

SPECIAL OPHTHALMOLOGIC DIAGNOSTIC TESTS INTERPRETATION & REPORT REQUIREMENTS THE THREE C's

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INTRODUCTION

In the audits I have conducted, both recently and in the past, I have found a marked lack of compliance with the Interpretation and Report requirement for special diagnostic tests. Once again, there has been increased audit activity in this area. For Medicare, the Interpretation and Report needs the **Three C's** to be addressed: **Clinical Findings, Comparative Data and Clinical Management.** Let's see how we can proceed to understand the difference in these requirements.

ORIGINS

In CPT (Current Procedural Terminology) ophthalmological services with this requirement include sensorimotor examination (92060), visual fields (92081,92082, 92083), serial tonometry (92100), tonography (92120), scanning computerized ophthalmic diagnostic imaging/ocular computerized tomography (92132,92133, 92134), provocative tests for glaucoma (92140), ophthalmoscopies (92225, 92226), remote imaging (92227, 92228), fluorescein/ICG angiographies (92230, 92235, 92240), fundus photography (92250), oculoelectromyography (92265), electro-oculography (92270), electroretinography (92275), external ocular photography (92285), special anterior segment photography (92286, 92287).

This CPT phrase "with interpretation and report" follows the description of the service. This is the origin of the requirement. The Medicare Carriers' Manual is full of interpretation and report references but is markedly lacking in what the actual requirements are.

Nor is the answer is not well defined in CPT; however, here are some general guidelines gleaned from various publications. The Medicare Carriers Manual (15023) specifies that an interpretation and report should address the findings, relevant clinical issues, and comparative data (when available). There must be a written report that becomes part of the patient's medical record and this should be as

complete as possible. Simple reviews or notations generally will not be considered sufficient. Sometimes this is difficult to do, particularly on such tests as fundus photography.

Ultrasound interpretation and report requirements are defined in the beginning of the Diagnostic Ultrasound section. Instructions are as follows:

“All diagnostic ultrasound examinations require permanently recorded images with measurements, when such measurements are clinically indicated. For those codes whose sole diagnostic goal is a biometric measure (ie, 76514, 76516, and 76519), permanently recorded images are not required. A final, written report should be issued for inclusion in the patient’s medical record. The prescription for an intraocular lens satisfies the written report requirement for 76519.”

CHART DOCUMENTATION - THE THREE C’s

The presence of the written report in the chart documentation is paramount when one is audited. I highly recommend that a separate form be used which leaves an audit trail indicating that there is an interpretation and report. This is a particular problem with digital imaging where in many instances the images are reviewed without the chart, and the physician neglects to provide a written interpretation and report.

Clinical Findings. The interpretation and report should succinctly summarize your clinical findings. It does not have to be lengthy - just the pertinent findings. It shouldn’t be scribbled within the body of the examination where it looks like part of the examination. Auditors will miss it and you will be challenged.

Comparative Data. Medicare always likes to know if something is better, worse or just the same as before. And this is true for interpretation and report requirements. If a hemorrhage has resolved, visual field loss has progressed, or a lesion size has changed - then these findings need to be noted.

Clinical Management. Documenting the effect of the diagnostic test on your clinical management is the area that is almost always lacking in the interpretation and report. Medicare wants to know why they are paying you extra for this test - this extended ophthalmoscopy, this visual field, this fundus photo. You must

address how this is going to help you or affect your clinical management. Are you going to change/increase/stop medications? Are you going to recommend surgery? Are you suggesting further diagnostic testing? The answer to the pertinent question needs to be part of your written report.

EXAMPLES

As a general principle, try to address the reason why the diagnostic test was ordered. There should be an order in the patient record for the test and medical necessity should be apparent. If not, then a written notation should be present explaining the rationale for ordering the test.

Let's review some clinical examples.

Visual fields. A notation "visual fields reviewed - OK" would not suffice. A better notation would be "visual fields of 1.12.04 reviewed and show no defects. There is no evidence of changes attributable to glaucoma." A sufficient report (dated and signed) would be "Visual fields of 1.12.04 reviewed. There is progressive visual field loss secondary to glaucoma. This has increased since fields of 6.18.02. Medications to be reviewed and adjusted."

Extended Ophthalmoscopy. The drawing itself with arrows pointing to the drawing of the problem (labeled or not) does not suffice. You must address the Three C's. This needs to be in addition to your ophthalmoscopic findings when billing higher level codes.

Fundus Photos. "Normal" is not acceptable as an interpretation and report. Even if the photos are just baseline you still must note "C/D ratio 0.3 OU - no evidence of glaucomatous findings- no specific therapy indicated at this time".

The question that I am frequently asked is what to do with biometric tests, such as A scan with IOL calculations. The calculation suffices; however, make sure that becomes part of the chart documentation.

CONCLUSION

It is highly recommended that a form be used to capture the interpretation and report for all diagnostic tests. Under audit you may be refunding a lot of money - and not only for Medicare. I recently was consulted on several audits where there was no separately identifiable

written interpretation and report and Medicare demanded the monies issued for the professional component of the test be repaid.

Remember, each test, with the exception of gonioscopy and extended ophthalmoscopy, has a professional component (the physician is paid for the interpretation and report) and a technical component (the physician or facility is paid for the overhead for running and owning the equipment). Gonioscopy (92020) does not require an interpretation and report nor does ophthalmic biometry (92136), and Tonography with water provocation (92130).

The only documentation that the physician has for the interpretation and report requirement having been met is that written report!