Ask the AOA Coding Experts
Vision vs Medical

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Medical Eye vs. Well Vision: The Great Coding Dilemma
Discussing Reality

- Medical vs. Vision
  - What to do when patient has vision insurance but medical problem
  - What to do when patient has medical insurance but vision problem
  - What to do when patient has both medical and vision insurance and NO problem
  - What to do........
Coding Basics - Don’t Fall Asleep
Coding Systems

- CPT ® Procedure Codes
  - What You Do
- ICD-9-CM/ICD-10-CM Diagnosis Codes
  - What You Find
- HCPCS Codes
  - What You Supply (sometimes what you do)
- Modifiers
  - What is Different
Supply of Ophthalmic Materials

- Medicare/Medicaid and Other Carriers
  - HCPCS Codes V2020 - V2799 (materials)
  - HCPCS Codes S series
    - Some services and material (S0500-S0625)
      - Note not all are ophthalmic codes
  - Contact Lens and Spectacle Services/materials
  - Ocular Prosthetics
New versus Established

- **New** patient
  - Not received **any** professional services from physician or another physician of the **exact** same specialty **and** subspecialty who belongs to the same group practice, within the **past three years**
New versus Established

- **Established** patient
  - Received professional services from the physician or another physician of the **exact same specialty and subspecialty** who belongs to the same group practice, within the past three years
92000 versus 99000 code choices

- Allowed to use BOTH systems BUT documentation dependent
- General ophthalmologic services as opposed to E&M:
  - Intermediate and comprehensive examination types
  - Do not require three key components
    - History
    - Examination
    - Medical decision-making
  - Do not use documentation guidelines from CMS to determine proper code selection
92000 versus 99000 code choices

- Medical decision making cannot be separated from exam techniques
- Itemization of service components is not applicable
  - Slit lamp examination
  - Keratometry
  - Routine ophthalmoscopy
  - Retinoscopy
  - Tonometry
  - Motor evaluation
• HIPAA requires **all providers and insurers** to use CPT codes and definitions for describing services provided to patients

• CPT copyright requires anyone who uses the codes to comply with the definitions for the codes

• Choosing codes by matching the content of the record to the CPT definition provides effective support in the case of a payer audit
92000 code use

- Appropriate when service includes several routine optometric/ophthalmologic examination techniques
  - Integrated procedures not separated from diagnostic evaluation
- Common physical examination elements must be documented
- Exam elements are indicated by issues being evaluated
General Ophthalmic Codes

92002
Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient

92004
;comprehensive, new patient, 1 or more visits
General Ophthalmic Codes

92012
Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient

92014
; comprehensive, established patient, 1 or more visits

Note: Current Procedural Terminology(© American Medical Association) is the only accepted source of definitions for these services.
Comprehensive 92004 and 92014

Introduction in CPT®

General evaluation of the complete visual system (1 + sessions)

Includes:

- History
- General medical observation**
- External examination
- Ophthalmoscopic examination
- Gross visual fields
- Basic sensorimotor examination

Often includes:

- Biomicroscopy
- Examination with cycloplegia or mydriasis
- Tonometry

Always includes:

- Initiation/continuation of diagnostic and treatment programs
Intermediate 92002 and 92012

Introduction in CPT®

Evaluation of new/existing condition *complicated by new diagnostic/management problem* not necessarily related to primary diagnosis

Includes
- History
- General medical observation **
- External examination
- Adnexal examination

May Include
- Other diagnostic procedures
- Mydriasis of ophthalmoscopy

Always includes
- Initiation/continuation of diagnostic and treatment programs
Wording creating confusion
Get the FACTS!

1. CPT® is ONLY official definition for codes
2. CPT® code wording is the ONLY official definition for codes
3. CPT® code introductions are NOT official definitions - only to further explain code use

► Official Code Wording - established patients
Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program

► Introduction to Code Wording - established patients
Evaluation of new/existing condition complicated by new diagnostic/management problem not necessarily related to primary diagnosis
Wording creating confusion
Get the FACTS!

