

Chart Documentation for Ophthalmic Diagnostic Tests

BY RIVA LEE ASBELL

During Medicare audits, it is not unusual that claims for diagnostic tests are rejected or subject to audits. The rules governing compliance and reimbursement are rigid and sometimes confounding. This article offers guidelines for achieving compliance with Medicare guidelines for diagnostic testing. Although this information is specific to Medicare, many other insurers use Medicare regulations as benchmarks.

DOCUMENTATION IN THE CHART NOTES

Order for the Test

There must be an order in the chart for all diagnostic tests. It can be part of the chart documentation in the previous visit or it can be in the current chart notes when the test is performed on the same day. When the latter occurs, it is important that the order precede the results of the test itself. This is frequently not the case with many electronic health record (EHR) systems. In addition, the rationale for the medical necessity of the test, if not readily apparent to an auditor, must be described.

Signature Requirements

The order for the test must be signed. The signature is valid if it appears in any part of the chart documentation, including at the end of that day's chart documentation. If it is needed elsewhere, or a physician has inadvertently forgotten to sign an order, an attestation statement to correct the omission may be used if Medicare requests copies of the records.

Extended Ophthalmoscopy

In the context of office visit documentation, the dilated posterior segment examination must be documented before a physician can bill separately for extended ophthalmoscopy. The medical necessity issue in play here is that there must be findings or symptoms that prompt the physician to order and perform any further testing. If a chart note reflects only dilation followed by extended

ophthalmoscopy, then it runs the risk of being down-coded to a level 3 during an audit because only 12 of the 14 required examination elements for E/M level 4 or 5 New Patient Examination will be fulfilled. For the Eye Codes, the requirements for standard ophthalmoscopy will not have been fulfilled, and the examination will be down-coded from comprehensive to intermediate.

INTERPRETATION AND REPORT REQUIREMENTS

Whenever there is a notation of "with interpretation and report" included in a Current Procedural Terminology (CPT) code descriptor, Medicare requires the following:

- An Interpretation and Report containing the three C's—clinical diagnosis, comparative data, and clinical management—included in the chart documentation. This should be separate from the examination and on a form or in an area of the EHR that is clearly labeled Interpretation and Report. Medicare's rationale is that because physicians get paid separately for these tests, they must have additional separate documentation. The information may be, and usually is, duplicative of that in the Impression and/or Plan in the chart documentation.
- Each test billed for should have its own Interpretation and Report document. For example, fluorescein angiography and fundus photography must each have a separate report. All ophthalmic diagnostic tests listed in the CPT manual that include "with interpretation and report" in the description must each have one. This includes all tests except gonioscopy and ultrasound for performing IOL calculations.
- Each diagnostic test, with the exception of extended ophthalmoscopy and gonioscopy (both are considered physician services only, but only extended ophthalmoscopy requires an Interpretation and Report), has a professional component and a technical component. The technical component covers the cost of equipment,

maintenance, and technician services, whereas the professional component is the Interpretation and Report document itself. Without the Interpretation and Report, the provider is not entitled to the full global fee for the test. (The global fee equals the sum of the professional component and the technical component.)

DIAGNOSIS CODING FOR OPHTHALMIC DIAGNOSTIC TESTS

The most serious harm a physician can cause a patient in chart documentation is attaching an inaccurate or non-existent diagnosis. That diagnosis follows the patient for the rest of his or her life and can irrevocably damage various aspects of their future, such as haunting them when they try to obtain employment or insurance coverage.

Medicare's guidelines for selecting the diagnosis mandate the following:

- If the test confirms a diagnosis, then code the diagnosis. An example of this is a patient who is referred for possible cystoid macular edema. Fluorescein angiography is performed, and a diagnosis of cystoid macular edema is made. Therefore, code the findings, in this case macular edema (abnormal test = code findings).
- If the test results do not yield a diagnosis, or are normal, then the signs and/or symptoms that prompted ordering/performing the test should be coded. For example, a patient is referred for treatment of possible cystoid macular edema, fluorescein angiography is performed and no evidence of macular edema is present. Because the test is normal, the claim is coded according to what prompted ordering of the test, such as blurred vision (368.8) (normal test = code signs or symptoms that prompted the doctor to order the test).
- If the physician performs a test on a referred patient to rule out a diagnosis or with an uncertain diagnosis, then the diagnosis is coded according to the signs and/or symptoms that prompted ordering or performing the test. For example, a patient is referred to a retina specialist by a comprehensive ophthalmologist with a working diagnosis of cystoid macular edema in the right eye, fluorescein angiography is performed, and it does not confirm the presence of macular edema. An appropriate diagnosis for the test would be blurred vision (368.8) (normal test = code signs or symptoms prompting ordering of test).

Medicare does not accept status post (s/p) or rule out (r/o) diagnoses. Thus, it becomes the physician's responsibility to make sure this does not occur in the chart documentation. Do not list a final diagnosis that is not confirmed at the time of the visit, and instruct billers not to use a diagnosis that is not confirmed and definitive.

BILLING DILEMMAS AND OCCASIONAL CONTROVERSIES

National Correct Coding Initiative Bundles

The National Correct Coding Initiative bundles CPT codes that cannot be billed together when performed by the same physician at the same session on the same day. Each code-pair has a modifier-indicator attached to it. The bundle can be broken (modifier-indicator of 1) by appending modifier 59 to the CPT codes. Note that, just because a bundle can be broken, this does not mean it necessarily should be. This concept is crucial when dealing with Medicare internal and contingency-based audits. It is the concept perhaps least understood by physicians and their staffs.

Optical Coherence Tomography (OCT) versus Fundus Photography

Except for the misuse of modifier 25, the unbundling of OCT and fundus photographs or choosing to code fundus photographs rather than OCT (due to the higher reimbursement of fundus photography) leads to most of the erroneous practices in retina coding. In the context of treating a patient for wet age-related macular degeneration, OCT determines the medical necessity. There will be occasions when a different clinical entity (ie, presence/absence of pigment, lipid, or blood in the macula) warrants a fundus photograph. However, when a patient is being evaluated for an intravitreal injection based on OCT findings, then OCT is the test for which there is medical necessity. Also, keep in mind that if excessive fundus photography is coded, the physician's high utilization pattern for that code may prompt an audit query.

Coding Fundus Autofluorescence Imaging and Standard Fundus Photography

Fundus Autofluorescence Imaging is billable using CPT code 92250, the same code as fundus photography. However, both should not be coded when performed on the same day or at same session. Widefield digital photography also qualifies for CPT code 92250.

CONCLUSION

In the setting of an audit, it is imperative that an auditor understand why the physician ordered a diagnostic test and that the Interpretation and Report document how the test helped clinical decision-making and management. ■

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