MEDICAID REIMBURSEMENT POLICY

New Patient

Active

Policy Number: Evaluation and Management - 013
Policy Title: New Patient
Section: Evaluation and Management
Effective Date: 01/01/24

Description

This policy addresses coding and reimbursement for new patient evaluation and management (E/M) codes.

Definitions

New Patient: A new patient is one who has not received any professional services from the provider or another provider of the same specialty who belongs to the same group practice within the past three years.

Professional Services: E/M or other face-to-face services.

Same Specialty Physician or Other Qualified Health Care Professional (QHP): Physicians and/or other qualified health care professionals of the same group and same specialty.

Policy Statement

Consistent with the Centers for Medicare and Medicaid Services (CMS), in the office or outpatient setting, a new patient E/M is eligible for reimbursement when the patient has not received any professional services within the past three years from:

- the same physician or other qualified healthcare professional, or
- another physician or other qualified healthcare professional of the same specialty who belongs to the same group practice.

When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty as the physician.

If a physician or QHP has seen the patient within the last three years, then joins a different group practice and the patient follows, the physician should assign an established E/M code for the services provided.

If the primary physician has seen the patient within the last three years, the on-call or covering physician should not assign a new patient E/M for the visit. The physician on-call or covering for another physician, should assign an established E/M code for the services provided.

Documentation Submission

Documentation must identify and describe the services performed. If a denial is appealed, this documentation must be submitted with the appeal.

Coverage

Eligible services will be subject to the subscriber benefits, applicable fee schedule amount and any coding edits.

The following applies to all claim submissions.

All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in the Provider Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply subscriber coverage or provider reimbursement.

CPT/HCPCS Modifier:	N/A						
ICD-10 Diagnosis:	N/A						
ICD-10 Procedure:	N/A						
CPT/HCPCS:	92002	92004	99202	99203	99204	99205	99341
	99342	99343	99344	99345	99381	99382	99383
	99384	99385	99386	99387			
Revenue Codes:	N/A						

Resources

Current Procedural Terminology (CPT®)
Medicare Claims Processing Manual, chapter 12, section 30.6.7

Policy History

10/24/2023	Initial Committee Approval