CODING Q&A

Determining New vs. Established Patients for E/M Coding

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Q. We are in the process of adding urgent care services to our occupational medicine clinic. How do we determine when to use a new or established E/M code for the patients who are seen for urgent care services?

Question submitted by Mari Lukowski

A. I continue to receive questions regarding the "when to code new or established patient E&M codes" conundrum, so let's try to simplify the issue.

The official CPT definition of *new patient* is: A patient who has **not** received **professional services** from a **physician** or another **physician of the same specialty** in the **same practice** within the **past three years**. [Emphasis added.]

One problem with this definition is that the scope of professional services that counts here is defined differently by the American Medical Association and the Centers for Medicare & Medicaid Services:

- AMA (i.e., CPT): includes any "professional services" as establishing a patient.
- CMS: limits these services to face-to-face E/M services.

Figure 1 shows how to use the CMS algorithm to determine if a patient is a new or established patient.

Figure 2 shows how to use the AMA algorithm to determine if a patient is a new or established patient.

Many practices have chosen to use the CMS definition for all payors, but a particular payor may insist on the AMA rules.

The big question for your practice when making this conversion is this: Will you count occupational medicine visits toward establishing patients in the urgent care?

The simplest (but not necessarily the most profitable) way

Continued on page 44.

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Figure 1. New vs. established patient: CMS Algorithm

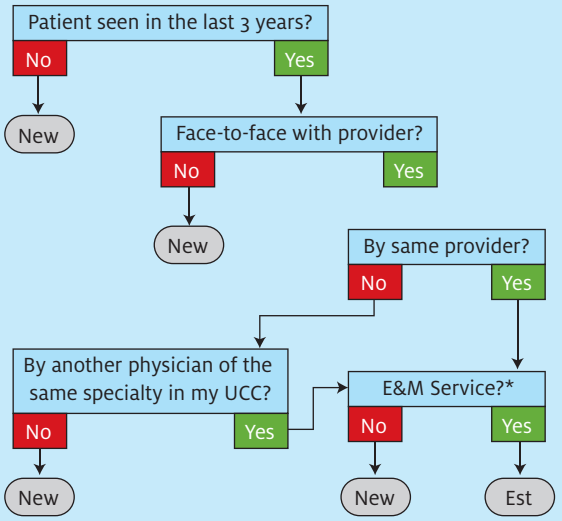
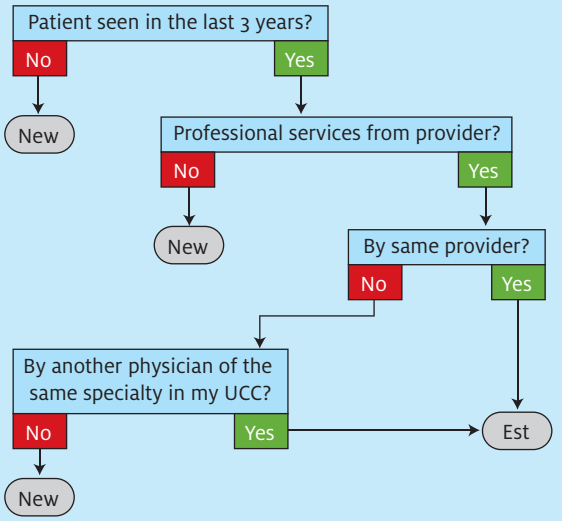


Figure 2. New vs. established patient: AMA Algorithm



transfer, unless the ED is closed to ambulance traffic. And even if they are closed to ambulance transfers, they cannot refuse a patient who is being transferred by private vehicle.

Effective Provider-to-Provider Communication

There are other ways to communicate important facts germane to the patient who is changing venues to the emergency department.

When I work in the ED, I don't necessarily want to hear from an urgent care provider who is transferring a patient to my care. I simply don't want to be biased by their concerns.

What I do expect, however, is a written record of the history, exam, radiographs, and lab results, as well as a written statement identifying the UC provider's concern. "This 67-year-old diabetic patient presents with abdominal pain out of proportion to exam findings and I am concerned about the possibility of ischemic bowel."

If you feel more comfortable communicating directly with the receiving physician, more power to you, although don't let yourself be the recipient of any abuse.

When I transfer a patient, I call *after* the patient has already left the urgent care and I keep my communication fact-based: "I just sent you a 48-year-old man with a good story for acute coronary syndrome. His EKG, CXR and troponin are normal, as well as his d-dimer. He has hypertension and a family history for coronary artery disease and should be there is about 10 minutes."

This leaves the emergency physician no out; the patient is on his way.

Compare this method with "I'm thinking about sending a patient who may have angina. Everything else is normal but I'm not sure what else to do. Would you mind if I sent him your way?"

You get the picture. If you are constantly getting pushback from the ED, choose another receiving hospital or, if you have to use the particular ED, quit calling. After all, you are sending them a patient who will augment their income; why should you be abused?

Epilogue

You know the old saying, "what goes around...." Well, you guessed it. A short while after placing one of the calls I confessed to previously, I was on the actual receiving end of one of these scenarios.

A bus load of handicapped kids *were* involved in a minor accident and they all arrived unexpectedly—"unexpected" only because I did hang up on the University of Chicago EM resident who called on the patch phone. And I did say "bite me!"

Lesson learned. n

or to the highest-priority prospects that for the moment have little interest. The offer is usually made toward the end of the sales call when the disposition of the call is apparent.

How to Make the Offer

It is not what you say; it is how you say it. When offering a complimentary service, you need to go beyond simply offering the product/service by mentioning its value; give an honest appraisal of why the prospect should accept the free commodity.

That is, you should quantify both the dollar value of the product or service and the functional value (e.g., what's in it for the prospect) in the same breath that you are offering the complimentary service.

Your clinic should be well past the trinket era and focused on providing complimentary services of genuine value and/or offer a true hands-on experience to prospects.

Developing a plan on what to offer, who to offer, when to make the offer, and how to verbalize the offer can provide your clinic with a cost-effective yet excellent marketing tool for converting both near- and non-prospects into clients. n

to answer this is this: *If the patient has been seen in the urgent care or occupational medicine clinic in the past three years (not counting drug screens), then the patient is* ***established***.

If the urgent care and the occupational medicine clinics are incorporated separately, you may be able to count most new patient visits to the urgent care center as new patients, even if the patient has been previously seen in the occupational medicine clinic.

One exception must always be considered: If the patient has been seen for evaluation and management by the same physician (whether it be in a private practice, emergency department, occupational medicine clinic, or any other setting), then for three subsequent years the patient is an established patient for that particular physician in any practice setting.n

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