The word from CMS:

New diagnosis *to the physician* carries greater weight

Get out the audit tool you use to score your E/M charts, and turn to the medical decision-making (MDM) section. Now look at the sub-section for "number of diagnoses or treatment options." You'll need to determine whether the problem is stable, improved, or worsening, and whether additional workup is planned. But does your audit tool score based on whether the problem is new or established *to the examiner*, or does it assign points based on whether the problem is new or established *to the patient*?

You won't find it in writing, unfortunately, but the audit tools that tell you to score the MDM portion of the chart based on whether the problem is new or established *to the patient* are flat-out wrong in their interpretation of Medicare's E/M documentation guidelines, according to an E/M expert at the Centers for Medicare and Medicaid Service (CMS) (formerly HCFA) headquarters.

"It's not stated in the E/M documentation guidelines, so you can't really get the policy interpretation from the guidelines. But, it is new to the physician, not new to the patient," the CMS E/M expert says.

As an example: When a diabetic patient who has been treated for diabetes for 20 years sees a new physician, the problem or diagnosis is treated as a new problem. "We have always adhered to this policy," says the CMS official.

The problem, of course, is that there is no written policy statement regarding this issue. So, private companies and even some Medicare carriers have advised that you score the MDM by looking at whether the problem is stable, improved or worsening, and whether it is new to the patient (See PPC 6/00).

But the CMS official contacted by PPC tells us "this is, in capital letters, INCORRECT."

If you think about the rationale, it makes sense. This section of the guidelines is an attempt to give physicians credit for the decisions *they* must make. The decisions, of course, are based on the *doctor's* knowledge of the problems they're seeing. And, since a problem is often easier to treat when the physician is familiar with the way it affects the patient, the MDM section provides a way to give a higher value to those problems that are new to the physician. *–J. Gardner* ♦

Proposed 2002 physician fee schedule: Watch for changes in modifier –62 and glaucoma codes

New codes for glaucoma screenings are just some of the coding goodies included in the proposed physician fee schedule for 2002 (*Federal Register,* Aug. 2, 2001). The final physician fee schedule is due Nov. 1, 2001. Proposed changes include:

• **There are two new HCPCS 'G' codes for glaucoma screening** furnished by a physician for high-risk patients (G0117) and glaucoma screening furnished under the direct supervision of a physician for high-risk patients (G0118), according to the fee schedule and CMS program memo B-01-46.

CMS proposes to cover glaucoma screening services that include a dilated eye exam with an intraocular pressure measurement, and a direct ophthalmoscopy or a slit-lamp biomicroscopic examination, provided by or under the direct supervision (physician must in the office suite) of an optometrist or an ophthalmologist. Current Medicare policy covers glaucoma tests only if used to evaluate a specific complaint or symptom, or to monitor an existing condition, CMS notes.

Note: Don't use the two new G codes with an E/M service or any other optometry service for the same patient on the same date of service. Medicare will pay when the screening service is the only service provided, or when it is provided as part of an otherwise non-covered service, such as code 99397 (preventive services visit), according to the proposed rule.

• CMS proposes to allow providers to **list CPT's new categories of codes, performance measurement codes (category II) and emerging technology codes (category III), on their Medicare bills,** to facilitate the tracking of these services. Payment would not be made for the category II codes; payment for category III codes would be made on a case-by-case basis "only in specific situations when we determine that the codes represent services that are not, in fact, experimental, but have been shown to be safe and effective."

• Also, keep an eye out for **possible changes in the codes Medicare will allow you to bill with modifier –62, co-surgery,** (PPC 5/7/01). In a nod to changes in medical practice, CMS welcomes comments on which procedures require a co-surgeon and what documentation should be required for payment.