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CPD C-104862

How to use early re-test codes 3.1, 3.2 and 3.3 on a GOS form in England

In this guide, we will provide guidance on using early re-test code 3.1, 3.2 and 3.3 on a GOS (General Ophthalmic Service) form.

This is worth half a non-interactive Continuous Professional Development (CPD) point and is suitable for all General Optical Council (GOC) registrants.

**Learning Objectives**

* To understand the process required to correctly use early re-test codes 3.1, 3.2   
  and 3.3.
* To understand best practice for submitting a GOS1 and GOS6 form.

### How to gain the CPD point

This CPD will take approximately 30 minutes to complete.

To obtain 0.5 CPD points, you must:

* read the information in this article
* read the cited references
* pass the Multiple-Choice Questionnaire (MCQ) assessment with a score greater than 60%

The link to the MCQ assessment is available at the end of this article.

### What happens next?

Upon completion of the MCQ assessment, you will receive an email outlining whether you have passed or failed.

This will be sent to the email address you entered on registering for the MCQ assessment. The email you receive stating that you have been successful in your MCQ attempt should be saved. You will need to upload the email as evidence when you are logging your CPD on the MyGOC website.

Feedback of the correct responses will be shared with both successful and unsuccessful responders.

### This guide covers:

* An overview of GOS claiming and NHSBSA (NHS Business Services Authority) Post Payment Verification (PPV) activity
* Early re-test codes 3.1, 3.2 and 3.3: what these codes are and how to use them correctly
* Best practice for submitting a GOS1 or GOS6 form

As specified in the Memorandum of Understanding (MoU), part of which is summarised in ‘Vouchers at a Glance’ (Figure 1), the Department of Health and Social Care (DHSC) made recommendations for the minimum interval between sight tests for specific patient categories in England.

If a contractor undertakes a GOS sight test at a shorter interval, you must annotate the GOS1 or GOS6 form with the appropriate early re-test code.

Furthermore, as per paragraph 2.1 of the Memorandum of Understanding, Contractors and Performers should not apply a blanket retest period for patients within a particular category.

“2.1 The GOS regulations require practitioners to satisfy themselves that a sight test is clinically necessary. Therefore, the intervals given below are not to be read as applying automatically to all patients in a category.”

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Figure 1

**We encourage that any GOS sight test undertaken at an interval of less than two years has a reason noted on the clinical record card, along with an early retest code. This will also help the next optometrist to understand the reason for the early test.**

The MoU guidelines do not always reflect the impact of current practice or new professional guidance. For example, most diabetic patients are now seen in the national Diabetic Retinal Screening programme and would not be expected to present for a sight test at an interval of less than two years. The College of Optometrists’ guidance supports this:

“A216:If patients are in an NHS diabetic eye screening programme, recall should be the same as for patients who do not have diabetes.”

The College of Optometrists also recommends:

“A64: In the absence of clinical indications, you should not examine patients who are being monitored by the hospital eye service (HES) more frequently than every two years.”

As required by the regulations, you should only undertake a GOS sight test if it is clinically necessary (Figure 2, an extract from the GOS Model Contract July 2018). You should also exercise clinical judgement when recalling patients for their next sight test or issuing a change in prescription.

**General Ophthalmic Mandatory Services Model Contract (July 2018)  
Standard (Additional Services) General Ophthalmic Services Contract (October 2010)**

37.4.1 Subject to clause 38 the Contractor shall satisfy itself that the testing of sight is necessary

**Testing of Sight**

30. The Contractor shall, having accepted an application from or on behalf of an eligible person for the testing of sight—

30.1. secure the testing of the patient’s sight to determine whether he needs to wear or use an optical appliance; and

30.2 in so doing, secure the fulfilment of any duty imposed on a tester of sight by, or in regulations made under, section 26 of the Opticians Act (duties to be performed on sight testing).

Figure 2: an extract from the GOS Model Contract – July 2018

GOS eligibility is based on clinical need and not refractive outcome. Therefore, you should not tell the patient they may need to pay privately for the sight test if no change in prescription is found.