NEVER THE INTENTION OF CPT TO INDICATE THAT YOU CANNOT USE THE 92000 CODE SERIES FOR ALL OPHTHALMIC CARE IF DESIRED!

Some lecturers have stated you have to switch between 92000 codes and 99000 codes and this is simply NOT TRUE!
Diagnostic and Treatment Program

- Includes, but **not complete list:**

  1. Prescription of medication
  2. Special ophthalmological diagnostic or treatment services
  3. Consultations
  4. Laboratory procedures
  5. Radiological services

Many other options...
92000 Code Elements
Per CPT Assistant Article

- Confrontation fields
- Eyelids/adnexa
- Ocular motility
- Pupils/iris
- Cornea
- Anterior Chamber
- Lens
- Intraocular pressure
- Retina (vitreous, macula, periphery, and vessels)
- Optic disc

(12 elements? acuity and bulbar and palpebral conjunctiva not listed)
Elements of Examination

- Comprehensive has been described as 8 or more elements including:
  - Fundus examination with dilation**
  - Motor evaluation
    - (varied by carrier specific definition)
- Intermediate has been described as 7 or fewer elements
  - Still good “rule of thumb” - examination varies by reason for examination
  - **Note that CPT definitions do NOT require dilation but is in the introduction of codes and some carriers do- sometimes using further statement “with dilation unless contraindicated”
General Ophthalmologic Codes vs Evaluation and Management (E&M) Codes?

• No mandated use of one code set over other

• Report code(s) most accurately identifies service(s) or procedure(s) performed

• General ophthalmological service codes are specific for services typical of ophthalmological visit

Note that some carriers state: Services that require minimal ophthalmologic examination techniques are reported with E/M CPT codes (99201 - 99499)
Evaluation and Management (E & M)

• 1995 or 1997 guidelines for E&M codes
  • 1997 simpler, have to specify in audit
  • Presenting 1997 guidelines from CPT®
• 99--- codes
  • Office
  • Hospital
  • Nursing facility
  • Domiciliary/rest home
  • Home

Medicare no longer covers consultations
Elements of E & M Codes

Major elements
• Chief Complaint - Always
• History
• Examination
• Medical decision-making

Other factors considered
• Counseling
• Coordination of care
• Nature of presenting problem
• Time
Elements of E & M Codes

- Chief Complaint - TRUE WITH 92000 AND 99000 codes!
  - Always, every encounter
  - Concise statement describing
    - Symptom
    - Problem
    - Condition
    - Diagnosis
    - Physician recommended return
    - Any other factor related to reason for the encounter
- Usually stated in the patient's words
Elements of E & M Codes

- History of present illness: 8 elements, 2 levels
- Review of systems: 14 elements, 3 levels
- Past, family, social history: 3 elements, 2 levels
History of Present Illness

Elements

- Location
- Quality
- Severity
- Duration
- Timing
- Context
- Modifying factors
- Associated sign & symptoms

1997 documentation guidelines
Descriptions of the elements (e.g., location, quality, severity, etc.)
or
Status of three chronic/inactive diseases.

Levels

Brief: 1-3 elements
Extended: 4+ elements
Review of Systems

An inventory of body systems obtained via questions to identify signs/symptoms that patient may be experiencing or has experienced

- Constitutional
- Eyes
- Ears, nose, throat (E/N/T)
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic
Review of Systems

Problem oriented:
- +/- system related to problem

Extended problem oriented:
- +/- 2-9 systems

Complete:
- +/- 10 or more systems
Review of Systems

- Individually document all positives
- Individually document all negatives
- Up to the number of elements required for level
- Then may indicate all other systems negative

**BUT**

- Avoid saying “all 10 systems negative”
Past, Family, Social History

- Pertinent:
  - One in any of the three areas

- Complete:
  - One in all three areas for new
  - Two of three for established
Overall History Components

- **Problem focused**
  - Brief HPI
  - Problem oriented ROS
  - (1-3 elements)

- **Expanded problem focused**
  - Brief HPI
  - Extended HPI
  - (4+ elements)
  - Problem oriented ROS
  - (2-9 systems)
  - Pertinent PFS
  - (1/3)

