The Role of Medical Records and Protocols in Eye Care
Better Records for Patients, Doctors, Staff, and Payers
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Why Talk About Records?
- The goal is to make you more comfortable with your medical records; paper or electronic
- Most eye care providers need to improve their forms and the way they use them
- Providers’ grasp of coding is very poor
- Time to turn choices of codes over to staff
- Good medical records enhance patient care, inter-office and intra-office communication
- All Payers require good records

Medicare Audits Are On the Upswing!
- Doctors/suppliers are being audited by DMEPOS
- Doctors are being audited for office visit and procedure coding
  - Billing for visits without a reason for the visit recorded on the exam form
  - Billing for visits without a medical reason for visit
  - Choosing and billing for codes that don’t match the content of the medical record
  - Some settlements have been quite expensive!

This Seminar (and your practice) Will Be A Success If You:
- Provide the services the patient needs; no more, no less
- Keep a record of what you have done
- Keep a record of what you have done
- Inform the payer regarding what you have done
  - Choosing Codes based on what was done/recorded
  - Receive payment for your services as reported
  - Are able to keep your payments, even if you are audited

Time to Do Things On Purpose!
The Optometric CE Pledge:
- I (state your name), do solemnly pledge to make at least one change in my practice in the next two weeks, based upon what I learn during today’s presentation.

Considerations For Records and Coding/Billing
- Health Care “System” = “Orchestrated Chaos!” (CBB)
- Payers
  - Make up their own rules
  - Change the rules without notifying providers
  - Keep employees in the dark regarding rules
  - Reject claims for no reason
  - Reject claims for no good reason
  - Add ‘Middle Men’ to further reduce payments and confuse providers
  - Etc!
3rd Party Provider Agreement Considerations

- Doctors and staff
  - Don’t read contracts before signing
  - Don’t read contracts after signing
  - Don’t abide by national rules for medical records, coding, etc.
  - Make up their own rules to make things ‘simpler’
  - Bill based on payers’ payments rather than upon the rules and upon what the medical record shows

Providers Must Take the Lead or Get the Shaft!

- Only three nationally recognized sets of rules in medical records
  - International Classification of Diseases
  - 1997 Documentation Guidelines for Evaluation and Management Services
- Doctors should abide by the rules and INSIST payers do, too!
  - AMA should enforce copyright on CPT (but won’t)
  - All doctors should quote references and insist on compliance with all payers

Considerations Regarding Re: Patient Records

- Today, nearly every doctor is reimbursed based upon RVUs, directly or indirectly
  - Knowledge of payers’ systems for creating fees and,
  - Accurate coding is critical to income!
- Doctors often neglect billing for office visits when special ophthalmological services are done

Findings From Our Reviews of Eye Doctors’ Records

- We grade charts supplied by doctors, as “friendly audits”, “Chart Reviews”, 10 per doctor
  - Some will avoid having records reviews, even if someone else is paying!
  - Many records are graded one or more levels low
  - Some are graded one or more levels too high
  - Many are inappropriately graded as 92004/92014
- Typical finding for 10 charts = 3-5 levels low
  - Average lost income from 10 charts, approx. $120-$200*
  - 2,600 visits per year, lost income approx. $31,200-$52,000*/doctor
  - *Calculations based on Medicare Allowed Charges

General Information/Motivation for Improvement

- A recent review of 120 charts for twelve eye doctors revealed:
  - Wide variety of coding choices for similar medical records among doctors
  - e.g. Some doctors code a record as a 99214, others code a similar record as 99212 or 99215
  - Some doctors code special ophthalmological services (imaging, fields, gonioscopy, etc.) without office visits
  - Average coding error is between one and two levels low
  - Dollar value of this sample of 120 indicates potential gain of doctor/clinic income of approximately $3,720 (120 x $31)

Motivation, continued

- Annual gain from correcting coding errors for each of these twelve doctors would be $80,600/year (2,600 visits/year @ $31 increase / visit)
- Extrapolated to this group of 12 doctors, it represents $967,200
- All gains refer to doctor/clinic net income
- Imagine the total impact if the data are similar for your practice or for the entire population of eye doctors in the US of A!
In Coding, There is No Place to Hide

