Smith remains a patient of Dr. Jones and an established patient service is billed for Dr. Roberts.</p> <p>However, if a “face-to-face” service was provided by the “on call” provider and a bill was generated for professional services with that physician’s provider number, all future services would be considered established also (within the three year period).</p>
<p>Procedure Professional Medicaid</p>	<p>Texas Medicaid limits a new patient visit to one every three years, per patient, per provider. Therefore, an E/M service cannot be billed as new if the patient has received either a new or an established E/M service within the last three years. Services coded as new patient visits in excess of this limitation are changed by Medicaid to established patient services and reimbursed as such.</p>

<p>Procedure Facility</p>	<p>Currently, Medicare defines a new patient for the facility as one who does not have a medical record. However, the codes for new or established patients crosswalk to the same Ambulatory Payment Classification (APC) for each E/M level of service. Therefore, if there is any question whether a patient has a medical record, default to an established patient facility E/M level even if the professional service is a new patient code.</p> <p>Medicare is moving toward a single level system of unique facility codes (G codes).</p>
<p>References</p>	<p>Common Procedural Terminology 2003, American Medical Association CPT Assistant, American Medical Association Center for Medicare and Medicaid Services Texas Medicaid Bulletin No. 204 May/June 2007 Ambulatory Payment Classification Final Rule (42CFR 409, 410, 411, 412, 413, 419, 424, 489, 498, and 1003)</p>