- **Detailed**
  - Extended HPI
  - (4+ elements)
  - Complete ROS
  - (10+ systems)
  - Pertinent PFS
  - (3/3 New; 2/3 Est)

- **Comprehensive**
  - Extended HPI
  - (4+ elements)
  - Complete ROS
  - (10+ systems)
  - Complete PFS
  - (3/3 New; 2/3 Est)
## HPI Summary Table

<table>
<thead>
<tr>
<th>Type of History</th>
<th>History of Present Illness (HPI)</th>
<th>Review of Systems (ROS)</th>
<th>Past, Family, and/or Social History (PFSH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>Brief</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td>Brief</td>
<td>Problem Pertinent</td>
<td>N/A</td>
</tr>
<tr>
<td>Detailed</td>
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<td>Extended</td>
<td>Pertinent</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Extended</td>
<td>Complete</td>
<td>Complete</td>
</tr>
</tbody>
</table>
Examination Elements

4 Levels (1997)

- Problem focused
- Expanded problem focused
- Detailed
- Comprehensive
Examination Elements
Single System

14 elements

- Visual Acuity
- Confrontation Field
- EOM/Alignment
- Conjunctiva
- Adnexa/lacrimal
- Pupils/iris
- IOP
- SLE - cornea/tears
- SLE - anterior chamber
- SLE - Lens
- DFE - Optic nerve
- DFE - Posterior seg
- Orientation
- Mood/affect
Examination Elements

Single System

- Visual acuity (Does not include refraction)
- Gross visual field testing *by confrontation*
- Ocular motility include primary gaze alignment
- Inspection of bulbar/palpebral conjunctivae
- Examination of
  - Ocular adnexae including lids (eg, ptosis or lagophthalmos),
  - Lacrimal glands, lacrimal drainage, orbits
  - Preauricular lymph nodes
- Examination of pupils/irises
  - Shape
  - Direct and consensual reaction (afferent pupil)
  - Size (eg, anisocoria)
  - Morphology
Examination Elements
Single System

- Slit lamp examination
  - Corneas
  - Anterior chambers
  - Crystalline lens
  - Measurement of intraocular pressure
Examination Elements
Single System

- Dilated fundus examination
- Ophthalmoscopic examination
  - Optic discs
  - Posterior segments
PLUS - Orientation to time place person

AND
- Mood and affect
  (eg, depression, anxiety, agitation)
Examination Elements
Single System

- Problem oriented
  1-5 elements
- Expanded problem oriented
  6 elements
- Detailed
  9 elements
- Comprehensive
  14 elements*
  * all elements plus one Mood or orientation
Medical Decision Making

- Number of possible diagnoses
- Amount & complexity of medical records, diagnostic tests, other information
- Risk of significant complications, morbidity and/or mortality
- Comorbidities
Other secondary factors to consider

- Counseling
- Coordination of care
- Nature of presenting problem
- Time

Time is key only when counseling and care coordination are the primary component (> 50% of time spent with patient)
Medical Decision Making

**Straightforward**
- Minimum number diagnoses
- Minimal management options
- Minimal risk

**Low complexity**
- Limited number of diagnoses
- Limited management options
- Low risk
Medical Decision Making

**Moderate Complexity**
- Multiple diagnoses
- Moderate management options
- Moderate risk

**High Complexity**
- Extensive number diagnoses
- Extensive management options
- High risk
Medical Decision Making

The highest level of risk in any of the three determines overall risk

- Presenting problems(s)
- Diagnostic procedures
- Management options
Medical Decision Making

Document
  - Findings
  - Visualizations
  - Plans
  - Test results
  - Consultations
  - Old record requests

In short DOCUMENT EVERYTHING!!
CPT
Examples for Eye Care New Patients

99201
Initial office visit for a 10-year-old girl for determination of visual acuity as part of a summer camp physical (does not include determination of refractive error)

99203
Initial office visit for a 55-year-old female with chronic blepharitis. There is a history of use of many medications