Good record keeping is not only good practice but also ensures continuity of care and effective ongoing management for patients. It also supports GOS claims in the event of queries by the NHS. If a practice is subject to a PPV review, not documenting an early re-test code and the reasons for its use, on both the patient record and GOS 1/6 form, may lead to payment recovery.

Selection for PPV review is not an indication of wrongdoing. It is a process for both the NHS and contractors/performers to ensure claims are accurate and in accordance with the GOS contract. GOS Contract section 52 says you must:

“Keep full, accurate and contemporaneous records.”

If the sight test is at an interval of less than two years then it is essential that these records include the clinical reason for the early re-test, the relevant early re-test code and the next sight test recall. Under PPV, the NHSBSA can make a written request to review NHS patient records. The records must be produced within 21 days. The NHSBSA will assess both the clinical record and the GOS1/6 form (eGOS or paper format).

### Suggested evidence

The Contractor will be asked to submit relevant records for the patient. [The GOC Standards of Practice for Optometrists and Dispensing Opticians](https://optical.org/media/201flx0e/standards_of_practice_for_optoms_dos.pdf), section 8, states that a registrant must “maintain clear, legible and contemporaneous patient records which are accessible for all those involved in the patient’s care”. As a minimum, these records should show:

* the consultation date
* the patient’s personal details
* the consultation reason and any presenting condition
* any examination findings
* any treatment details, referrals, or advice that you provided, including any drugs or optical devices prescribed or a copy of a referral letter
* the consent obtained for any examination or treatment
* the details of all those involved in the optical consultation, including names and signatures

To validate a GOS claim, the NHS also requires:

* the date of the last sight test (or approximate date)
* the previous prescription, including presenting vision or visual acuities (VA) at distance and near- *in the event the patient previous spectacle are not available at the sight test but the previous prescription is known, (from previous records, previous prescription copy or by contacting the previous optometrist), the visual acuity from this previous prescription should be attained by inserting it in a trial frame/phoropter.*
* the condition and age of the current spectacles

A GOC registered clinical advisor will assess individual GOS claims marked for payment recovery.

When considering performing an early sight test, you should investigate whether there is an alternative pathway or commissioned service that may benefit the patient more than a GOS sight test. Further information can be found through your Local Optometric Committee (LOC) <https://www.loc-online.co.uk/> .

A GOS sight test must not be used more frequently for patients:

* with specific learning difficulties, including dyslexia, dyspraxia, dyscalculia, and attention deficit hyperactivity disorder.
* Under myopia management interventions. [Information from the College of Optometrists](https://www.college-optometrists.org/category-landing-pages/clinical-topics/myopia/myopia-management-guidance-faqs) currently says: “Myopia management is not currently funded by the NHS in the UK. This means you must pay for myopia management, and it is more expensive than traditional glasses or contact lenses.”

* Under locally commissioned services e.g., MECS/CUES. Existing urgent eye care services (MECS, CUES, PEARS or local equivalent) are not funded under GOS. Many ocular conditions we see in routine practice are not an emergency. This should be managed by the contractor/performer.

### What is early re-test code 3.1?

“Patient has presented with symptoms or concerns requiring ophthalmic investigation resulting in referral to a medical practitioner”.

If a patient has presented for a sight test at an interval less than two years, with symptoms that require clinical investigation and resulting in a referral to a medical practitioner, then applying re-test code 3.1 could be considered appropriate.

The clinical records should include:

* the reason for the visit - the full nature of any symptoms, visual disturbance, or impairment
* focimeter any spectacles to determine the most current prescription
* record the visual acuity in the presenting spectacles distance and near
* record the visual acuity in the final prescription distance and near
* record the additional tests that have been carried out necessary to investigate the symptoms
* record the actions being taken and reason for the referral. It should be clear that the referral has been made i.e., a copy of the referral enclosed. Keeping in line with the GOC Standards of Practice, Section 8, you should as a minimum record:

*8.2.5 Details of any treatment, referral or advice you provided, including any drugs or optical device prescribed or a copy of a referral letter.*

* the re-test code needs to be noted on both the clinical record and the GOS 1/6
* inform the patient of when their next sight test should take place, providing clinical justification for the recall period in the clinical record.

