Vision Rehabilitation Coding

CONTENT DIRECTORS
Stephen A. Kamenetzky, MD, OCS, has indicated the following financial interest or relationships relevant to this activity:
- Employee — Anthem Blue Cross/Blue Shield
- Consultant/Advisor — Ophthalmic Mutual Insurance Company (OMIC)

Sue J. Vicchielli, COT, OCS, Academy Coding Executive, has indicated she has no financial interest or relationships relevant to this activity.

AUTHORS
The following authors have indicated they have no financial interest or relationships relevant to this activity:
Kim M. Ross, OCS, CPC, Academy Coding Specialist
Sue J. Vicchielli, COT, OCS, Academy Coding Executive

CONTRIBUTING AUTHORS
The following contributing authors have indicated they have no financial interest or relationships relevant to this activity:
Michael X. Repka, MD, OCS, Medical Director for Government Affairs
William L. Rich III, MD, Medical Director of Health Policy
Donald C. Fletcher, MD
Lylas G. Mogk, MD

The following contributing author has indicated the following financial interest or relationship relevant to this activity:
Anne T. Riddering, OTR, COMS, CLVT
- Consultant /Advisor — VisionCare Technologies

The following American Academy of Ophthalmology staff have indicated they have no financial interest or relationships relevant to this activity:

Staff Project Managers
Janine Barth and Peggy Coakley

Academy Staff
Stacey Samuels and Jacob Coverstone

Ophthalmic Coding Specialist (OCS) Exam

The American Academy of Ophthalmic Executives (AAOE) and the Joint Commission on Allied Health Personnel in Ophthalmology (JCAHPO) are partners in offering the Ophthalmic Coding Specialist™ (OCS) Exam designed to help professionals in ophthalmology improve their coding and documentation abilities.

Reassure yourself that your coding knowledge is up to date — The OCS exam is designed to educate and thoroughly test the coding knowledge of professionals in ophthalmology, including: physicians, coders/billers, ophthalmic medical personnel, office managers, administrators, consultants, and paraprofessionals.

This open-book exam includes questions on the following 19 content areas: anterior chamber; code this chart; compliance; cornea; CPT® and ICD-9; E&M and Eye codes; frequently asked questions; glaucoma; ICD-10; introduction to ophthalmic coding; major and minor surgery; modifiers; neuro-ophthalmology; oculoplastics; optical dispensing; pediatrics and strabismus; retina; testing services and vision rehabilitation.

Visit www.aao.org/ocs for complete details.

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Product #0123012V

Updates to this coding topic made throughout the year may be found at www.aao.org/aaoesite/ocs38.cfm
Questions or comments about this publication should be sent to coding@aao.org.

CME and CEU credit for this module is valid from January 1, 2012 through December 31, 2012.

Target Audience
The primary target audience for this activity is practicing ophthalmologists, practice administrators, technicians and billing staff working in an Ophthalmology practice across a variety of settings.

NOTE: BEFORE BEGINNING THIS ACTIVITY
Pre- and Post-Test Requirements for Claiming CME and CEU Credit

♦ All participants must complete an online pretest before beginning this module to assess baseline knowledge for this activity.
♦ All participants must complete an online post-test and the course evaluation form to receive the appropriate CME or CEU credit for this activity.
♦ A score of 80% or greater must be achieved to be eligible for CME and CEU credit.

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The American Academy of Ophthalmology designates this educational activity for a maximum of 1.0 AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

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This course has been approved for 1.0 JCAHPO “Group A” CE credits.

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Please keep any certificate earned in your own personal file.
JCAHPO, AAPC, and AAOE do not retain records of CE credits earned.

Learning Objectives — Vision Rehabilitation Coding
Upon completion of this self study course, the participant will be able to:
1. Identify and implement Medicare rules and regulations that apply to vision rehabilitation practices.
2. Identify and discuss the appropriate billing for rehab therapy and low vision exams.
3. Identify and discuss the appropriate billing for rehab therapy and low vision exams.
4. Discuss the appropriate documentation for a vision rehab plan of care.
Background Information

Comprehensive vision rehabilitation has two consecutive parts—the low vision evaluation followed by rehabilitation therapy. These two parts have different content, providers, billing, coding and documentation from each other but are undertaken with ongoing interaction and communication between and among providers regarding each patient.

Medicare patients with vision loss may be eligible for rehabilitation services to improve function, including performance of activities of daily living, self-care and home management, and community integration.

Medicare Coverage for Vision Rehabilitation

Who May Provide the Services?

Low vision evaluation: The low vision evaluation is performed by an MD, DO, or OD.

Rehabilitation Therapy: Medicare Program Memorandum Transmittal AB-02-078 specifies that rehabilitation services may be provided by a physician or an occupational therapist (OT). No billing may be submitted for rehabilitation services performed by any other individuals.

The Center for Medicare and Medicaid Services (CMS) has launched a demonstration project in vision rehabilitation mandated by Congress because of proposed legislation to add new providers as rehabilitation therapists. In two cities (Atlanta and the five boroughs of New York) and four states (New Hampshire, North Carolina, Kansas, and Washington State) the rehabilitation services of Certified Low Vision Therapists, Certified Vision Rehabilitation Therapists, and Certified Orientation and Mobility Specialists may be billed with certain coding and documentation requirements for the duration of the project.

Who Qualifies for Coverage for Rehabilitation Therapy?