99205
Initial office visit for a 70-year-old diabetic patient with progressive visual field loss, advanced optic disc cupping and neovascularization of retina
CPT

Examples for Eye Care Est. Patients

99213
Office visit for a 65-year-old female, established patient, with primary glaucoma for interval determination of intraocular pressure and possible adjustment of medication

99214
Office visit for a 68-year-old male, established patient, with the sudden onset of multiple flashes and floaters in the right eye due to a posterior vitreous detachment
Example of Comprehensive Services
From CPT®

The comprehensive services required for diagnosis and treatment of a patient with symptoms indicating possible disease of the visual system, such as glaucoma, cataract or retinal disease, or to rule out disease of the visual system.
Examples of Intermediate Examination
From CPT®

• Acute complicated condition (eg, iritis) not requiring comprehensive ophthalmological service
• Review of history
• External examination
• Ophthalmoscopy
• Biomicroscopy
Examples of Intermediate Services
From CPT®

- Established patient with known cataract not requiring comprehensive ophthalmological services
- Review of interval history
- External examination
- Ophthalmoscopy
- Biomicroscopy
- Tonometry
**General Ophthalmologic Services**

**Summary**

- General ophthalmologic code set requirements is more straightforward than E&M code set requirements.
- Do NOT include refraction.
- Some carriers have specific definitions for intermediate and comprehensive levels apparently beyond what CPT® states.

**IMPORTANT:** Initiation of diagnostic and treatment program seems to be the most audited item by Medicare.
General Ophthalmologic examination can also includes:

None of these special tests have individual CPT codes and are included in intermediate and/or comprehensive general ophthalmologic examinations
1. Laser interferometry
2. Potential acuity meter
3. Keratometry
4. Exophthalmometry
5. Transillumination
6. Corneal sensation
7. Tear film adequacy
8. Phacometry
9. Schirmer’s test
10. Slit lamp
11. History
12. General medical observation
Describe services in which a special evaluation of part of the visual system is made, which goes beyond the services, or in which special treatment is given.

Special ophthalmological services may be reported in addition to the general ophthalmological services or evaluation and management services.
92000 Codes
Special Ophthalmological Services

92015 to 92499

Reported in addition to general ophthalmological services or E&M services

Interpretation and report by the physician or QHP is integral part of special ophthalmological services where indicated
92000 Codes
Special Ophthalmological Services

- Extended Ophthalmoscopy
  - Not a Routine BIO
- Angiography (Fluorescein / Indocyanine Green)
- Fundus Photography
- Scanning Laser Technology
- Color Vision Examination
- Gonioscopy
- External Ocular Photography
- Sensorimotor Evaluation
- Visual Fields
Effect of Lenses

Without Lenses

With Lenses
Refraction-92015

- Determination of refractive state
- Statutorily not covered by Medicare
  - May file for denial
  - GY modifier may be necessary
    - service is statutorily excluded from Medicare coverage

- Consider Modifiers
How about something routine?
Medicare DOES Cover - Routine:
Annual dilated exam for diabetics
Special code for glaucoma screening
G0117 with V80.1
S-Codes

- **S0620** - routine ophthalmologic examination including refraction, new patient
- **S0621** - routine ophthalmologic examination including refraction, established patient
Routine Examination Codes?

S CODES PROBLEMS

No valuation

No further definitions

Insurers free to interpret at will
Well Vision Examinations
Possible Future??

CPT - Preventative Medicine Services

99381-99397

- Used to report the preventative medicine evaluation and management of infants, children, adolescents, and adults

- Include the management of insignificant or trivial problems which do not require additional work
Preventative Medicine Codes

★ New Patient

★ 99381 < 1 year old
★ 99382 1-4 years
★ 99383 5-11 years
★ 99384 12-17 years
★ 99385 18-39 years
★ 99386 40-64 years
★ 99387 >65 years

★ Established Patient

★ 99391 < 1 year
★ 99392 1-4 years
★ 99393 5-11 years
★ 99394 12-17 years
★ 99395 18-39 years
★ 99396 40-64 years
★ 99397 >65 years
## Well Vision Examinations
### Comparison of RBRV S
#### New Patient

