Reimbursement Policy	
Title: New Patient Visit	
Policy Number: RP-P-260X	**Application:** All Medica Members
Last Reviewed: 03/23/2023	**Effective Date:** 02/08/1993
Related Policies: N/A	

Disclaimer: *This reimbursement policy is intended to provide general guidance regarding Medica's policy for the services described, and does not constitute a guarantee of payment. You are responsible for submitting accurate claims. Factors affecting claims reimbursement may include, but are not limited to, state and federal laws, regulations and accreditation requirements, along with administrative services agreements, provider contracts, and benefit coverage documents. Coding methodology and industry standards are also considered in developing reimbursement policy.*

Medica routinely updates reimbursement policies, and new versions are published on this website. If you print a copy of this policy, please be aware that the policy may be updated later, and you are responsible for the information contained in the most recent online version. Medica communicates policy updates to providers via Medica's monthly e-newsletter, Medica Connections®, as well as through Medica Provider Alerts.

All content included on the provider portion of medica.com is an extension of providers' administrative requirements, which all Medica network providers are contractually obligated to follow.

Summary:

This policy describes the requirements for billing and reimbursement of new patient evaluation and management (E/M) codes.

Policy Statement:

New patient E/M visit codes are eligible for reimbursement only when the patient has not received any professional services within the previous three years:

- From the same individual physician regardless of the Federal Tax Identification number or
- From the same physician or another physician of the same specialty reporting the same Federal Tax Identification number

For purpose of this policy, "professional services" would include any E/M service or other face-to-face service (e.g., surgical procedure). An interpretation of a diagnostic test, reading an x-ray or EKG etc., does not affect the designation of a New Patient by this policy.

This policy recognizes physician specialty; physician subspecialty is not considered.

If a physician/qualified health care professional is on-call or covering for another physician/qualified healthcare professional of the same specialty and billing under the same Federal Tax Identification number, the on-call or covering physician/qualified healthcare professional should not assign a new patient E/M for the visit. The physician/qualified healthcare professional on-call or covering for another

physician/qualified health care professional should assign an established E/M code for the service provided.

If a physician/qualified health care professional changes group practice and an established patient receives services from the same individual physician/qualified health care professional within a three year period, the patient is still considered an established patient. An established patient E/M code should be assigned for the service provided.

If both a preventive and problem oriented E/M service are provided on the same date of service, and the patient meets the criteria for a new patient E/M, only one of the E/M services billed can be a new patient E/M code.

Code Lists:
New Patient Visit Code List

Definitions:	
New Patient	An individual who has not received professional services within the past three years, either from the same physician/qualified health care professional *or* from a different physician/qualified health care professional, of the same specialty, belonging to the same group practice.
Professional Service	Face-to-face services rendered by physicians and other qualified health care professionals.
Same Group Practice	Determined by the reporting of the same federal tax identification number.

Q & A:
Q: The patient was seen in the emergency department by our on call doctor. The patient is following up with us for the first time. Can I bill a new patient visit? **A:** No, professional services were previously rendered to the patient by the same physician in the ER. The appropriate established patient code should be billed for the follow up visit. **Q:** We are a multi-specialty practice. We bill using the same federal TIN for all of our providers. The ophthalmologist has referred the patient to a neurologist. Can I bill a new patient E/M for the neurology visit? **A:** Yes, a new patient E/M can be billed for the neurologist visit. Even though the same federal TIN is reported, the providers' specialties differ. **Q:** The patient was last seen by their provider on 01/01/2017 and returns to see the same provider on 12/31/2019. Can I bill a new patient visit? **A:** No, it is not quite three years. The appropriate established patient E/M code should be billed for the service provided.

Resources:
Centers for Medicare and Medicaid Services (CMS)
Current Procedural Terminology (CPT®)
Healthcare Common Procedure Coding System (HCPCS)
National Physician Fee Schedule (NPFS)

Effective Date:	01/01/2022

Revision Updates:	
03/23/2023	Code List Update
01/12/2022	Code List Update
05/17/2021	Annual Policy Review