- ODs and OMDs use more 92000 codes than 99000 codes to report their services
- Most eye doctors do not know the definitions for the 92000 codes and use them out of habit
- Most eye doctors choose their own codes, rather than training and trusting staff to do the choosing

No Place to Hide

- All eye care visits can be coded as one of the 99000 series services
- Only approximately 70-80% can alternatively be coded as a 92000 series service
- Many auditors/reviewers don’t know the rules so doctors and staff must in order to win audits

Our Comments On ODs’ Forms

- 60-70% of ODs still use paper forms
- Exam form needs spot for indicating doctor reviewed earlier case history
  - May make notes next to this section to update or change information from earlier case history
  - Note must be initialed by doctor
- **Elements from history form related to today’s visit must be entered in HPI section of medical record—By ‘Provider’**
  - ODs’ HPIs are pretty limited, in general
  - Reason for visit and HPI are key to payers

Chief Complaint/Reason for Visit/Presenting Problem

- Every record must include the reason the patient is in the office today
- If reason is linked to previous visit, record for previous visit must be consistent
  - E.g Today’s reason = “Pat. RTO @ Dr’s request for repeat IOPs.”
  - OK if record of previous visit included, “RTO 2wks, repeat IOPs”

A Peek At Charts

- Many doctors’ forms should be redesigned, generally in SOAP format
- Be sure to indicate negatives in physical exam
  - Should not use vertical line to indicate a series of negatives
  - Careful with handwriting in history and A & P; especially if acute care!
  - **Medicare: Each record must have signature of responsible person... “Legible identity of the observer”**

More Comments On Charts

- Patient’s health history form (review of systems) should permit patient to indicate positive or negative for each organ system
- Alternative is to indicate only positives, with statement at end, “All other systems are normal.”
  - Without such a statement, grading would be only on the systems that had positives
Your Charts...

- Most special ophthalmological services require 'interpretation and report'
- Can be on a separate sheet, but must also be on the day’s medical record; better than a staple!
- Include the “Three R’s”
  - ‘R’eason—Why you did the test
  - ‘R’esults—What you found
  - ‘R’ecommendation—What you’ll do about it

Be Careful Billing Visits with Surgical Codes

- CPT says surgery includes one office visit
- Visit should not be billed on day of surgery unless ‘separately identifiable’ (use -25 modifier)
- Medical record must show details of a visit (history/exam/decision making)
- Diagnosis for visit should be different than Dx for surgery

Sources of Rules for Record Keeping

- Centers for Medicare and Medicaid Services (CMS), Federal Government
  - The ‘managers’ of Medicare
    - http://www.cms.hhs.gov/providers/
  - Local Medicare Carriers Websites; e.g. trailblazers
  - Insurers’ websites
  - American Medical Association
    - Current Procedural Terminology © CPT
    - International Classification of Diseases-9th Edition
    - ICD-10 not in force until October 1, 2013
  - Software Vendors

Coding Info from the AOA

- “Codes For Optometry” + CPT, $135
  - Two volumes, including CPT
  - Includes ICD-9 abridged for the eye, HCPCS codes for material, the Documentation Guidelines for the Evaluation and Management Services
  - AOACodingToday.com and AOA.ReimbursementPlus.com
  - Articles in AOA News and Journal of the AOA
  - Monthly webinars on issues related to medical records, archived at aoa.org/coding
  - PQRS info, tools for internal audits of your charts, sample medical record forms and more

CMS Documentation Guidelines Are Key to Good Records

- Provide outline for good medical records
- New Guidelines are not expected
- CMS audits will continue indefinitely, using 1994 or 1997 guidelines
- 1997 guidelines better for eye doctors
- Honest mistakes are recouped