If re-test code 3.1 is used to perform an early sight test, the recall for the next sight test should not be any earlier than it would normally have been, unless there is a clinical reason or justification for a shorter recall. If the performer does suggest an earlier recall period, then they are recommended to note the clinical justification and a suggested early re-test code on the record to better inform the performer at the next sight test.

### Examples of the appropriate use of early re-test code 3.1

**Clinical Record 1**

A 77-year-old patient who notices a change in the vision of his right eye over the past three days.

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On the clinical record, the history and symptoms clearly note the patient symptoms with additional detail that is necessary. The performer has been able to obtain the visual acuity from the last sight test to confirm there has been a change in vision. Investigations done as part of the sight test show it was not possible to improve the vision with a new prescription.  Retinal examination indicates a right eye macula hemorrhage. The clinical record clearly explains the actions that are taken and that a referral is made to the HES. Further detail is given to show how the referral has been made i.e., letter given to the patient to take to HES and a copy sent to the GP. The clinical record satisfies the suggested evidence needed to support the early sight test and use of re-test code 3.1. The re-test code is noted on the record and should also be noted on the GOS 1/6 form.

**Other examples:**

* A patient presents for an early sight test, reporting blurred vision and headaches in recent weeks.

After further investigation into the patient's symptoms, the retinal examination shows bilateral blurred disc margins and swollen optic nerves. All necessary tests to investigate the symptoms have been carried out and results recorded. The performer makes a referral to the HES for papilledema. The clinical notes record the steps taken in submitting the referral and a copy is kept with the patient record.  Re-test code 3.1 can be used on the clinical record and GOS 1/6 form.

* A patient presents for an early sight test complaining of reduced distance vision in the right eye over the past six to eight weeks.

On fully investigating the symptoms it is found that the patient has a cataract causing reduced vision. After discussion, the patient is keen for a referral for cataract surgery and the patient meets NHS policy requirements for referral for cataract surgery. The clinical record shows all the necessary tests have been carried out to investigate the presenting symptoms, a referral has been made to the HES and a re-test code 3.1 can be used on the clinical record and GOS 1/6 form.

* A patient presents for an early sight test complaining of bilateral intermittent blurry vision.

On investigating the symptoms, no significant prescription is found, and the vision is good. The peripheral retinas show scattered dot hemorrhages. There are no other abnormalities found. The performer makes a referral to the GP informing them of their findings and for further cardiovascular investigations to determine underlying pathology that is likely causing the patient’s symptoms. The clinical record should justify that necessary tests to investigate the symptoms have been carried out and it has resulted in a GP referral.  In this case, re-test code 3.1 is appropriate and should be used on the clinical record and GOS 1/6.

In the examples given above, it should be assumed that all other necessary tests have been done to investigate the symptoms that the patient has presented with.

**Please note that the list of examples is non-exhaustive and professional clinical judgement should always be used. The clinical record must support the clinical judgement and reason for the sight test.**

**What is early re-test code 3.2?**

“Patient has presented with symptoms or concerns requiring ophthalmic investigation resulting in issue of a changed prescription”.

If a patient has presented for a sight test at an interval less than two years, with symptoms that require clinical investigation and that results in a change of prescription, then applying re-test code 3.2 could be considered appropriate.