Transmittal AB-02-078 states: “The patient must have potential for restoration or improvement of lost functions, and must be expected to improve significantly within a reasonable and generally predictable amount of time. Rehabilitation services are not covered if the patient is unable to cooperate in the treatment program or if clear goals are not definable.”

Medicare has defined the clinical levels of impairment in visual acuity or visual field that qualify patients for rehabilitation therapy. These impairments may be caused by any disease, condition or injury, including but not exclusive to diabetes, macular degeneration, retinitis pigmentosa, glaucoma, and cerebrovascular accidents.

Rehabilitation therapy is limited to three consecutive months per calendar year preceded by a physician visit and renewable within the same calendar year with documentation of a significant change in the patient’s vision or living situation. Specific coding and documentation requirements apply (page 4).

Impairment Levels Related to Acuity

♦ Moderate: best-corrected visual acuity is less than 20/60
♦ Severe: best-corrected visual acuity is less than 20/160, or visual field is 20 degrees or less
♦ Profound: best-corrected visual acuity is less than 20/400, or visual field is 10 degrees or less
♦ Near total blindness: best-corrected visual acuity is less than 20/1000, or visual field is 5 degrees or less
♦ Total blindness: no light perception
♦ Impairments related to visual field: hemianopsias, generalized constriction, and central scotomas

(Note: Severe, profound, near total and total impairments are included in the term “legal blindness.”)

Modifier –GO

Services delivered under an outpatient occupational therapy plan of care.

This HCPCS Medicare modifier is required for all vision rehabilitation claims to track the amount of therapy for all causes a patient receives during a calendar year.

Covered ICD-9 Diagnosis Codes

These visual impairment codes are used for the low vision evaluation and for rehabilitation therapy. The disease codes are the secondary codes.

BE = better eye
LE = lesser eye
### Codes for Low Vision Examination

The impairment code is the primary code and the disease code is the secondary code. Low vision evaluations may be billed under Evaluation and Management codes (99201-99205) corresponding to the levels indicated above. If more than half of the total time is devoted to counseling and advising the patient, billing may be according to time spent, although levels of care and complexity of decision-making should be documented.

#### Content of Comprehensive Low Vision Evaluation as Reflected in E&M Coding Levels

<table>
<thead>
<tr>
<th>I. E&amp;M Codes</th>
<th>III. History</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Patient:</td>
<td>History of Present Illness (HPI) (i.e. Visual Impairment):</td>
</tr>
<tr>
<td>Low Complexity, 30 min</td>
<td><strong>Problem focused</strong>: Brief, 1–3 elements</td>
</tr>
<tr>
<td>Moderate Complexity, 45 min</td>
<td><strong>Expanded PF</strong>: Brief, 1–3</td>
</tr>
<tr>
<td>High Complexity, 60 min</td>
<td><strong>Detailed</strong>: Expanded, &gt; 3 elements</td>
</tr>
<tr>
<td>Established Pt:</td>
<td><strong>Comprehensive</strong>: Extended: 4 or more</td>
</tr>
<tr>
<td>Low Complexity, 15 min</td>
<td>Onset/progression: duration, severity, quality</td>
</tr>
<tr>
<td>Moderate Complexity, 25 min</td>
<td>Safety: falls, injuries, medication management, nutritional compromise</td>
</tr>
<tr>
<td>High Complexity, 40 min</td>
<td>Charles Bonnet Syndrome</td>
</tr>
</tbody>
</table>

### Diagnosis Codes 368.41–369.08

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>368.41</td>
<td>Scotoma involving central area</td>
</tr>
<tr>
<td>368.45</td>
<td>Generalized contraction or constriction</td>
</tr>
<tr>
<td>368.46</td>
<td>Homonymous bilateral field defects</td>
</tr>
<tr>
<td>368.47</td>
<td>Heteronymous bilateral field defects</td>
</tr>
<tr>
<td>369.01</td>
<td>BE - total impairment</td>
</tr>
<tr>
<td></td>
<td>LE - total impairment</td>
</tr>
<tr>
<td>369.03</td>
<td>BE - near-total impairment</td>
</tr>
<tr>
<td></td>
<td>LE - near-total impairment</td>
</tr>
<tr>
<td>369.04</td>
<td>BE - near-total impairment</td>
</tr>
<tr>
<td></td>
<td>LE - near-total impairment</td>
</tr>
<tr>
<td>369.06</td>
<td>BE - profound impairment</td>
</tr>
<tr>
<td></td>
<td>LE - total impairment</td>
</tr>
<tr>
<td>369.07</td>
<td>BE - profound impairment</td>
</tr>
<tr>
<td></td>
<td>LE - near-total impairment</td>
</tr>
<tr>
<td>369.08</td>
<td>BE - profound impairment</td>
</tr>
<tr>
<td></td>
<td>LE - profound impairment</td>
</tr>
</tbody>
</table>