Medical record is your key to good care and good relations with payers

- Your Record Should Show That You Have Provided What the Patient Needed
- All health care should be provided based upon the patient’s chief complaint or reason for the visit
- The case history, physical examination and the medical decision making then ‘flow’ from the reason for the visit
- Additional tests are done only when appropriate to the reason for the visit and/or the patient’s condition
General Ophthalmological Services

(92002, 92012, 92004, 92014)

- Intermediate and comprehensive ophthalmological services are important medical services
- Guidelines, CPT definitions, for these services are less specific, more general in nature, often matching very well with the eye doctor’s medical record for a general encounter

Choosing A 92000 Code

- As with all services, must use these codes only when the documentation matches the definitions in CPT
- Most visits can be reported using either 99000 or 92000 codes (70-80%)
- Approximately 20% of the eye doctors’ charts we review are missing at least one requirement for the intermediate or comprehensive ophthalmological services and must be coded as a 99000 visit

General Ophthalmological Services

- General Ophthalmological Service codes, as all other CPT codes, are designed to report medical eye care visits
- General ophthalmological service codes may be used to report routine eye care
- Refraction is a separate service (92015) and is not included in any other code, unless required by contract with payer

CPT Definition for Intermediate Ophthalmological Services

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

"Intermediate ophthalmological services describes an evaluation of a new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis, including history, general medical observation, external ocular and adnexal examination and other diagnostic procedures as indicated; may include the use of mydriasis for ophthalmoscopy…with initiation (or continuation) of diagnostic and treatment program."

New (92002) or established patient (92012)

Requirements of Intermediate Ophthalmological Service

Payers develop their own interpretations of these definitions, but the elements that are clearly included in the CPT definition are:

1. A new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis
2. and, it must be complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis
3. History
4. General medical observation

Required Elements for Intermediate Ophthalmological Service

5. External ocular/adnexal examination
6. Other diagnostic procedures as indicated
7. Initiation (or continuation) of a diagnostic and treatment program

If one (or more) of these elements is missing, the visit cannot be coded as intermediate ophthalmological service.
CPT Definition for Comprehensive Ophthalmological Service

- "Comprehensive ophthalmological services describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated: biomicroscopy, examination with cycloplegia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs."
- New (92004) or established (92014) patient

Requirements of Comprehensive Ophthalmological Service

Again, payers develop their own interpretations of these definitions, but the elements that are required by the CPT definition are:
1. General evaluation of the complete visual system
2. History
3. General medical observation
4. External examination
5. Ophthalmoscopic examination (with or without cycloplegia or mydriasis
6. Gross visual fields
7. Basic sensorimotor examination
8. Initiation of diagnostic and treatment program

If one (or more) of these elements is missing, the visit cannot be coded as comprehensive ophthalmological service.

Initiation of Dx/Tx Program Is Critical Component of Medical Record

- Most likely target of reviewers/auditors of eye care records
- Visit will be downcoded or rejected if coded as ophthalmological service and without initiation of diagnostic/treatment program
- No detailed nationally accepted, detailed definition, so...
  - Every office must have their own definition of what's included in initiation (continuation) of diagnostic and treatment program

Your Definition of Initiation of Initiation of Dx/Tx Program...

- Probably will include 15-20 items, ie:
  - Diagnoses pertinent to today’s visit
  - RTO
    - For recheck
    - For additional tests
  - For treatment
  - Rx meds
  - Rx specs

More Dx/Tx

- Rx CLs
- Refer for Dx/Tx
- Recommended OTC meds
- Lid hygiene, lid scrubs, etc.
- Ergonomic adjustments at work or home
- Adjustments in school environment
- Refer to another doctor or clinic for Dx/Tx
- Etc.
**Good Records Help...**
- Good records reflect good understanding of CPT, the Documentation Guidelines and ICD-9
- Medical records will all be computerized in format of Guidelines
- Clearer records yield better communication with payers and with other providers
- Good records enhance communication among doctors and staff
- Good records assist self esteem and self confidence in payer audits!

