

The Ophthalmic Coding Series

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Vision Rehabilitation Coding  
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AMERICAN ACADEMY  
OF OPHTHALMIC EXECUTIVES®  
Solutions for Practice Management

## Vision Rehabilitation Coding

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## 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](http://www.aao.org/ocs) for complete details.

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## OCS: 2012 Vision Rehabilitation Coding Product #0123012V

Updates to this coding topic made throughout the year may be found at [www.aao.org/aaosite/ocs38.cfm](http://www.aao.org/aaosite/ocs38.cfm)  
Questions or comments about this publication should be sent to [coding@aao.org](mailto: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.

To access the online pre- and post-test visit: [www.aao.org/aaosite/ocs38.cfm](http://www.aao.org/aaosite/ocs38.cfm)

### CME Credit Reporting Statement

The American Academy of Ophthalmology is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

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

### JCAHPO CE Credit Reporting

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

### AAPC — American Academy of Professional Coders Continuing Education Information

The AAPC will accept a certificate reporting *AMA PRA Category 1 Credits*<sup>™</sup>. The certificate will give the total CMEs possible for the offering. Coders are advised to claim only the actual hours they were present during the education.

From your AAPC home page open up your CEU Tracker; select “ADD CEU”; select “No” indicating you do not have an index number and then enter in the requested information. You will need to submit supporting documents **ONLY** if requested for verification purposes. Keep your supporting documents for six months as the AAPC may randomly select you for CEU verification.

**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 burroughs 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

**Diagnosis Codes 368.41–369.08**

368.41	Scotoma involving central area
368.45	Generalized contraction or constriction
368.46	Homonymous bilateral field defects
368.47	Heteronymous bilateral field defects
369.01	BE - total impairment LE - total impairment
369.03	BE - near-total impairment LE - total impairment
369.04	BE - near-total impairment LE - near-total impairment
369.06	BE - profound impairment LE - total impairment
369.07	BE - profound impairment LE - near-total impairment
369.08	BE - profound impairment LE - profound impairment

**Diagnosis Codes 369.12–369.25**

369.12	BE - severe impairment LE - total impairment
369.13	BE - severe impairment LE - near-total impairment
369.14	BE - severe impairment LE - profound impairment
369.16	BE - moderate impairment LE - total impairment
369.17	BE - moderate impairment LE - near-total impairment
369.18	BE - moderate impairment LE - profound impairment
369.22	BE - severe impairment LE - severe impairment
369.24	BE - moderate impairment LE - severe impairment
369.25	BE - moderate impairment LE - moderate impairment

**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**

**I. E&M CODES**

New Patient:

Low Complexity, 30 min	99203
Moderate Complexity, 45 min	99204
High Complexity, 60 min	99205

Established Pt:

Low Complexity, 15 min	99213
Moderate Complexity, 25 min	99214
High Complexity, 40 min	99215

**II. CHIEF COMPLAINT, IN THE PATIENT’S OWN WORDS**

**III. HISTORY**

**History of Present Illness (HPI)**

**(i.e. Visual Impairment):**

**Problem focused:** Brief, 1–3 elements

**Expanded PF:** Brief, 1–3

**Detailed:** Expanded, > 4 elements

**Comprehensive:** Extended: 4 or more

Onset/progression: duration, severity, quality

Safety: falls, injuries, medication management, nutritional compromise

Charles Bonnet Syndrome

ADLs, communication (e.g. reading, writing, phoning), self-care (e.g. cooking, grooming), community participation, including driving and/or alternative transportation;

**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 reintegration
  - 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**

<i>2 of 3 required for each respective level:</i>	<b>Complexity</b>			
	<b>Straightforward</b>	<b>Low</b>	<b>Moderate</b>	<b>High</b>
<b># of Diagnoses or Management Options</b>	minimal	limited	multiple	extensive
<b>Amount and/or Complexity of data</b>	minimal or low	limited	moderate	extensive
<b>Risk of Complications</b>	minimal	low	moderate	high

*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

CPT Code	Description
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
97116	gait training (includes stair climbing). Not generally applicable to vision rehabilitation.
97532	Development of cognitive skills to improve attention, memory, problem solving, direct (one-on-one) patient contact by the provider, each 15 minutes <i>Includes scotoma/PRL training, scanning</i>
97533	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 <i>Used for scotoma/preferred retinal locus (PRL) training</i>
97535	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
97537	Community/work reintegration (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact by provider, each 15 minutes

**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.

**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 ophthalmologists 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)

## SMARTSIGHT™ Patient Handout

### MAKING THE MOST OF REMAINING VISION

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 ball-point. 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:*

U.S. National Library Service: 800-424-8567, [www.loc.gov/nls](http://www.loc.gov/nls).