### Diagnosis Codes 369.12–369.25

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>369.12</td>
<td>BE - severe impairment</td>
</tr>
<tr>
<td></td>
<td>LE - total impairment</td>
</tr>
<tr>
<td>369.13</td>
<td>BE - severe impairment</td>
</tr>
<tr>
<td></td>
<td>LE - near-total impairment</td>
</tr>
<tr>
<td>369.14</td>
<td>BE - severe impairment</td>
</tr>
<tr>
<td></td>
<td>LE - profound impairment</td>
</tr>
<tr>
<td>369.16</td>
<td>BE - moderate impairment</td>
</tr>
<tr>
<td></td>
<td>LE - total impairment</td>
</tr>
<tr>
<td>369.17</td>
<td>BE - moderate impairment</td>
</tr>
<tr>
<td></td>
<td>LE - near-total impairment</td>
</tr>
<tr>
<td>369.18</td>
<td>BE - moderate impairment</td>
</tr>
<tr>
<td></td>
<td>LE - profound impairment</td>
</tr>
<tr>
<td>369.22</td>
<td>BE - severe impairment</td>
</tr>
<tr>
<td></td>
<td>LE - severe impairment</td>
</tr>
<tr>
<td>369.24</td>
<td>BE - moderate impairment</td>
</tr>
<tr>
<td></td>
<td>LE - severe impairment</td>
</tr>
<tr>
<td>369.25</td>
<td>BE - moderate impairment</td>
</tr>
<tr>
<td></td>
<td>LE - moderate impairment</td>
</tr>
</tbody>
</table>
Review of Systems (ROS):

- **Problem focused:** None
- **Expanded PF:** 1 system pertinent to prob.
- **Detailed:** Exp’d, 2–9 systems
- **Comprehensive:** Complete, >10 systems

**Constitutional**
- Respiratory
- ENT/hearing
- Psychiatric
- Cardiovascular
- Genitourinary
- Neurological (e.g. CVA)
- Hematological
- Gastrointestinal
- Integumentary
- Endocrine (e.g. diabetes)
- Allergic/immunological
- Ophthalmological
- Musculoskeletal (e.g. tremors, arthritis)
- Other

**Past Family & Social History (PFSH):**

- **Problem focused:** (PF): None
- **Expanded PF:** None
- **Detailed:** 1 element pertinent to prob.
- **Comprehensive:** New pt, 3 elements; Est’d pt, 2 elements

**Past History:** Ophthalmic
- Family History: Ophthalmic, other medical
- Social/psychosocial history: living situation, responsibilities, supports; smoking, drinking, adjustment to vision loss, fear of blindness, fear of falling

IV. Examination

- **Problem focused:** 1–5 elements
- **Expanded problem focused:** At least 6 elements
- **Detailed:** At least 9 elements
- **Comprehensive:** 14 elements, including and requiring A and/or B

16 elements of a low vision examination (1–15 plus A and B)

1. Visual acuity, precise to 20/2000
2. Near acuity
3. Reading performance
4. Contrast sensitivity/glare
5. Scotoma/PRL identification/fixation stability
6. Binocularity
7. Peripheral field assessment
8. Determination of visual potential (refraction)
9. Assessment of eye/PRL/hand coordination
10. Initial response to magnification options for near tasks
11. Initial response to magnification for intermediate tasks
12. Initial response to magnification for distance tasks
13. Response to lighting, contrast enhancement, filters
14. Assessment of mobility
15. Assessment of Charles Bonnet hallucinations
   - A. Assessment of depression/mood and affect
   - B. Assessment of cognitive status/orientation

V. Plan

- Recommendation for:
  - Optical and non-optical devices
    - Adaptive equipment
    - Home adaptations
    - Rehabilitation training
  - Referral (order) for rehabilitation assessment and therapy:
    - Visual skill training
    - Scotoma/preferred retinal locus training
    - Activities of daily living
    - Medication management
    - Community reintroduction
    - Safe mobility

- Referral for support services
  - Group therapy/counseling
  - Support group
  - Community and/or State or national services
  - Veteran’s Administration services

- Return to primary eye care physician for treatment of disease
VI. Medical Decision Making

<table>
<thead>
<tr>
<th>Complexity</th>
<th>Straightforward</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Diagnoses or Management Options</td>
<td>minimal</td>
<td>limited</td>
<td>multiple</td>
<td>extensive</td>
</tr>
<tr>
<td>Amount and/or Complexity of data</td>
<td>minimal or low</td>
<td>limited</td>
<td>moderate</td>
<td>extensive</td>
</tr>
<tr>
<td>Risk of Complications</td>
<td>minimal</td>
<td>low</td>
<td>moderate</td>
<td>high</td>
</tr>
</tbody>
</table>

Examples:

Straightforward: Complains only of difficulty reading newsprint; impairment = blurred vision; no scotomas; minimal contrast loss; no suspicion of depression; problem resolved with higher add and/or light,

Low complexity: Complains of difficulty reading all small print and seeing signs when driving; small paracentral scotoma in one eye not interfering with fixation or reading, dense central scotoma in other; mod contrast loss; requires device for reading, filters, advice on driving, may require OT, scotoma training

Moderate complexity: Complains of difficulty with all reading, ADLs at home, transportation, shopping; central or ring scotomas OU or paracentral in one eye interfering with reading; moderate to severe contrast loss; multiple medical issues (e.g., arthritis, risk of falls, CBS, hearing, depression); discouraged; requires range of devices and filters; requires OT training

High complexity: Complains of difficulty with all reading, ADLs at home, transportation, shopping; central scotomas OU; severe contrast loss; multiple medical issues as above; no support system and/or primary caretaker of spouse; high risk for depression; requires range of devices, strategies, OT training

VII. Sample Topics for Discussion

Pattern of loss: central and peripheral field deficits, PRLs, training
Minimizing risk/rate of progression
Safety: fall prevention
Activities of daily living
Depression: relationship of depression to function
Fear of blindness
Family dynamics, role reversals
Driving: rules, options, strategies
Alternative transportation
Charles Bonnet Syndrome
Lighting, contrast and glare control
Non-optical devices: e.g. large checks, bold pens, large print items
Environmental adaptations
Local services and resources: radio reading service, phone
National services: e.g. Library of Congress talking books
Legal blindness: definition, benefits
**Documentation for the Low Vision Evaluation**

Documentation should include all ingredients of the low vision evaluation performed. The order for Medicare-reimbursed rehabilitation services by the occupational therapist should include the level of impairment, the disease causing the impairment, the resulting functional deficits, the therapy needed, the expected frequency of visits and total time of therapy intervention and the patient’s potential to benefit from it.