**General Rules For Record Keeping In Today’s Health Care System**
- **Doctor** is responsible for good medical records
- **Doctor** should review all records before they are filed
- All doctors and staff need to recognize good medical records and bad

**General Rules for Medical Records**
- If it is not recorded, it was not done
- If it is not legible, it is not recorded/not done
- ‘Abnormal’ is not sufficient documentation for ordering additional tests
- ‘Normal’, ‘WNL’, ‘Neg...’ are sufficient to indicate no problems were detected with an organ or organ system

**More Rules for Records**
- Every record must include the date and legible identity of the observer
- Doctor’s signature and printed name will safely cover all payers’ requirements
- Initials are OK within a chart, to indicate a doctor or staff person has reviewed a section of the record or has made changes or additions to the record
- Keep list of initials and abbreviations to clarify office procedures and reduce audit problems

**Protocols for Care Can Help Your Practice Grow!**
- Create a committee to customize protocols for your practice
- Choose several common visits and establish protocols for each; e.g.
  - Progress evaluation for COAG patient
  - Evaluation for patient diagnosed with dry eyes
  - Annual examination for person with systemic diabetes, no ocular manifestations
  - Examination for person using high risk medications; e.g. Plaquenil

**Use Actual Cases As Models**
- Pull several for each type of visit
- Outline the key characteristics of each
- Compare what you’ve done with national standards, such as AOA’s Preferred Practice Patterns
- Create a new outline of your ideal protocol for each type of visit
Write Down the Expected Contents of Each Type of Visit

- What would the history contain?
  - Reason for the visit, history of present illness, review of systems, past family and social history?
  - What examination elements should be included?
  - How would the assessment and plan/medical decision making evolve?

Professional Judgment Rules the Roost!

- Decide what to put in and what to leave out based upon your professional judgment
- Create format for ideal office visit for each type of patient, without concern for payers’ rules
- After that process is done, consider each payer’s rules

Professional Judgment Rules!

- If your professional judgment meshes with payer’s rules, stay with your protocol
- If payer’s rules are restrictive, but patient care is not compromised, build the rules into your format
- If payer’s rules are restrictive and you believe patient care is compromised, follow your professional judgment, explain it to the patient, have the patient sign the advance beneficiary notice, proceed.

Glaucoma Guidelines

- Review AOA and AAO’s Guidelines for glaucoma and ocular surface disease
- Create your own guidelines for internal use
- Will assist in making care consistent among doctors
- Will help ensure good patient outcomes
- Will assist in accurate coding of visits

Plan of Action for Each of You

- The Office of Inspector General’s Medical Records Compliance Program for Small Offices has established the stimulus for internal audits of charts; don’t wait for external audit!
- Current Procedural Terminology (CPT© American Medical Association) and the 1997 Documentation Guidelines for the Evaluation and Management Services provide measuring criteria for doctors and staff for choosing codes and for conducting the internal audits
- Review CPT definitions for your twenty most commonly used services (92000 office visits, 99000 office visits, 92000 special ophthalmological services, surgical services, etc.

POA, continued

- ‘Re-read’ (probably translates, ‘read for the first time’) the 1997 Documentation Guidelines for the E&M services (approx. 14 pages, found in AOA Codes for Optometry, or on CMS website)
- Utilize clinic’s ‘grading sheets’ (copies at end of handout) to help make accurate choices of codes for each encounter and to do audits of your own medical records
- Take ten minutes per day to discuss challenging choices of codes (procedures and/or diagnosis codes) with other doctors and staff in the clinic
Let's Review Our Goals For This Seminar

- Provide the services the patient needs
- Keep a record of what you have done
- Inform the payer regarding what you have done, using CPT and ICD codes
- Receive payment for your services as reported
- Keep your payments, even if you are audited!

How Did We Do?

