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A Complete Interpretation & Report is NOT Optional

Over a year ago, I wrote about the need to fully document the Interpretation & Report (I&R) for nearly every special test we perform. This includes OCTs, fundus photos, visual fields, topographies, ERGs, VEPs, and many more. Special tests that don't need an I&R are those like pachymetry where the result is a numeric number, and there is not much else that needs to be said. An easy way to find out if a test requires an I&R is to look in the current year's CPT book. *(By the way, have you bought your 2018 copies of CPT and ICD-10 yet?)* If the description of the code includes the words: "…with interpretation and report," it requires an I&R. If you look up 92250, it states, "Fundus photography **with interpretation and report**." If you look up 92020, it states, just "gonioscopy." That means you just need to document the findings, but no formal report needs to be followed. Despite this not being a new rule, but rather a requirement for these codes for many years, it is surprising how often I find no I&R documented when doing audits. The reason this is such a big concern is if the I&R is not complete, the test is not billable. The report is just as much of a requirement as the performance of the actual test. In an audit, any payment for a test that is incomplete would be recouped. A visual field with a check mark on it or the letters "WNL" won't cut it.

The documentation does not need to be a novel, but it must include five things: the **Order** and the "**4R's.**" All testing requires a written order in either the chart on that day or in a previous chart. That means a legitimate order could be found in a prior day's visit. If a patient presented for her annual exam, and you find suspicion of glaucoma, you could write: "Glaucoma suspect - RTC within 1 month for 24-2, RNFL OCT, pachy, and gonio." This statement clearly states the tests needed and the reason for them. In other cases, the need for the test is determined and the order is written during the same visit when the test is done.

Once the order has been established, a complete I&R needs to be documented either in the chart of that day, in a separate I&R document, or directly on the test's printout. There is no rule that says where the I&R needs to be; you just need one! If the I&R is not directly in the chart, it is best to have a statement like, "I&R on printout." This would clearly direct an auditor where to find it.

The "4R's" of an I&R are:
Reason for the test • **R**eliability of the test • **R**esults of the test • **R**ecommendations based on the results

An I&R does not need to be long or complex. A simple statement such as one of these below is perfectly acceptable. Nothing fancy, just complete.

24-2	Macular OCT
• *Moderate POAG – monitor progression* • *Reliable results* • *Stable inf. arcuate consistent with OCT and rim tissue thinning* • *Continue latanoprost 1 GT QHS OU* • *Repeat VF 1 year*	• *Early ARMD – baseline testing* • *Good quality scan - reliable* • *Mild RPE dispersion, no neo or fluid* • *Start AREDS 2 supplement* • *Repeat 6 months*

These examples certainly take more time to write than just "WNL." But they take less than a minute. Not only is it required by the payers, it provides better patient care. Imagine getting an MRI that just said, "WNL." Or one with "defect" and an arrow pointing to something. Your report needs to contain enough info to explain the results and what you are going to do with that information. Once you get used to the pattern of documentation, an I&R can typically be completed on-the-fly while seeing the patients.