**Coding for Rehabilitation Therapy**

Note that these CPT codes are used only for rehabilitation and have no role in the physician’s low vision evaluation.

**Visual Rehabilitation Therapy Codes**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>97110</td>
<td>Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility</td>
</tr>
<tr>
<td>97116</td>
<td>Gait training (includes stair climbing). Not generally applicable to vision rehabilitation.</td>
</tr>
<tr>
<td>97532</td>
<td>Development of cognitive skills to improve attention, memory, problem solving, direct (one-on-one) patient contact by the provider, each 15 minutes. Includes scotoma/PRL training, scanning.</td>
</tr>
<tr>
<td>97533</td>
<td>Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes. Used for scotoma/preferred retinal locus (PRL) training.</td>
</tr>
<tr>
<td>97535</td>
<td>Self-care/home management training, activities of daily living, compensatory training, and instruction in use of adaptive equipment, direct (one-on-one) patient contact by the provider, each 15 minutes.</td>
</tr>
<tr>
<td>97537</td>
<td>Community/work reintegration (eg, shopping, transportation, money management, avocational activities and/or work environment/modified analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact by provider, each 15 minutes.</td>
</tr>
</tbody>
</table>

**Note:** The last three codes listed are most commonly used for visual rehabilitation. Medicare carriers in some regions accept the code 97530 when used for scotoma/PRL training. Check with your Medicare carrier.

**Documentation for Rehabilitation Therapy**

The use of the therapy codes above requires the following documentation. Narrative description is required, at least in part; forms used for the following may not be exclusively checklists:

1. **Assessment and plan of care (treatment plan) includes:**
   a. Statement of type and degree of functional deficits
   b. Physical or cognitive factors that may affect therapeutic outcome
   c. A list of specific, attainable goals developed in consultation with the patient
   d. The method to be used in achieving the goals
   e. The patient’s rehabilitation potential
   f. An estimation of the frequency of visits and total time required

2. **Daily treatment/progress notes include:**
   a. Therapeutic activity provided under each code used
   b. Patient’s progress. If there is no progress in two consecutive visits, therapy must be discontinued
   c. Time units for each code used (one unit = 15 minutes) and beginning and ending times of treatment session

3. **Monthly progress note:**
   a. Required if therapy extends beyond one month, regardless of number of visits in that month
   b. Summarizes activity and states the degree to which each goal has been accomplished, and reflects patient’s current status compared to status during previous monthly note or initial evaluation
   c. Provides justification that additional treatment is reasonable and medically necessary
   d. Physician ordering the therapy should review the monthly progress note; however, a reorder is not required for continued therapy.

4. **Discharge summary**
   a. States the extent to which each goal in the plan of care was accomplished
   b. Describes the final disposition of the patient
   c. Should be reviewed by the ordering physician, but a signature is not required
**Additional Rehabilitation Rules**

1. The physician’s initial rehabilitation order or certification is valid for 90 calendar days from the first day of evaluation or treatment.

2. Therapy can only be offered within one continuous three-month period per calendar year. The only exception is if the impairment code changes (e.g., from moderate/severe to severe/severe) or if the patient’s situation materially changes (e.g., a spouse dies, the patient moves to a new home, or the patient has a stroke and can’t hold the magnifier that was prescribed). If the physician re-examines the patient and there are no changes, additional therapy may not be undertaken in that calendar year.

3. Only one set of goals can be worked on at a time. If the patient is already receiving occupational therapy for a stroke or a hip fracture, they may not receive visual rehabilitation during the same period. Rehabilitation under different impairment codes must be consecutive, not simultaneous.

For Content of Rehabilitation, see under SmartSight Level 3 below.

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**SMARTSIGHT™**

*The Academy Initiative in Visual Rehabilitation*

SmartSight is the Academy’s response to the growing number of patients with visual impairments, and its recognition that ophthalmologist’s are responsible for their ongoing care, SmartSight offers ophthalmologists with a quick, easy way to provide patients with excellent, life-saving self-help information. SmartSight is organized in three levels:

**Level 1: SMARTSIGHT Patient Handout**

Download free from [www.aao.org/smartsight](http://www.aao.org/smartsight), in English, Spanish and French.

Smartsight Level 1 calls on all ophthalmologists to:

1. Recognize that patients with vision 20/50 or less need help and
2. Respond by giving them a copy of this free handout that provides tips and resources essential to patients’ wellbeing. A copy is printed below.

**Level 2: SMARTSIGHT**

calls on all general ophthalmologists to add a few easy steps when for patients with best acuity 20/50 or less: the four “R’s of Rehabilitation”: Record — Refract — Rx — Report. Printed below and in Materials for Ophthalmologists at [www.aao.org/smartsight](http://www.aao.org/smartsight)

**Level 3: SMARTSIGHT**

provides information for academic ophthalmology departments and large group practices about establishing comprehensive vision rehabilitation services. Printed below and in Materials for Ophthalmologists at [www.aao.org/smartsight](http://www.aao.org/smartsight)
Is it difficult to read newspapers and price tags, set dials, or manage glare? If so, SmartSight can help, with tips about lighting, contrast, and the tools, techniques and resources of vision rehabilitation. Losing vision does not mean giving up your activities, but it does mean applying new ways of doing them.

