PREMERA BLUE CROSS
An Independent Licensee of the Blue Cross Blue Shield Association

Payment Policy

cmi_051738

Title	**New and Established Patient Guidelines**		
Number	**CP.PP.229.v2.7**		
Last Approval Date	08/12/24	**Original Effective Date**	10/10/03
Cross Reference	N/A		

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose	To define when the Plan recognizes new and established patient evaluation and management (E&M) services that are submitted on a CMS 1500 paper claim or 837P electronic claim form.
Scope	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company, and Premera Blue Cross HMO lines of business and products.
Policy	The Plan validates new versus established patient evaluation and management (E&M) services using the guidelines established by the American Medical Association (AMA) and published in its annual Current Procedural Terminology (CPT) Codebook as its foundation. A **new patient** is one who has not received any **face-to-face professional services** from the physician(s) or other qualified healthcare professional(s), or another physician(s) or other qualified health care professional(s) of the same specialty and subspecialty who belongs to the same group practice, within the past three years. An **established patient** is one who has received **face-to-face professional services** from the physician(s) or other qualified healthcare professional(s), or another physician(s) or other qualified health care professional(s) of the same specialty and subspecialty who belongs to the same group practice, within the past three years. In the instance where a physician/qualified health care professional is on call for or covering for another physician/qualified health care professional, and both providers share the same Tax Identification Number (TIN) and the same specialty/subspecialty, the patient's encounter will be classified as it would have been by the physician/qualified health care professional who is not available. The patient will not be considered a new patient to the covering provider even if that provider has not seen the patient before. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty as the physician. Professional services are those **face-to-face** services rendered by a physician or other qualified healthcare professional and reported by a specific CPT code(s). The location where the patient was seen has no bearing on status. If a provider furnished a face-to-face service to a patient within the previous three years (**in any prior physical location or under a different TIN**), the patient is still considered established with that provider in all locations.

	Interpreting diagnostic tests, reading x-rays or electrocardiograms (EKG), etc., without an E&M service or other face-to-face service with the patient does not affect the designation of a new patient. If the provider interprets a patient's test result but does **not** provide a face-to-face service, the patient is **not** considered established to that provider. New patient E&M codes are not reimbursed when the Plan determines that an established patient relationship exists.
Violations of Policy	Violations of this policy by any party that enters into a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties and/or termination of the contract. Disciplinary actions will be determined in Plan's sole discretion. Violations of this policy may be grounds for corrective action, up to and including termination of employment.
Exceptions	None
Laws, Regulations & Standards	None
References	American Medical Association's Current Procedural Terminology, Professional Edition (AMA/CPT)

Policy Owner Review	Payment Integrity Oversight Committee	
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department.	
Annual Review Dates	08/12/24; 11/09/23; 12/07/22; 01/07/22; 01/27/21; 02/10/20; 02/18/19; 02/27/18; 04/10/17; 05/23/16; 05/30/15; 06/08/14; 06/09/13; 06/10/12; 07/05/11; 07/04/10; 08/10/09; 12/19/08; 12/20/07; 11/24/06; 08/29/05; 10/08/04; 05/07/04	
Version History	02/27/18	Annual review; no changes
	02/18/19	Annual review; no changes
	02/10/20	Annual review; no changes
	01/27/21	Clarified the Purpose statement to indicate that the policy pertains to Professional services billed on a CMS-1500 or 837P electronic claim forms
	01/07/22	Annual review; no changes
	12/07/22	In the Policy section, clarified the descriptions for "new" and "established" patients as set forth in the AMA CPT Codebook
	11/09/23	In the Policy section: • in the fourth paragraph, added clarification on how covering providers will affect the status of the patient; • in the sixth paragraph, added clarification that if a provider sees a patient in the prior three years in any location, that patient is considered an established patient in all locations and • added the seventh paragraph indicating if no face-to-face patient encounter is rendered, only reading/interpreting of tests, the patient is NOT considered an established patient
	08/12/24	Annual review; no changes