A Workshop on Medical Records

- Dr. Brownlow will discuss the content of each medical record and make recommendations regarding the proper choices of codes

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Grading Our First Case

- CC: ocular discomfort OU (medical reason for visit)
- History of Present Illness
  - Continuous over past three months (duration)
  - Both eyes, right eye worse than left (location)
  - Seems a little better with drops (modifying factors)
  - Vision seems blurrier as discomfort increases (associated signs and symptoms)
- (Represents ‘Extended’ history of present illness)

Case #1

- The doctor’s notes indicated “reviewed review of systems from visit from last year, no changes except she has changed heart meds and she has recently been diagnosed with adult onset diabetes. Dietary restrictions only.” (previous review of systems had been complete, therefore today’s visit also is graded as ‘complete’ review of systems.)
- Record showed that the doctor asked the patient if she was still involved in factory work and whether dust was still a factor and that the doctor recorded the new heart meds in the chart. (two elements of past/family/social and occupational history is graded as ‘complete’ PFSH.)
- History shows extended history of present illness, complete review of systems and complete past, family and social history and is graded as Comprehensive History.
Case #1

The Physical Examination Included:
- Visual acuity, near and far, uncorrected and corrected
- Pupils
- Motilities
- Confrontation Fields
- Slit lamp exam
- Lids/lashes
- Tears
- Cornea
- Anterior chambers
- Iris
- Angles
- Lens
- Bulbar and palpebral conjunctiva

Goldmann tonometry, OU

Undilated Fundus Examination:
- Vitreous
- ONH
- C/D
- Macula
- Vasculature
- Peripheral retina

Checked boxes for patient’s orientation to time/place/person and mood/affect
(Ten of twelve ophthalmic elements of physical examination were completed, Detailed physical examination)

Case #1

Medical Decision Making Consisted of Diagnoses and Management Options
- Diagnoses:
  - Hyperopia* and presbyopia*
  - Keratoconjunctivitis sicca OU
  - Diabetes by history, without ocular findings
- Management options:
  - New spectacle Rx*
  - Changed meds for her dry eye condition
  - Asked her to return to the office in one month or PRN for re-evaluation of meds
  - Scheduled fields and imaging at that visit for her diabetes
- Diagnoses and management options (total 5) = Multiple

Risk:
- Chronic illness with mild complications or a new problem with uncertain prognosis = Moderate Risk
- Medical decision making with extensive diagnoses and management options and moderate risk is Moderate Complexity

Case #1

Choosing the codes:
- Established patient, including comprehensive history, detailed physical examination and moderate complexity medical decision making is coded as a 99214 or 92014
- Refraction is reported separately as 92015

Based upon hundreds of recent reviews of medical records for eye doctors, this would more likely have been reported using the 99212 or 92012 code, resulting in significant reduction in reimbursement and therefore net income.

Grading Case #2

Reason for the visit (CC): Occasional soft contact lens wearer reporting itching and discomfort which makes it difficult to wear her contact lenses

History of present illness (HPI):
- Replaces lenses frequently when she does wear them (assoc. signs/symptoms) *
- Has been worse for past two months (duration) **
- Eyes crusty & itchy upon awakening (assoc. signs/symptoms)
- Can’t wear lenses for computer work (context) ***
- Symptoms worse (severity) ****
Case #2

- Notices 'gunky' discharge after a few hours of wear (assoc. signs/symptoms) *****
- Gets a little relief from putting drops in her eyes (AT) after removing her lenses (modifying factors) *****

Six elements of HPI = Extended HPI

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Review of systems (ROS): The doctor included no reference to previous reviews of systems. Could have gotten credit for earlier ROS if she/he had made note in today's chart regarding review of earlier ROS, "No changes except as noted" and initialed.

One system reviewed = Problem Pertinent ROS

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Past/Family/Social and Occupational history (PFSH)

Past
- The patient reported frequent episodes of red eyes and infections over the past several years
- No current general health problems or long term meds

Family; ocular and medical
- Father, mother and two aunts had COAG
- Father had diabetes, high blood pressure and halitosis
- Mother had heart trouble

Established patient, 2 elements of PFSH = Complete PFSH

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Grading the Case History

- Extended HPI and complete PFSH each are required for comprehensive history, but because doctor did only 'problem pertinent' ROS, the history can be graded no higher than Expanded Problem Focused.

