Payment Policy: New Patient

Reference Number: CC.PP.036
Product Types: ALL
Effective Date: 01/01/2014
Last Review Date: 12/02/2024

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
Claim submissions containing a new patient E/M code are denied if a previous claim line containing any E/M code was billed within a three-year period by the same provider or another provider in the same practice with the same specialty. The new patient code is denied and replaced with the appropriate established patient code based on medical decision making, per the below crosswalk.

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

New Patient Coding Crosswalk

New Patient E/M Codes	Established Patient E/M Codes
92002	92012
92004	92014
99202	99213
99203	99214
99204	99215
99205	99215
99341	99347
99342	99348
99344	99350
99345	99350

New Patient E/M Codes	Established Patient E/M Codes
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 2025, 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.

References

1. *Current Procedural Terminology (CPT®), 2025*
2. *American Medical Association*
3. *Medicare Claims Processing Manual - Chapter 12 - Physicians/Nonphysician Practitioners: Sections 30.6.7*
   https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c12.pdf
4. *The Medicare Learning Network (MLN): MLN Matters, MLN006764*
   https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/eval-mgmt-serv-guide-icn006764.pdf

Revision History	
11/11/2016	Initial Policy Draft Created
03/10/2018	Reviewed and revised policy, validated codes.
03/10/2019	Conducted review and updated policy
11/01/2019	Annual Review completed
11/01/2020	Annual Review completed
11/30/2021	Annual review completed; no major updates required
12/01/2022	Annual review completed; updated crosswalk to reflect 2022 CPT updates; removed code table since this info can be found in CPT book
12/01/2023	Annual Review completed
02/23/2024	Annual Review completed

12/03/2024	Annual Review completed

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations 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 plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

 Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.