Your patient record should include:

* the date of the last sight test (approximate if necessary)
* the consultation date
* the reason for visit
* any presenting condition
* any symptoms that the patient is experiencing
* the age and condition of the current spectacles
* the details of previous prescription, presenting visual acuity’s (VA) distance and near or unaided vision
* refraction with VA’s
* the finding of any assessment or examination.
* record the additional tests that have been carried out necessary to investigate the symptoms
* record the reason for the change in prescription issued i.e., improved visual acuity or improvement to symptoms.
* details of all those involved in the consultation, including names and signatures
* the re-test code which should also be recorded on the GOS 1/6 form
* the recommendation for the date of the next sight test with the justification on the clinical record. If the recall is shorter than two years, then it is encouraged to note a suggested re-test code to help the next performer understand the rationale behind this

**What is considered a significant prescription change in PPV?**

### When considering prescribing a prescription change, the College of Optometrists recommends:[[1]](#footnote-2)

“A310: You must only prescribe or recommend a change of spectacles when it is in the patient’s best interests to do so.112

NHS Counter Fraud Services have a remit to pursue cases where sight tests are carried out at inappropriate intervals and spectacles are supplied when they may not be clinically necessary.”

“A313: If you make a small change to an existing prescription, you must:

1. be clear about the benefit of the change.
2. keep a record of the reason and any advice given.”

The [GOC Standards of Practice for Optometrists and Dispensing Opticians](https://optical.org/media/201flx0e/standards_of_practice_for_optoms_dos.pdf), section 7 says:

“7.6: Only provide or recommend examinations, treatments, drugs or optical devices if these are clinically justified, and in the best interests of the patient.”

When using early re-test code 3.2, the ‘prescription change’ should be clinically justifiable and benefits the patient, as well as being evidenced in the clinical record. For PPV purposes, we will look for recorded VA improvements or a clear record of how the patient is benefitting from the prescription change.

Additionally, when prescribing prism as part of the ‘prescription change,’ you should consider the College of Optometrist guidance which states:

**“**A315:if you decide to prescribe a small prism (less than 1 prism horizontally or 0.5 prism vertically), you should consider all the clinical factors including the patient’s ocular muscle status, and whether the use of the prism is appropriate. You should consider any presenting symptoms.”

We would expect the necessary ocular muscle balance tests and any further investigations done to support the prescribing of prism to alleviate patient symptoms or concerns. There must be clinical justification for this, with the results noted on the clinical record. This should form the evidence for determining a prescription change in response to patient symptoms, and for using early re-test code 3.2.

Further information on issuing prescription changes and valid GOS 3 claims can be found in our article: ‘GOS 3 Voucher Claiming in England’. You can find this article on our [CPD webpage for GOC registrants](file://C:\Users\LADRI\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\VHIVUEUO\The%20reason%20for%20the%20sight%20test%20is%20recorded%20as%20symptoms%20of%20blurry%20vision%20and%20these%20are%20expanded%20on%20in%20further%20detail.%20Both%20eyes%20are%20found%20to%20be%20healthy%20and%20appropriate%20tests%20have%20been%20done%20to%20investigate%20the%20symptoms.%20Ocular%20muscle%20balance%20test%20results%20are%20shown%20to%20be%20normal.%20Although%20a%20prescription%20change%20has%20been%20found,%20there%20is%20no%20demonstrable%20improvement%20in%20VA%20with%20the%20new%20prescription.%20The%20performer%20is%20however%20able%20to%20record%20and%20justify%20the%20prescription%20change%20based%20on%20the%20results%20of%20the%20additional%20tests%20they%20have%20done,%20which%20in%20this%20case%20is%20the%20retinoscopy%20and%20the%20+1.00%20blur%20test.%20The%20record%20shows%20that%20the%20patient%20was%20advised%20that%20the%20prescription%20change%20may%20help%20alleviate%20the%20blurry%20vision.%20Therefore,%20the%20use%20of%20early%20re-test%20code%203.2%20is%20appropriately%20supported%20by%20the%20clinical%20record%20and%20should%20be%20added%20to%20the%20GOS%201\6%20form%20too.).

### Examples of the appropriate use of early re-test code 3.2

**Clinical Record 2**

A 17-year-old patient presents for an early sight test complaining of blurry vision for close tasks towards the end of the day.

