CODING Q&A

An Update on New vs. Established Patients

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Q. I read your column about new vs. established patient coding in the January issue of *JUCM*. Although the information provided was correct at one time, I believe that Medicare has updated its algorithm to come closer to the algorithm provided by AMA for new vs. established patients.

Question submitted by Seth Canterbury, University of Florida, Jacksonville Physicians

A. You are correct. In a somewhat obscure and rarely referenced information release, (*www.cms.hhs.gov/MLNMattersArticles/downloads/MM4032.pdf)* CMS did change its position on this issue: "Physicians should note that this article clarifies and corrects the definition of 'new patient' and 'physician in a group practice' for billing evaluation and management (E/M) services...."

The release (which denotes new language in bold and italic) further advises:

> **"Interpret the phrase** 'new patient' to mean a patient who has not received any professional services, ***i.e., evaluation and management (E/M) service or other face-to-face service (e.g., surgical procedure)*** from the physician or ***physician group practice (same physician specialty)*** within the previous three years. For example, if a professional component of a previous procedure is billed in a three-year time period, e.g., a lab interpretation is billed and no ***E/M service or other face-to-face*** service ***with the patient*** is performed, then this patient remains a new patient for the initial visit. An interpretation of a diagnostic test, reading an x-ray or EKG etc., in the absence of an ***E/M service or other face-to-face*** service ***with the patient*** does not affect the designation of a new patient."

Thus, CMS no longer limits the definition of such face-to-face services to those services defined by an E/M code. Now any face-to-face service with a physician will suffice to establish a patient in a practice. This brings the CMS definition of a "new patient" more into line with the AMA (CPT) definition of the "new patient."

One discrepancy does still exist. CMS restricts the use of the definition of "same physician specialty" to the specific specialties defined by CMS with two-digit physician specialty codes. This list of these specialties and their two-digit designations can be found on the Internet at *www.cms.hhs.gov/GEM/Downloads/GEMMethodologies.pdf*. AMA (CPT), however, does not specifically define what constitutes a physician of "same physician specialty."

This discrepancy can make a practical difference when a patient is seen in a practice by a physician who is practicing a specialty that is not defined by a two-digit CMS code.

For example, occupational medicine is a recognized specialty with a board certification. CMS, however, does not have a two-digit specification for an "occupational medicine" physician. Board certification in occupational medicine, however, is actually performed by the American Board of Preventive Medicine, and CMS does list specialty code 84 as designating a specialist in occupational medicine.

Thus, if a patient has been evaluated and treated in your urgent care center by a physician who is board certified in occupational medicine (i.e., by the American Board of Preventive Medicine) for an injury covered under workers compensation, and if the patient is subsequently seen for an illness by a physician specializing in family practice, then you may code the second visit with an E/M code for a "new patient."

If, however, the first visit was with a physician specializ-

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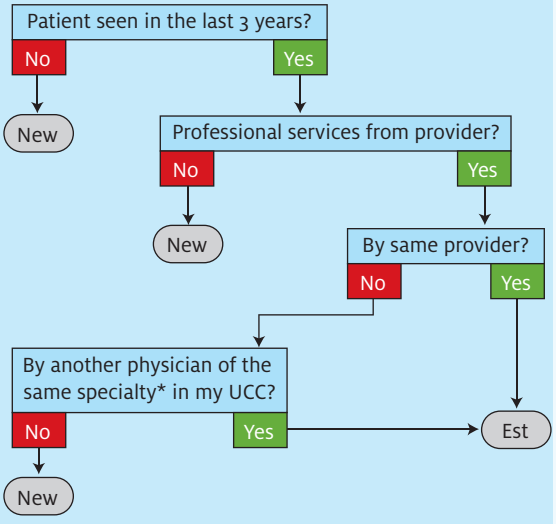
ing in "urgent care medicine," which CMS does not recognize with a two-digit code, then the second visit would have to be coded as an "established patient" visit.

Under AMA (CPT) rules, we are not limited to a specific, defined list of physician specialties. Again, whether the first visit was with a specialist in occupational medicine or a specialist in urgent care medicine, the second visit might be coded as a "new patient" visit, since the second visit was with a "specialist" in a different specialty.

One might recommend caution, however, when using undefined specialties such as "urgent care" that are not recognized by CMS nor have board certifications that are generally recognized by the medical establishment, as this may place the coder in the uncomfortable position of having to defend the legitimacy of a specialty that is not generally recognized.

The diagram below updates the one published in the January 2009 issue of *JUCM*. ■

New vs. established patient



**Specialty is narrowly defined by CMS, but not specifically defined by AMA.*

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strategic thinking (see Fear as a Factor in Occupational Health Sales, *JUCM*, September 2008).

Promote on-site services. Growing numbers of large companies are offering on-site medical services. A 2008 survey by Watson Wyatt noted that "nearly 30% of large employers had a clinic on site or planned to open one by 2009." Your clinic may well have the expertise to contribute to the operation of such clinics in a manner that provides the employer with superior management at a lower overall cost. Incremental losses in patient volume can be more than offset by just one significant on-site services contract.

Reactivate dormant relationships. The blog ieYou Marketing suggests that a clinic should contact past clients to persuade them to do business with you again. It boils down to a numbers game: make 10 such calls and you are likely to reactivate at least one dormant account.

Lock in client loyalty. Don't take your clients for granted. Call each and every one—soon—and ask if there is anything more your clinic can do to better serve them. Saving potential revenue from attrition is just as good as generating that same revenue anew.

Troll for a big fish. Most clinics consider some employers in their market off limits; they are either too big, have an in-house orientation, or have an established relationship with a competitor. But these companies are facing a recession, too. All of a sudden, your clinic's "Let us help you control your health and safety costs" pitch might have considerably more appeal. Nothing ventured, nothing gained.

Plan ahead. Recessions do not last forever. Meanwhile, there will be a pent-up demand for exceptional occupational health services.

Occupational health sales and marketing professionals who focus on establishing and cultivating relationships during the first half of 2009 with the expectation that financially strapped companies will be better positioned several months down the road are likely to see a payoff.

Change is in the air. This appears to be one of those watershed years in which change in almost any form is perceived as positive, and status quo is out of fashion. In this environment, there are opportunities to woo business from competitors and/or introduce new products, services, or concepts in your market. This can best be done through a vigorous and focused sales effort that trumpets innovation and value.

Be a contrarian. Be an optimist when others are forlornly predicting economic doom. Put greater effort into sales and marketing when others put their collective sales/marketing heads in the sand. People tend to be attracted to optimists during a storm. Be the star upon which your clients and prospects can hitch a ride. ■