In Canada: Canadian National Institute for the Blind Library: 800-268-8818, [www.cnib.ca](http://www.cnib.ca)

*Books and magazines on tape, to keep, free:*

American Printing House for the Blind: 800-223-1839, [www.aph.org](http://www.aph.org)

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

*Large print books and checks:*

[www.navh.org](http://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](http://www.lowvision.com)

Eschenbach: [www.eschenbach.com](http://www.eschenbach.com)

LS&S: 800-468-4789, [www.lssgroup.com](http://www.lssgroup.com)

Independent Living Aids: 800-537-2118

### *Computer Enlargement*

Accessibility features built into your computer;  
Magnifying Mouse: Microsoft

Magnification software: Ai Squared, [www.aisquared.com](http://www.aisquared.com)

*National organizations, for support, information, and research updates:*

Are You Aware?: [visionaware.org](http://visionaware.org)

[www.macula.org](http://www.macula.org)

Macular Degeneration Partnership: 888-430-9898,  
Association of Macular Disease: [www.amd.org](http://www.amd.org)

MD Support: [www.mdsupport.org](http://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](http://www.nei.nih.gov).

Offers free materials (e.g., What You Should Know About  
Low Vision, also in Spanish).

National Federation of the Blind, [www.nfb.org](http://www.nfb.org);  
news by phone, 866-504-7300

### *Vision Rehabilitation Self Help Books:*

*Making Life More Livable*, M. Duffy, NY: Amer. Found. for  
the Blind, 2001; 800-232-3044.

*Macular Degeneration: The Complete Guide to Saving and  
Maximizing Your Sight*, L. Mogk, MD, & M. Mogk, PhD, NY:  
Ballantine 2003; bookstores and [amazon.com](http://amazon.com).

*The First Year — Age Related Macular Degeneration*, D.  
Roberts, NY: Marlowe, 2006; bookstores and [amazon.com](http://amazon.com)

*Overcoming Macular Degeneration: A Guide to Seeing  
Beyond the Clouds*, S. Solomon, MD, & J. Solomon, NY:  
Avon 2000; bookstores and [amazon.com](http://amazon.com).

### *To Locate Vision Rehabilitation Professionals and Services:*

Veterans: U.S. Department of Veterans Affairs:  
877-222-8387, [www.va.gov/blindrehab](http://www.va.gov/blindrehab)

Everyone: Contact SmartSight's partner, VisionConnection,  
for directory of services at [www.lighthouse.org](http://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](http://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 clips-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](http://precision-vision.com)

Lighthouse near charts, individual letters and continuous print: [lowvision.com](http://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](http://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](http://lowvision.com)

*Filters*

Fitovers: NOIR: 800-521-9746;

Solar Shield Ultra, Eschenbach: 800-487-5389

Solarshield: [lowvision.com](http://lowvision.com)

Clip-ons: Sunshields (flip-up): [lowvision.com](http://lowvision.com)

Corning lenses (yellow, orange, amber):

Eschenbach, 800-487-5389

More detailed information on the American Academy of Ophthalmology Web site at [www.aao.org/smartsight](http://www.aao.org/smartsight).

## SMARTSIGHT™ Level 3

### GUIDE, FOR ACADEMIC PROGRAMS AND LARGE GROUP PRACTICES

#### 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](http://Lowvision.com); [Precision-vision.com](http://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](http://Lowvision.com);  
[Precision-vision.com](http://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 Microperimeter, 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](http://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 and 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