**Patterns of Vision and Vision Loss**

Central vision is the detailed vision we use when we look directly at something. Macular degeneration (AMD) affects only central vision. Diabetic retinopathy can affect central or peripheral vision. Peripheral vision is the less detailed vision we use to see everything around the edges. Glaucoma affects peripheral vision first. Strokes can affect one side of the peripheral vision.

Contrast sensitivity is the ability to distinguish between objects of similar tones like coffee in a black cup or facial features. All eye problems can decrease contrast sensitivity.

Depth perception is the ability to judge the position of objects. New vision loss in one eye can affect depth perception. Visual processing: The lens in our eye, like a camera lens, focuses the image onto the retina, like camera film. Our optic nerve carries those images to our brain, which “develops” them. Impairments in each of these affect our vision differently.

**The Experience of Vision Loss**

It is always a shock to learn that your vision loss is irreversible. It is important to acknowledge the anger and frustration you may feel, to get help working through these feelings, and to apply the strategies of vision rehabilitation to stay active. Doing all of these will help you avoid depression, which may appear as fatigue or lack of interest. If depression occurs, address it with treatment and counseling. A good support group can help you recognize that your value to yourself and others does not depend on your vision and that you are worth the effort it takes to make the most of the vision you have.

**The Phantom Visions of Charles Bonnet Syndrome (CBS)**

About 20 to 30 percent of people with vision loss see life-like images they know are not real. This is called Charles Bonnet Syndrome and it is not a loss of mental capacity but just part of vision loss for some.

**Making the Most of Remaining Vision**

*Finding and Using Your “Next-Best Spot:” Scotomas and PRLs*

When the center of your vision is obscured by a blind spot (scotoma), it is helpful to locate your “next best spot” (the Preferred Retinal Locus, PRL). To find your PRL, imagine that the object you want to see is in the center of a large clock face. Move your eyes along the clock numbers and notice when you see the center object most clearly. Use that same viewing direction for other objects.

*Making Things Brighter*

Improve lighting. Use a gooseneck lamp directed onto your task. Carry a penlight.

Reduce glare. Indoors, cover wood tables and shiny counters; wear yellow clip-on or fitover glasses. Outdoors, try dark yellow or amber glasses. For indoors and out: a visor.

Increase contrast. Use a black ink gel or felt pen, not a ballpoint. Draw a dark line where you need to sign. Use a white cup for coffee, for example.

*Making Things Bigger*

Move closer. Sit close to the TV, and up front at performances. Enlarge. Get large checks, large print playing cards, bingo cards, crosswords, phone dials, TV remotes, calendars, keyboards and books.

Magnify. Magnifiers come in many powers and types, suited to different people and different tasks: hand-held for price tags and menus, stands and video magnifiers (CCTVs or closed circuit TVs) for sentences, a magnifying computer mouse, enlargement software for computers.

*Organizing*

Designate spots for the items in your refrigerator, and for your keys and wallet. Minimize clutter. Separate black clothes from blue.
Labeling

Mark thermostats and dials with high contrast markers from a fabric store; label medications with markers or rubber bands; safety-pin the labels of similar colored clothing.

Substituting: Let’s Hear it for Ears!

Get books and magazines on tape free on loan, also talking watches, clocks, calculators, glucometers and computers. Use reading services. (See Resources)

Participating

Don’t isolate yourself. Keep your social group, volunteer job, or golf game. It might require lighting, large print cards, a magnifier, a ride, or someone to watch your ball. Ask for the help you need. There is nothing independent about staying home to avoid asking for help.

Driving

Pick your times and map routes carefully. Consider yellow or amber sunglasses for glare. Ask yourself: if cars appear unexpectedly or if drivers honk at you. Are you having fender-benders? If “yes,” consider the following transportation alternatives.

Transportation Alternatives: Creative Solutions

Hire a driver, share your car, arrange for a taxi, buy gas for a friend who drives, use senior and public transit systems. Try a three-wheel bike or battery-powered scooter at walking speed. Walk if you are able. Set the pace for your peers by using these alternatives now. The future will offer even more solutions.

For Family and Friends

Your loved one with vision loss needs to be empowered to do as much as possible independently. Recognize the challenge of vision loss, but don’t take over their tasks. Instead, help identify the adjustments they need to make to maximize their independence.

Vision Rehabilitation

A low vision evaluation and rehabilitation training can help you make the most of your vision. To locate services near you, contact VisionConnection (see Resources).

Ask if services include:
- A low vision evaluation by an ophthalmologist or optometrist
- Prescription for devices. Are some devices loaned before purchase, or returnable?
- Rehabilitation training: reading, writing, shopping, cooking lighting and glare control?
- Home assessment? Mobility? Resources and support groups?

Are services free, billed to Medicare or other insurances? If not, what is the charge? (Note: Medicare covers most services, but not devices.)