<table>
<thead>
<tr>
<th>Preventative Medicine</th>
<th>General Ophthalmologic</th>
</tr>
</thead>
<tbody>
<tr>
<td>99381 to 99387</td>
<td>92002 (Inter) 2.32</td>
</tr>
<tr>
<td>Range: 3.10 to 4.64</td>
<td>92004 (Comp) 4.22</td>
</tr>
<tr>
<td>Average: 3.97</td>
<td></td>
</tr>
</tbody>
</table>
Well Vision Examinations
Comparison of RBRVS
Established Patient

Preventative Medicine
99391 to 99397
Range: 2.87 to 3.81
Average: 3.38

General Ophthalmologic
92012 (Inter)  2.43
92014 (Comp)  3.52
Preventative Medicine Codes

- Preventative Medicine codes (99381-99397)
  - Precedent: some carriers require for child (Superior Vision)
  - Currently little general use of this approach

- Encourage HIPAA compliance by payers
  - Refraction not a part of any other code

- Encourage HCPCS to delete S codes
  - Maybe after progress with Preventative Medicine codes
SO WHAT NOW?

- How do I solve the daily dilemma of patient with Well vision coverage and a Medical problem?
- What options do I have?
- Will my patient get mad and leave my practice?
- Will the well vision plan back me up when I decide problem is medical?
- What should I do?
Well Vision Examinations

- Fundamental difference: medical vs. well vision care
  - Chief complaint and detail needed
  - Medical decision-making complex
  - Risk increased - morbidity/mortality
  - Examination more detailed
    - Anterior segment
    - Posterior segment
    - Neurological
    - Patient counseling
    - Ordered tests
    - Record review
The Problem

Medical Eye vs. Well Vision

- How to code
- How to differentiate
- How to be consistent
- How to “play by the rules”
- CPT code for Well Vision Unlikely
Well Vision Examinations

- Well vision visits vs. Medical visits
  - Many approaches around the country
  - Many with validity
  - All have unacceptable aspects

- Key:
  Consistency in coding regardless of payment method
Well Vision Examinations

- Why the problem?
  - Carriers (MAC) used to have LCD for 92 code
    - Can require use of 92 codes for medical claims
    - Can require use of 99 codes for medical claims
  - Private carriers inconsistent on code use
    - May include refraction in 92 codes
    - May include refraction in 99 codes
    - May require S codes for well vision, sporadic
  - No longer 99-medical and 92 well vision
Well Vision Examinations

Coding approaches across nation

- Use medical diagnosis for all examinations
- Routine coverage - refractive diagnosis

Concern:
- Diagnosis based on payment
- Creative diagnosing
Well Vision Examinations
Coding approaches across nation

- 92004/14 medical only
  - No well vision under this code
  - Concern: overcoding at times?
- 99 medical only
- 92002/12 well vision only

Concern: undercoding
  - Too many elements of exam performed
Well Vision Examinations
Coding approaches across nation

- Internally use S code for all well vision
  - Internal code only
  - Converted to “plan accepted code” (92 series?)
  - All routine patients - same exam = same fee concept
  - Payment method disregarded in coding
  - 92 and 99 would be used only for medical
    - Refraction separate
- **Concern:** “different” charge for same code when actually files to insurance
Patient with Medical Plan & well vision plan

Case History

68 yo previous patient, not seen in 4 years

Chief complaint: decreased vision LE

VA: OD 20/30 OS 20/70

Pupils: equal, no APD

EOM: full, balanced

Confrontation Fields: Full to Finger Counting
Medical vs Wellness

Patient with Medical Plan & well vision plan

- SL: WNL except Lens→NS + cortical opacities OU
- IOP: 18 OU
- Internal exam (volk super fundus & 20D):
  - RPE changes + drusen OU
  - Optic nerve and peripheral fundus = normal
- Amsler grid: normal OU