The reason for the sight test is recorded as symptoms of blurry vision and these are expanded on in further detail. Both eyes are found to be healthy and appropriate tests have been done to investigate the symptoms. Ocular muscle balance tests are shown to be normal. Although a change in prescription has been found, there is no demonstrable improvement in visual acuity with the new prescription. The performer is however able to record and justify the prescribing of a change in prescription based on the results of the additional tests they have done, in this case retinoscopy and the +1.00 blur test. The record shows that the patient has been advised that the change in prescription may help alleviate the presenting symptoms. In this situation, the use of early re-test code 3.2 is appropriately supported by the clinical record and should also be added to the GOS 1/6 form.

**Other examples:**

* A patient presents for an early sight test with reduced vision in their current spectacles, and the sight test shows a change in prescription.

The clinical record will need that the patient presented with symptoms or concerns.  It should also show clear evidence of the presenting visual acuity/vision and the final visual acuity in the given prescription to demonstrate the improvement in visual acuity. Good record keeping will be important to demonstrate that all other necessary tests were done to investigate the presenting symptoms.  If the clinical record provides and supports the clinical judgement for a change in prescription then a re-test code of 3.2 can be appropriate and should be noted on the clinical record and GOS 1/6 form.

* A patient presents for an early sight test with recent asthenopia symptoms when on their VDU (visual display unit) at work.

The clinical record describes the nature of the reported symptoms. The presenting prescription of a small astigmatic prescription used for VDU work is noted. Ocular muscle balance tests show there is a decompensating exophoria at near with an exophoric fixation disparity slip at near, with and without the habitual prescription.  This is found to correct with a defined level of prism. There is normal convergence and accommodation recorded. A new prescription is prescribed with the incorporation of the prism that was found to help alleviate the symptoms. The clinical record will need to show the tests carried out and the corresponding results, to support the clinical justification for a change in prescription. In this case early re-test code 3.2 is appropriate and should be noted on the clinical record and GOS 1/6 form.

In the examples given above, it should be assumed that all other necessary tests have been done to investigate the symptoms that the patient presented with.

**Please note that the list of examples is non-exhaustive and professional clinical judgement should always be used. The clinical record must support the clinical judgement and reason for the sight test.**

**What is early re-test code 3.3?**

“Patient has presented with symptoms or concerns requiring ophthalmic investigation resulting in either no change or no referral (the patient record should indicate any symptoms shown to support this category of claim if necessary)”.

On examination, your clinical record should include:

* the date of the last sight test (approximate if necessary)
* the consultation date
* the reason for visit
* any presenting condition
* any symptoms that the patient is experiencing
* the age and condition of the current spectacles
* the details of previous prescription, presenting visual acuity’s (VA) distance and near or unaided vision
* refraction with VAs
* the findings of any assessment or examination
* record the additional tests that have been carried out necessary to investigate the symptoms
* record that no change in prescription has been found, and a referral is not required.
* record any actions being taken by the performer
* details of all those involved in the consultation, including names and signatures
* the re-test code which should also be recorded on the GOS 1/6 form
* the recommendation for the date of the next sight test with the justification on the clinical record. If the recall is shorter than two years, then it is encouraged to note a suggested re-test code to help the next performer understand the rationale behind this

### Examples of the appropriate use of early re-test code 3.3

**Clinical Record 3**

A patient has presented for an early sight test with symptoms of reduced vision in one eye.

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The sight test has identified the patient has a cataract in their right eye, however the VA is still of a satisfactory level. The VA is not shown to improve with the small change in prescription that is found, and the patient is happy for the cataract to be monitored in practice. In this case, early re-test code 3.3 is appropriate and should be recorded on both the clinical record and GOS 1/6 form. The clinical record shows that the patient has been advised to have another sight test in 24 months with suggestion to use early re-test code 2 for the next performer’s information if the patient presents sooner due to cataract symptoms. This is suggested good practice and will help the performer at the next GOS 1/6 form submission. It is encouraged to see an asymptomatic patient with a mild cataract at a two-year interval.

Other examples:

* A patient has presented for an early sight test with symptoms of eye strain when using the VDU for gaming for prolonged periods of time.