Resources

Books and magazines on tape loaned by mail free; tape player provided:


Books and magazines on tape, to keep, free:


Choice Magazines (bimonthly articles, unabridged): 888-724-6423

Large print books and checks:

www.navh.org

Large print checks and registers (from your bank or check catalog)

Large print materials — crosswords, bingo cards, address books, calendars:

Optelec: www.lowvision.com

Eschenbach: www.eschenbach.com


Independent Living Aids: 800-537-2118
Computer Enlargement
Accessibility features built into your computer;
Magnifying Mouse: Microsoft
National organizations, for support, information, and research updates:
Are You Aware?: visionaware.org
www.macula.org
Macular Degeneration Partnership: 888-430-9898,
Association of Macular Disease: www.amd.org
MD Support: www.mdsupport.org,
Also video: Learning to Live with Low Vision
National Eye Health Education Program of National Institutes of Health: www.nei.nih.gov,
Offers free materials (e.g., What You Should Know About Low Vision, also in Spanish).
news by phone, 866-504-7300

Vision Rehabilitation Self Help Books:
The First Year — Age Related Macular Degeneration, D. Roberts, NY: Marlowe, 2006; bookstores and amazon.com

To Locate Vision Rehabilitation Professionals and Services:
Veterans: U.S. Department of Veterans Affairs:
877-222-8387, www.va.gov/blindrehab
Everyone: Contact SmartSight’s partner, VisionConnection, for directory of services at www.lighthouse.org. In the “Help Near You” section, search under both “low vision services” and “vision rehabilitation,” or call 800-829-0500. Also www.afb.org. Ask the questions listed under Vision Rehabilitation above, and ask them also when making an appointment for services.
SMARTSIGHT™ Level 2

GUIDE FOR COMPREHENSIVE OPHTHALMOLOGISTS

Recognize and Respond with the SmartSight Handout, plus:

*Record* precise visual acuity, to 20/1600 with easy, inexpensive charts. “Count fingers” does not distinguish among acuities with very different functional implications and incorrectly implies no useful vision.

*Refract.* Retinoscope with phoropter or loose lenses in dark room with short working distance for accurate results. Manifest in trial frame to allow viewing around scotoma.

*Rx:* Adds to +5 allow many with 20/50 to 20/100 to read, with closer focal distance. Separate readers or clip-ons may be preferred. Upper clip-ons for computer use or for those with inferior scotomas.

*Direct Lighting.* A gooseneck lamp alone allows many to read, sew, etc. Sources below.

*Filters for glare:* Yellow, orange, amber, plum, gray per patient preference in fitovers, wraparounds and clip-ons, polarized optional. Visor or brimmed hat.

Level 3 evaluation and training when the above does not suffice for reading and ADLs.

*Report to Patients’ Primary Care Providers.* Central vision loss is invisible to others. Patients’ primary care providers need to know that their vision loss is permanent and increases risk for medication mix-ups, falls, isolation and depression, and that Charles Bonnet Syndrome relates to low vision not cognition.

**Sources**

*Charts for Distance and Near Acuity*
Colenbrander Low Vision Chart (inexpensive, foldable, 1-Meter): precision-vision.com
Lighthouse near charts, individual letters and continuous print: lowvision.com

*Reading Glasses/Clip-on Adds*
Clip-on flip-up adds, 1/2 lens upper or lower +1 to +4 in 1/2 D steps: Walters, 800-992-5837
Prism half-eyes ready-made +4 to +6: lowvision.com

*Gooseneck Lamps and Bulbs*
45-65W indoor floodlight bulb, chromolux bulb, or white light: hardware, fabric stores OTT-Lite; Brandt lamp with 50W halogen bulb: lowvision.com

*Filters*
Fitovers: NOIR: 800-521-9746;
Solar Shield Ultra, Eschenbach: 800-487-5389
Solarshield: lowvision.com
Clip-ons: Sunshields (flip-up): lowvision.com
Corning lenses (yellow, orange, amber): Eschenbach, 800-487-5389

Comprehensive Vision Rehabilitation

Low Vision Evaluation and Rehabilitation Training

Comprehensive vision rehabilitation addresses:

- Reading
- Scotoma/PRL training
- Activities of Daily Living
- Safety
- Community participation
- Physical, psychosocial, and cognitive wellbeing

It includes but is not limited to optical and non-optical adaptive devices.

Part I: Low Vision Evaluation

History

- Medical and ophthalmic history
- Functional history. Identify the patient’s needs and goals. Consider functional communication, nutritional issues including shopping and meal preparation, financial management, medication management, self-care, near tasks, distance tasks, history of falls, accidents and injuries, mobility, driving and transportation.

Assessment of Physical and Psychosocial Wellbeing

Note living situation, responsibilities and supports. Assess for depression and psychosocial adjustment.

Visual Acuity and Refraction

- Record distance, near and continuous reading acuity. To read continuous print without fatigue one must be able to read two or three lines smaller than the desired text size. Precise individual letter visual acuity to 20/1600 and reading acuity may be assessed with the following charts.

  Distance Acuity Charts
  - Colenbrander Low Vision Chart (1 meter)
  - ETDRS chart

  Near Acuity Charts
  - Lighthouse Individual Letter chart
  - Lighthouse Continuous Text Charts (adult and child)
  - Lea Symbol Screener
  (Sources: Lowvision.com; Precision-vision.com)

Tests for Reading

- Reading: MNRead, Pepper Test
- Retinoscopy may be done in phoropter or with loose lenses, with Rx confirmed in trial frame. Prescription for new glasses is best delayed until completion of occupational therapy training, when the potential benefit of new glasses can be reassessed, unless the refraction varies substantially from the current, e.g., by over 1.5 diopters.

Contrast Sensitivity

Loss of contrast sensitivity impacts function greatly. There is no current standard of measurement, although the FDA is in the process of developing one. Awareness of contrast sensitivity offers insight into functional problems and potential solutions.

