Payment Policy: New Patient

Reference Number: LA.PP.036
Product Types: ALL
Effective Date: 08/2020
Last Review Date: 08/2022~~0~~

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
According to the American Medical Association's (AMA) Current Procedural Terminology (CPT®) guidance, "A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years (1095 days)."

The purpose of this policy is to define payment criteria and appropriate use of the new patient evaluation and management (E&M) procedure codes.

Application.
Professional Services

Reimbursement
Claims submissions containing a new patient E&M code will be denied if a previous claim line containing any E&M code was billed within a three year period. The new patient code would be denied and replaced with an appropriate established patient code.

The new patient billing requirements apply even if the physician previously saw the patient while the physician was with a different group practice.

New Patient Recoding Crosswalk

New Patient Office Visit Codes	Established Patient Office Visit Codes
92002	92012
92004	92014
99201	99212
99202	99213
99203	99214
99204	99215
99205	99215
99324	99334
99325	99335
99326	99336
99327	99337
99328	99337

New Patient Office Visit Codes	Established Patient Office Visit Codes
99341	99347
99342	99348
99343	99349
99344	99350
99345	99350
99381	99391
99382	99392
99383	99393
99384	99394
99385	99395
99386	99396
99387	99397

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 20~~19~~21, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT/HCPCS Code	Descriptor
92002	Ophthalmological Services
92004	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits
99201	Office or other outpatient visit for the evaluation and management of a new patient (10 minutes)
99202	Office or other outpatient visit for the evaluation and management of a new patient (20 Minutes)
99203	Office or other outpatient visit for the evaluation and management of a new patient (30 minutes)
99204	Office or other outpatient visit for the evaluation and management of a new patient (45 minutes)
99205	Office or other outpatient visit for the evaluation and management of a new patient (60 minutes)

99324	Domiciliary or rest home visit for the evaluation and management of a new patient (20 minutes)
99325	Domiciliary or rest home visit for the evaluation and management of a new patient (30 minutes)
99326	Domiciliary or rest home visit for the evaluation and management of a new patient (45 minutes)
99327	Domiciliary or rest home visit for the evaluation and management of a new patient (60 minutes)
99328	Domiciliary or rest home visit for the evaluation and management of a new patient (75 minutes)
99341	Home visit for the evaluation and management of a new patient (20 minutes)
99342	Home visit for the evaluation and management of a new patient (30 minutes)
99343	Home visit for the evaluation and management of a new patient (45 minutes)
99344	Home visit for the evaluation and management of a new patient (60 minutes)
99345	Home visit for the evaluation and management of a new patient (75 minutes)
99381	Initial comprehensive preventive medicine evaluation and management (< 1year)
99382	Initial comprehensive preventive medicine evaluation and management of an individual (Age 1-4 years)
99383	Initial comprehensive preventive medicine evaluation and management of an individual (Age 5-11 years)
99384	Initial comprehensive preventive medicine evaluation and management of an individual (Age 12 – 17 years)
99385	Initial comprehensive preventive medicine evaluation and management of an individual (Age 18-39 years)
99386	Initial comprehensive preventive medicine evaluation and management of an individual (Age 40-64 years)
99387	Initial comprehensive preventive medicine evaluation and management of an individual (Age>65 years)
G0245	Initial physician evaluation and management of a diabetic patient
S0610	Annual gynecological examination, new patient
S0620	Routine ophthalmological examination including refraction; new patient

Modifier	Descriptor
NA	Not Applicable

ICD-10 Codes	Descriptor
NA	Not Applicable

Definitions
Not Applicable

Related Policies
Not Applicable

Related Documents or Resources
Not Applicable

References
1. *Current Procedural Terminology (CPT®)*, 20~~19~~21

Revision History	
08/15/2020	Converted corporate to local policy.
08/30/2022	Annual Review; Updated dates in the reference section from 2019 to 2021 Removed clinical and added payment policy in "Important Reminder" section

Important Reminder
This ~~clinical policy~~payment policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this ~~clinical policy~~payment policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this ~~clinical policy~~payment policy. This ~~clinical policy~~payment policy is consistent with standards of medical practice current at the time that this ~~clinical policy~~payment policy was approved.

The purpose of this ~~clinical policy~~payment policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This ~~clinical policy~~payment policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this ~~clinical policy~~payment policy. This ~~clinical~~

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POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, Centene's P&P management software, is considered equivalent to an actual signature on paper.

Senior Director of Network Accounts: _____Electronic Signature on File_