No prescription or binocular vision anomaly is found, and the eyes are healthy. There is no cause found for the eye strain other than length of time at visual task. The patient is issued advice on sensible VDU use with regular breaks and advised to seek advice if symptoms do not improve. The clinical record should contain a note of all the tests done and the advice that has been given to the patient. In this instance a re-test code 3.3 may be appropriate and should be annotated on the clinical record and GOS 1/6 form.

* A 30-year-old patient has presented for an early sight test complaining of not being able to see as well when driving in the dark with oncoming headlights. On further questioning about the symptoms, the patient mentions they have recently started a new job and so now find themselves driving home in the dark whereas previously they worked from home.

The patient’s symptoms are noted along with any further details such as duration of symptoms. It is noted that previously no prescription was found and today vision is still good. Retinal examination shows eyes are healthy, no other abnormality is found. There is small hypermetropic prescription found for which there is no demonstratable improvement in visual acuity or visual comfort. The patient is not prescribed a change in prescription, clinically there is no reason found to require a referral and the performer is satisfied there are no interventions required. Following the issuing of appropriate advice to the patient, the clinical record and GOS 1/6 form may be annotated with early re-test code 3.3.

In the examples given above, it should be assumed that all other necessary tests have been done to investigate the symptoms that the patient presented with.

**Please note that the list of examples is non-exhaustive and professional clinical judgement should always be used. The clinical record must support the clinical judgement and reason for the sight test.**

In summary, your clinical records should as a minimum include:

* the date of last sight test (approximate if necessary)
* the date of the consultation, and the reason for visit
* the reason for the consultation and any presenting condition
* symptoms that the patient is experiencing
* condition and age of current spectacles
* the details of, previous prescription, presenting VA’s distance and near or unaided vision, refraction with VA’s and findings of any assessment or examination conducted
* details of external and internal examination
* any additional tests carried out with results recorded
* details of any recommendations/ advice you provided, including any drugs or optical device prescribed or a copy of a letter to the GP
* consent obtained for any examination or treatment
* details of all those involved in the optical consultation, including name and signature, or other identification of the author
* recommendation for the date of the next sight test with explanation on    clinical record and advised to the patient

### Best practice for submitting your GOS 1/6 form

* Record the dates of the latest and last sight tests on both the patient’s record and the GOS 1/6 form. Make sure you provide the date within the last sight test field in a valid format. Only the year is required if the last sight test was more than two years ago. The following formats are accepted:  
  + YYYY (for example 2019)
  + MMMYYYY (for example MAR2019)
  + DDMMYYYY (for example 01032019)
* Clearly specify the clinical justification for the early re-test on the patient’s record.
* Record the tests you have performed and the corresponding results on the patient’s record.
* Include an early re-test code if the sight test is performed at a shorter interval than two years.
* Record the early re-test code on both the patient’s record and the GOS 1/6 form. Select the most accurate, appropriate, and consistent code across these records.
* Record all other information on the GOS 1/6 form in the correct place, correlated with the information on the patient record.
* Select a recall period for the next sight test on the patient’s record. If the interval is less than two years, it is good practice to suggest a retest code to help the next performer.

**Complete the MCQ assessment**

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Use the QR code or [access the online MCQ assessment](https://forms.office.com/e/hBpARuSaHb).

For more information:

* Visit [our website](https://www.nhsbsa.nhs.uk/provider-assurance-ophthalmic-services)
* Read [Making accurate claims England 2022](https://www.fodo.com/members/guidance/category-3/making-accurate-claims/)
* Read [Vouchers at a glance – England 2022](https://www.abdo.org.uk/wp-content/uploads/2023/03/13347B-2023-Voucher-England-FINAL.pdf)
* Read guidance from [The College of Optometrists](https://www.college-optometrists.org/clinical-guidance/guidance)

1. https://www.college-optometrists.org/clinical-guidance/guidance/knowledge,-skills-and-performance/prescribing-spectacles#Smallprescriptionsandmakingsmallchangestoex [↑](#footnote-ref-2)