Contrast Sensitivity Charts

- Pelli-Robson
- Colenbrander Mixed Contrast Card
- Lighthouse Letter Contrast Sensitivity Test

Sources: Lowvision.com; Precision-vision.com

Central Field: Scotoma and Preferred Retinal Locus (PRL)*

The size, shape and position of the central scotoma and the position of the PRL relative to the scotoma impact function, choice of device, and patient training. Assessment of the scotoma and PRL is therefore necessary for optimal rehabilitation.

State of the art technology for this assessment includes the following:

- Scanning Laser Ophthalmoscope (SLO), most precise: Rodenstock no longer produced; some used available
- OPKO: MP-1 Micropimeter, Nidek, Inc.
Manual methods which are also applicable to patient training:

- Fletcher Central Field Test: laser pointer method, from Lowvision.com.
- Flashcard method: Patient fixates on examiner’s nose, reads single-letter flashcards held at surrounding locations. Suggested Rdg #9, Ch. 11
- Clock or face method: Patient fixates on examiners nose, or center of clock face, reports blurred and clearest areas.
- Automated perimetry method. Suggested Rdg #8
- Fundus Photography method. Suggested Rdg #13

Peripheral Field
Map peripheral field, as indicated, with manual or automated perimetry or confrontation field. Mapping should extend to 140 degrees or more.

Magnification Requirements, Tolerance for Devices, and Application of Devices to Desired Tasks
Power and type of device may vary widely even with identical acuities depending on contrast sensitivity, scotoma/PRL pattern, and the patient’s physical attributes and needs. Poor contrast with fair acuity may suggest a bright-field magnifier for desk use, for example, a small PRL surrounded by scotoma may necessitate a screen reader, a tremor or upper limb paresis may preclude the use of a handheld device.

Non-optical Devices
Assess application of the range of non-optical devices.

Counseling and Advice
See Topics for Discussion under E & M Coding
Tests for Quality of life, Depression, Cognition
- Quality of Life: NEI Visual Function Questionnaire 25 (NEI VFQ-25) Inventory of Visual Impairment (IVI)
- Depression: Geriatric Depression Scale (GDS), 15 and 30 question forms
- Cognitive Status: Mini-mental Evaluation (adapted for low vision)
- Referral to PCP or Psychiatry as indicated.

Order for Rehabilitation Training
More detailed information at www.aao.org/smartsight: materials for ophthalmologists

Part 2: Rehabilitation Therapy

Occupational Therapy Assessment
Rehabilitation begins with the therapist’s assessment of the patient’s current level of function with respect to desired and necessary tasks, consideration of contributing physical, cognitive, psychosocial and environmental factors, and setting of clear, achievable therapy goals with the patient.

Rehabilitation Training
Rehabilitation training may include any or all of the following:
- Scotoma awareness and efficient use of the PRL in the presence of a central scotoma. Efficient use of the PRL may decrease magnification requirements.
- Scotoma awareness in the presence of peripheral field loss
- Visual motor skills including scanning, tracing, tracking and target localization
- Visual perceptual skills: visual closure, part-to-whole relationships, visual perspective, for patients with CVA-related visual impairment, for example
- Reading and writing techniques and training
- Performance of activities of daily living with or without optical devices
- Application of optical devices to specific tasks, care of devices
- Application of non-optical devices to specific tasks
- Adaptations to the environment to enhance function and safety: lighting, contrast, organization, labeling, glare control, hazard removal and other safety measures
- Workplace assessments and adaptations
- Use of adaptive computers: enlargement, speech output
- Safe mobility in home and community: use of support canes, glare filters and monoculars for orientation and spotting. (Long cane training is done by Certified Orientation and Mobility Specialists: COMS)
- Recreational and avocational activities assessment and training
- Application of local and national resources an services
- Caregiver support and training
- Driver evaluation and training (not reimbursable)
Counseling (reimbursable when performed by social worker or psychologist)

- Support groups (not reimbursable)
- Referral to further services as indicated, for example the Veteran's Administration Visual Impairment Services Team (VIST), Orientation and Mobility Training if not included in program, to other rehabilitation services, e.g., for balance or hearing, to physician for referral to psychology or psychiatry, to a support group, or to community service agencies, e.g., Area Agency on Aging.

**Suggested Reading**


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### Frequently Asked Coding Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can vision rehabilitation services be provided in a group setting in the office? Out of the office?</td>
<td>No. All therapy codes specify one-on-one, face-to-face time with therapist. Group sessions are not reimbursable in outpatient rehabilitation, in or out of the office.</td>
</tr>
<tr>
<td>Can an office technician, a certified low vision therapist or an orientation and mobility specialist provide rehabilitation services that are paid by Medicare?</td>
<td>No. Only physicians and occupational therapists may be reimbursed for services billed under rehabilitation codes, in any setting. Technicians may provide a valuable service for patients by advising on lighting, contrast and glare control, as in Level 2, but their services are not reimbursable. Services of vision rehabilitation professionals other than OTs are not billable.</td>
</tr>
<tr>
<td>Can the 97535 code (self-care/home management training) be used for training in using low vision devices? Is additional authorization required?</td>
<td>No. Simple training in using low vision devices is NOT covered by Medicare under any circumstances. (There is a code for this but it is not reimbursable). What IS reimbursable, under 97535, is training to accomplish activities of daily living with or without the use of low vision devices. The goal directing the therapy is to be able to read mail, bills and phone numbers, with the use of the appropriate device; the goal is not to learn to use the device.</td>
</tr>
<tr>
<td>Can any of the impairment codes be used for patients with 20/40 or 20/50 acuity in their best eye?</td>
<td>Five codes may be used for particular patients with 20/40 or 20/50 visual acuity. 368.41 requires a documented central scotoma in the best eye — for example, a ring-shaped scotoma surrounding a small central area of vision. 369.22 (severe/severe) includes a visual field of 20 degrees or less in the best eye. A somewhat better field than that might qualify under 368.45, “generalized constriction.” Finally, the two hemianopsia diagnosis codes, 368.46 and 368.47, apply regardless of acuity.</td>
</tr>
<tr>
<td>Can a technician or rehabilitation professional perform part of the low vision evaluation that is billed by the physician under Evaluation and Management codes?</td>
<td>No. A technician or other designee may take the history, which the physician reviews, but all parts of the low vision examination must be performed by the physician.</td>
</tr>
</tbody>
</table>
Professional Organizations

- Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP): www.acvrep.org. ACVREP is the organization certifying orientation and mobility specialists, rehabilitation teachers, and low vision therapists.

- American Optometric Association (AOA) Low Vision Section: (314) 991-4100
- Joint Commission on Allied Health Personnel in Ophthalmology (JCAHPO): (800) 284-3937
- National Association of Diabetes Educators: (312) 424-2426
I certify that I have seen this patient. I agree to the need for these services, and to this rehabilitation plan of treatment delivered under my care.

Initial assessment

Patient stated objective was to be able to read again. She did very well with this goal with a +12 D (3X) halogen illuminated stand magnifier. It allowed reading of 0.8M print. A reading stand was helpful in positioning her reading materials. Training included using the halogen magnifier for reading. She also received training in using eccentric viewing to see around her central scotomas and to help her maximize her vision function. The referring MD and I plan to see the patient again in two weeks for follow-up and further training. I appreciate the opportunity to help serve the patient with her low vision needs.

Professional Organizations

Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP)  
www.acvrep.org  
ACVREP is the organization certifying orientation and mobility specialists, rehabilitation teachers, and low vision therapists.

American Academy of Ophthalmology (AAO)  
Vision Rehabilitation Committee  
(415) 561-8500  
www.aao.org  
American Occupational Therapy Association (AOTA)  
(301) 652-AOTA  
www.aota.org  
Currently developing a specialty certification in low vision  

American Optometric Association (AOA)  
Low Vision Section  
(314) 991-4100  

Association for the Education and Rehabilitation of the Blind and Visually Impaired (AER)  
(877) 492-2708  
www.aerbvi.org

Joint Commission on Allied Health Personnel in Ophthalmology (JCAHPO)  
(800) 284-3937

National Association of Diabetes Educators  
(312) 424-2426

Appendix

CPT code 97535  
Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment)  
direct one-on-one contact by provider, each 15 minutes. Seventy-five (75) minutes were documented.

Modifer -GO  
Services delivered under an outpatient occupational therapy plan of care  
This HCPCS Medicare modifier is required for all vision rehabilitation claims to track the amount of therapy a patient receives during a calendar year.

The following chart note coded as 97535-GO in a recent audit was in compliance with Medicare's documentation requirements.

Plan of Treatment for Low Vision Rehabilitation

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Age</th>
<th>Referring physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glasses RX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OD</td>
<td>+10.75 +3.50 X 169 +3.25 add</td>
<td></td>
</tr>
<tr>
<td>OS</td>
<td>+10.72 +1.25 X 007 +3.25 add</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Visual acuity</th>
<th>Distance</th>
<th>Near</th>
<th>Contrast sensitivity function on the LEA Contrast Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>OD</td>
<td>20/100</td>
<td>2.5 m</td>
<td>10% OU</td>
</tr>
<tr>
<td>OS</td>
<td>20/320</td>
<td>5 m</td>
<td></td>
</tr>
</tbody>
</table>

Primary diagnosis: Advanced glaucoma, ARMD, corneal scarring, aphakia

Lower Vision Rehabilitation Plan: To evaluate and train in compensatory techniques to increase independence in daily living activities

Goals (Short term)

- read independently or more independently  
- see TV scenery and other items at distance better  
- read the computer screen more easily  
- continue to sew, crochet, knit or do other similar work  
- read signs, menu boards or other items at a distance  
- see or feel the dials on appliances or other controls  
- be able to write checks or other items  
- do crafts more easily  
- reduce glare  
- other ___________________________________

Outcomes (Long term)

Maximize functional vision to achieve independence in daily living activities.

Therapist signature

Estimated time to reach goals: 2-3 visits weeks months
2012

RESOURCES
To learn more or to order any of these 2012 products, visit www.aao.org/codingproducts or call (866) 561-8558 (U.S. only) or (415) 561-8540.

Ophthalmic Coding Coach #0120314
Ophthalmic Coding Coach Online #CODNGCOACH
Ophthalmic Coding Coach Mobile #CODNGMOBILE
ICD-9 for Ophthalmology #0120316
ICD-9 for Ophthalmology Online #ICDONLINE
CPT Standard Edition #0120319
CPT Professional Edition #0120317
CPT Pocket Guide for Ophthalmology #0120315

Online Courses
Audits: It’s Not a Matter Of If, But When #0123030V
Compliance for Ophthalmic Coding, Billing and Reimbursement #0123029V
Introduction to Ophthalmic Coding #0123031V