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Physical Examination

- Visual Acuities
- Pupils
- Motilities
- Confrontation Fields
- Slit Lamp Examination
  - Lids/lashes
  - Bulbar and palpebral conjunctiva
  - Corneas

Physical Exam, continued
- Anterior chambers
  - Angles
  - Irises
  - Crystalline lenses
- Contact lenses seemed to fit all right
- IOPs
- Dilated fundus evaluation
  - Discs
  - Peripheral retina
- Patient oriented to time/place/person
- Patient's mood and affect
Case #2

- Grading the Physical Examination
  - Twelve ophthalmic elements and both psychiatric elements = Comprehensive Physical Examination

Case #2

- Medical Decision Making
  - Number of diagnoses and management options
    - Two diagnoses (CL problems and dry eyes)
    - Five management options (rewetting drops, replacing lenses on schedule, reduce wearing time, OTC AT early morning and late evening, RTC one month or PRN)
    - Total of seven Dx and Tx options = Extensive Dx and Mn Options
  - Risk
    - Two or more self limited or minor illnesses = Low Risk

Projects for Doctors and Staff

- Review key resources for proper choice of office visit and procedure codes
  - International Classification of Diseases, ninth edition 1997
  - Documentation Guidelines for the Evaluation and Management Services (available on CMS website or in AOA Codes for Optometry)

Bargains for AOA Members

- Note: Best sources for these references is AOA Codes for Optometry, $135/year and AOACodingToday.com, free to AOA members renewing in 2010, and AOA.ReimbursementPlus.com, reduced fees for AOA members
- AOA.org/coding
  - Webinars, FAQs, etc.

Case #2

- Grading the Medical Decision Making
  - Extensive Dx and Mn options and low risk = Low Complexity Medical Decision Making

Projects for Docs and Staff

- Review and use attached grading documents from PMI, LLC
- "Master chart" of eye care office visits to be used for accurately choosing visit codes, titled “Codes for Eye Care Office Visits” (pg. 21)
- Grading sheets for audits of your own records, titled “Grading the Patient Encounter”
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- Note: Best source for these references is AOA Codes for Optometry, $125/year

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- Master Chart of eye care office visits to be used for accurately choosing visit codes, titled “Codes for Eye Care Office Visits”
- Grading sheets for audits of your own records, titled “Grading the Patient Encounter”

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How Did We Do?

Bonus Slides…Getting Staff More Involved for More Accurate Coding

Time for ODs to Enable and Permit Staff to Code Visits and Procedures

Thank You!
brownlowod@aol.com
www.pmi-eyes.com
**Why Now?**

- Doctors aren’t much good at it and are busy with patient care
- Nearly all MD offices/clinics have used staff to code accurately for years
  - Certified coders
  - New program for certification exam for paraoptometric coders
- All health care providers will eventually have EHR which codes itself
- The more ODs and staff know about coding, the more likely you’ll choose good EHR

**Why Now?**

- PMI ‘friendly audits’ in ‘11 show ODs under code by about 30%
- Medicare says docs’ undercoding saves Medicare over $1 billion per year!
- Accurate choice of visit codes is easily learned, objective, repeatable, consistent with the same national rules the auditors use
- Accurate coding enhances peace of mind and bottom line!!!
- PMI info suggests $30,000 to $85,000/year/doc for typical practice
- Accurate coding will very likely yield more annual income than Medicare incentives

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**Training Resources Available**

- AOA
  - Over one dozen archived voice over Power Point webinars on coding available at aoa.org/coding
  - At least one new webinar/month
  - askthecodingexperts@aoa.org

- PMI, LLC  [www.pmi-eyes.com](http://www.pmi-eyes.com)
  - Online coding course
  - VisitCoder—PDA based device for choosing 99000 and 92000 visit codes’ Also available as Excel spreadsheet and soon as an iPad/iPhone app!
  - “Friendly Audit” service—PMI Records Reviews
  - Assistance with developing logical fee schedule—PMI Fee Analysis