Diagnoses: Cataract, combined OU 366.19 (H25.813)
ARMD, OU 362.51 (H35.31)
Medical vs Wellness

Patient with Medical Plan & well vision plan

- At exam completion, fees are reviewed
- Patient announces expectation for exam to be covered by his well vision plan

WHAT DO YOU DO?
- Clearly exam has medical presentation, history & exam
Medical vs Wellness

Patient with Medical Plan & well vision plan
- Many offices are faced with this dilemma
- More and more Medical Plans are adding wellness care

Options:
1. Perform well vision exam and reschedule for medical
2. Inquire upon patient arrive which plan intend to use
3. Bill Medical Carrier → exam & Bill well vision → glasses
4. Bill Medical carrier & cross file to well vision plan for copay, refraction and glasses, if allowed
Current Advice

- Doctors need to make hard decisions on how will handle BEFORE they occur
- Doctors need to thoroughly and completely TRAIN staff on policies
- Doctors need to thoroughly and completely read Well Vision Carrier policies
- Doctors need to carefully consider WHICH Well Vision Plans they will accept
Medical vs. Wellness

Case History - Vision Plan only

- Complaint of itchy eyes for the past two weeks.
- Last eye examination over three years ago.
- Medical history includes hypertension (treated with Cozaar) and arthritis (treated with Plaquenil for the past year).
- VA: OD 20/20, OS 20/20 uncorrected
Patient with vision plan

- SL: Mild allergic conjunctivitis
- IOP: 18 OU
- Internal exam (volk super fundus & 20D):
  - Optic nerve and peripheral fundus = normal

Diagnoses: Allergic Conjunctivitis 372.14 (H10.45)

But what to do about the Plaquenil therapy and the ocular risks that occur with use?

Treat current symptoms. Explain of risks for plaquenil on ocular health and reschedule for further required baseline testing?
Patient with Medical Plan & well vision plan

- At exam completion, fees are reviewed
- Patient announces expectation for exam to be covered by his well vision plan

**WHAT DO YOU DO?**
- Clearly exam has medical presentation, history & exam
Current Advice

- Doctors need to put policies in WRITING for ALL patients
- Doctors need to educate PATIENTS on what policies are in place BEFORE service
- Doctors need to educate PATIENTS on WHY policies are in place
Guiding Principles to Consider

1. The chief complaint and examination findings should **RULE** the examination content **AND** the coding

- My vision has gradually gotten worse, especially at near and no known ocular disease
  - Findings- presbyopic shift, no medical issues → Well vision examination
  - Findings - early ARMD → Medical examination

- Examination content and technique for each similar but findings require more extensive examination, more knowledge and more risk
- Medical examination leads to other testing, often
Guiding Principles to Consider

2. Plans accepted MAY have contract limitations on when must use well vision plans and if coordination of benefits may occur

Some plans allow Coordination of benefits (COB)
Some plans are changing their guidelines to force medical care under the well vision plan service
Some plans are rolling more medical testing under their well vision plans
Some plans are requiring the listing of medical diagnoses in addition to the refractive diagnoses applicable

PROVIDERS MUST READ AND UNDERSTAND THEIR CONTRACTS SO ARE ABIDING BY THE RULES!
3. Develop office policies and approaches to this common issue THEN stick to them!!

Avoid making rules for the rare exceptions
Ensure excellent education of staff and patients
Understand the consequences of your office policy decisions- you cannot go wrong with well thought out policies
Accept the fact that you may lose a few patients
Review your policies yearly to ensure these policies still meet the needs of your practice
4. Do apply the CPT codes and coding rules correctly and across the board.

Remember waiving copays without clear case by case hardship documentation is considered fraud.

Remember that waiving charges for procedures without clear case by case hardship documentation is considered fraud.

Remember to develop policies that prevent fraud and abuse and uphold HIPAA rules.
Resources for you

  - Excellent educational resource covering basics
- American Optometric Association Website
  - [http://www.aoa.org/coding](http://www.aoa.org/coding)
  - Includes access to Ask the Coding Experts
  - Includes access to AOA Coding Today link
See you next time....