1. Brilliant, RL. *Essentials of Low Vision Practice*. Boston, MA: Butterworth-Heinemann, 1998.
2. *Canadian Journal of Ophthalmology* Special Issue on Low Vision Rehabilitation, June 2006, Ed: Markowitz, SN. <http://pubs.nrc-cnrc.gc.ca/cjo/cho41-03.html>.
3. Vision Rehabilitation Coding Module, Ophthalmic Coding Series. San Francisco: American Academy of Ophthalmology; 2007.
4. Monograph #12: *Low Vision Rehabilitation: Caring for the Whole Person*. San Francisco: American Academy of Ophthalmology; 1999.
5. Preferred Practice Pattern: *Vision Rehabilitation for Adults*. San Francisco: American Academy of Ophthalmology; 2007.
6. Policy Statement: *Vision Requirements for Driving*. San Francisco: American Academy of Ophthalmology; 2006.
7. Brown GC, Brown MM, Sharma S. Differences between ophthalmologists' and patients' perception of quality of life associated with macular degeneration. *Can J Ophthalmol* 2000;35:127-33.
8. Faye EE, Albert DL, Freed B, et al. *The Lighthouse Ophthalmology Resident Training Manual: A New Look at Low Vision Care*. New York: Lighthouse International; 2000.
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10. Ives RQ, Cumming RG, Mitchell P, et al. Visual impairment and falls in older adults: the Blue Mountains Eye Study. *J Amer Geriatr Soc* 1998;1:58-64.
11. Lee PP, Spritzer K, Hays RD. The impact of blurred vision on functioning and well being. *Ophthalmology* 1997;104:3906.
12. Markowitz SN, Muller C. Macular perimetry in low vision. *Can J Ophthalmol* 2004;39:56-60.
13. Massof RW, Lidoff L, eds. *Issues in Low Vision Rehabilitation. Service Delivery, policy and Funding*. New York: AFB Press, 2001.
14. Mogk LG, Mogk M. *Macular Degeneration: The Complete Guide to Saving and Maximizing Your Sight*. New York: Ballantine Books; 2003.
15. Rosenthal BP, Cole RG, London R. *Functional Assessment of Low Vision*. St. Louis, MO: Mosby, 1996.
16. Scott IU, Smiddy WE, Schiffman J, et al. Quality of life of low-vision patients and the impact of low-vision services. *Am J Ophthalmol* 1999;128:54-62.
17. Solomon Y, Solomon JD. *Overcoming Macular Degeneration: A Guide to Seeing Beyond the Clouds*. New York: Avon Books; 2000.
18. Somani S, Markowitz SN. Identification of fixation location in macular degeneration with retinal photography. *Can J Ophthalmol* 2004;39:517-20.
19. Williams RA, Brody BL, Thomas RG, et al. The psychological impact of macular degeneration. *Arch Ophthalmol* 1998;116:514-20.

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## Frequently Asked Coding Questions

Question	Answer
Can vision rehabilitation services be provided in a group setting in the office? Out of the office?	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.
Can an office technician, a certified low vision therapist or an orientation and mobility specialist provide rehabilitation services that are paid by Medicare?	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.
Can the 97535 code (self-care/home management training) be used for training in using low vision devices? Is additional authorization required?	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.
Can any of the impairment codes be used for patients with 20/40 or 20/50 acuity in their best eye?	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.
Can a technician or rehabilitation professional perform part of the low vision evaluation that is billed by the physician under Evaluation and Management codes?	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.

## Professional Organizations

- ◆ Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP): [www.acvrep.org](http://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](http://www.aao.org)
- ◆ American Occupational Therapy Association (AOTA): (301) 652-AOTA, [www.aota.org](http://www.aota.org). Currently developing a specialty certification in low vision
- ◆ 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



## 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.

Diagnosis code 369.24 BE moderate impairment  
LE severe impairment

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 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

Patient Name    Age                      Referring physician

Glasses RX    OD +10.75 +3.50 X 169 +3.25 add  
                  OS +10.72 +1.25 X 007 +3.25 add

Visual acuity	Distance	Near	Contrast sensitivity function on the LEA Contrast Test
OD	20/100	2.5 m	10% OU
OS	20/320	5m	

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

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

#### Goals (Short term)

- X 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

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

Physician signature

Date

### 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](http://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

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American Occupational Therapy Association (AOTA)

(301) 652-AOTA

[www.aota.org](http://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](http://www.aerbvi.org)

Joint Commission on Allied Health Personnel in Ophthalmology (JCAHPO)

(800) 284-3937

National Association of Diabetes Educators

(312) 424-2426

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## Notes

## RESOURCES

To learn more or to order any of these 2012 products, visit [www.aao.org/codingproducts](http://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,  
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#0123029V*

*Introduction to Ophthalmic Coding  
#0123031V*

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OPHTHALMIC ANATOMY AND PHYSIOLOGY FOR ICD-10

NEURO-OPHTHALMOLOGY CODING (ONLINE VERSION)

• VISION REHABILITATION CODING (ONLINE VERSION)

<http://www.aao.org/aaoc>

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