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

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INTRODUCTION

In audits that I have conducted, both recently and in the past, I have found a continual and 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 explore the differences in these requirements.

ORIGINS

In CPT (Current Procedural Terminology) ophthalmological services with this requirement include:

- Computerized corneal topgraphy (92025)
- Sensorimotor examination (92060)
- Visual fields (92081,92082, 92083)
- Serial tonometry (92100)
- Tonography (92120)
- Scanning computerized ophthalmic diagnostic imaging/ocular computerized tomography (92132, 92133, 92134)
- Corneal hysteresis determination, by air impulse stimulation (92145)
- Ophthalmoscopy. extended (92201, 92202)
- Retina imaging (92227, 92228, 92229)
- Fluorescein/ICG angiographies (92230, 92235, 92240, 92242)
- Fundus photography (92250)
- Needle oculoelectromyography (92265)
- Electro-oculography (92270)
- Electroretinography (92273, 92274)
- Dark adaptation (92284)
- External ocular photography (92285)
- Anterior segment imaging (92286, 92287)

This CPT phrase "with interpretation and report" follows the description of the service. This is the origin of the requirement information for reports.

The Medicare Carriers' Manual is full of interpretation and report references but is markedly lacking information regarding what the actual requirements are.

Nor is the answer is well defined in either other Medicare publications or 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). However, most of the material is under Radiology and nothing is available for ophthalmic diagnostic tests.

Nevertheless, Medicare does audit on the presence of complete diagnostic test reports being present in the chart, so there must be a written report that becomes part of the patient's permanent 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 a specific and separate written report in the chart documentation is paramount in preparing a response/defense 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.

Mandatory documentation should contain:

Clinical Findings. The interpretation and report should succinctly summarize your clinical findings. It does not have to be lengthy - just the pertinent findings. It should not 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 should be applied to the content of the interpretation and report. If a hemorrhage has resolved, visual field loss has progressed, or a lesion size has changed - then these findings need to be noted in the interpretation and report. As in each section addressed here, the information may be duplicative, and should be duplicative of information being provided elsewhere in the chart.

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 with or otherwise affect your clinical management. Are you going to change/increase/stop medications? Are you going to recommend surgery? Are you suggesting further diagnostic testing? Is no treatment indicated at this time? Were the findings normal? The answer to the pertinent questions 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 1.12.21

reviewed and show no defects. There is no evidence of changes attributable to glaucoma." Thus, a sufficient report (dated and signed) would read:

> "Visual fields of 1.12.21 reviewed. There is progressive visual field loss secondary to glaucoma. This has increased since fields of 6.18.20. 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 the 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. If audited 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 that had been 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).

The only documentation that the physician has for meeting the interpretation and report requirement is that written report!

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