KANSAS

MEDICAL

ASSISTANCE

PROGRAM

PROVIDER MANUAL

Vision

PART II
VISION PROVIDER MANUAL

Introduction

PART II
VISION PROVIDER MANUAL

Updated 11/03

This is the provider specific section of the manual. This section (Part II) was designed to provide information and instructions specific to vision providers. It is divided into three subsections: Billing Instructions, Benefits and Limitations, and Appendices.

The **Billing Instructions** subsection gives an example of the billing forms applicable to vision services. The forms are followed by directions for completing and submitting them.

The **Benefits and Limitations** subsection defines specific aspects of the scope of vision services allowed within the Kansas Medical Assistance Program.

The **Appendix** subsection contains information concerning procedure codes. The appendix was developed to make finding and using procedure codes easier for the biller.

HIPAA Compliance

As a participant in the Kansas Medical Assistance program, providers are required to comply with compliance reviews and complaint investigations conducted by the Secretary of the Department of Health and Human Services as part of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with section 45 of the code of regulations parts 160 and 164. Providers are required to furnish the Department of Health and Human Services all information required by the Department during its review and investigation. The provider is required to provide the same forms of access to records to the Medicaid Fraud and Abuse Division of the Kansas Attorney General's Office upon request from such office as required by K.S.A. 21-3853 and amendments thereto.

A provider who receives such a request for access to or inspection of documents and records must promptly and reasonably comply with access to the records and facility at reasonable times and places. A provider must not obstruct any audit, review or investigation, including the relevant questioning of employees of the provider. The provider shall not charge a fee for retrieving and copying documents and records related to compliance reviews and complaint investigations.

7000. VISION BILLING INSTRUCTIONS Updated 05/07

Introduction to the ~~HCFA-1500~~ CMS-1500 Claim Form

Vision providers must use the ~~HCFA-1500~~ CMS-1500 claim form (unless submitting electronically) when requesting payment for medical services and supplies provided under the Kansas Medical Assistance Program. An example of the ~~HCFA-1500~~ CMS-1500 claim form is ~~shown on the previous page~~ in the Forms section at the end of this manual. Instructions for completing this claim form are included in the following pages. The Kansas MMIS will be using electronic imaging and optical character recognition (OCR) equipment. Therefore, information will not be recognized if not submitted in the correct fields as instructed.

EDS does not furnish the ~~HCFA-1500~~ CMS-1500 claim form to providers. Refer to Section 1100 of the *General Introduction Provider Manual*.

Complete, line by line instructions for completion of the ~~HCFA-1500~~ CMS-1500 is available in the *General Billing Provider Manual*. ~~, pages 5-14 through 5-19.~~

SUBMISSION OF CLAIM:

Send completed first page of each claim and any necessary attachments to:

Kansas Medical Assistance Program
Office of the Fiscal Agent
P.O. Box 3571
Topeka, Kansas 66601-3571

7020. VISION SPECIFIC BILLING INFORMATION Updated 05/07

Complete the CMS-1500 claim form if the vision services meet the following criteria:

- The services provided are all professional (no material charges).
- The services are both professional and materials and the provider receives the payment for materials.

An invoice is **not** required.

~~**Contact Lenses:**~~

~~The following beneficiary information must be provided when prior authorization (PA) is requested:~~

- ~~Eyeglass lens prescription and the visual acuity achieved with this correction in both eyes~~
- ~~Type of contact lenses to be fitted~~
- ~~Original fitting (or refitting) information~~
- ~~Reason for recommending contact lenses~~
- ~~Outline of adaptation procedures~~
- ~~Probability of need for supplemental eyeglass lenses~~
- ~~Approximate cost to Medicaid~~

Diagnosis Codes:

Applicable ICD-9 diagnosis codes are required on all claims submitted for processing. Opticians and optometrists should share these codes with the dispenser.

Cataract Surgery:

If vision services such as eye exams, lenses, or frames are being rendered due to cataract surgery (diagnosis codes 366.50-366.53, 379.31) or lens replacement (diagnosis code V43.1), the date of surgery must be present in field 19 of the CMS-1500 claim form. If the date of surgery is not present, the services will be denied.

BENEFITS AND LIMITATIONS

8100. COPAYMENT Updated 11/03

Vision services require a copayment of $2.00 per date of service. Refer to Section 3000 for exceptions.

Bill all services occurring on the same date on the same claim form.

If multiple claims are submitted for the same date(s) of service, the copayment requirement will be deducted for each claim submitted.

Do **not** reduce charges or balance due by the copayment amount. This reduction will be made automatically during claim processing.

BENEFITS AND LIMITATIONS

8300. Benefit Plan Updated 08/08

KMAP beneficiaries will be assigned to one or more ~~Medical Assistance~~ benefit plans. ~~The assigned plan or plans will be listed on the beneficiary ID card.~~ These benefit plans entitle the beneficiary to certain services. From the provider's perspective, these benefit plans are very similar to the type of coverage assignment in the previous MMIS. If there are questions about service coverage for a given benefit plan, refer to Section 2000 of the *General Benefits Provider Manual* for information on the plastic State of Kansas Medical Card and eligibility verification~~ contact the Medical Assistance Customer Service Center at 1-800-933-6593 or (785) 274-5990~~.

BENEFITS AND LIMITATIONS

8400. MEDICAID Updated 05/07

Eye Exams:
One complete eye exam is covered every four years when provided by ophthalmologists and optometrists for non-KAN Be Healthy (KBH) beneficiaries. Eye exams are covered as needed up to one year following cataract surgery when provided by ophthalmologists and optometrists. Eye exams are limited to one every four years; however, a total of two eye exams are covered per month to detect and/or follow medical conditions.

Eye exams are covered as needed for KBH beneficiaries when provided by ophthalmologists and optometrists. The following basic eye exam procedure codes are considered KBH vision screens: 92002, 92004, 92012, 92014, and 99173.

Since ophthalmologists and optometrists provide more extensive eye examinations than are reflected by a KBH vision screening code, these vision providers shall bill vision exams using one of the CPT vision procedure codes listed in Appendix I of this manual.

Refraction (92015) is not included in a basic eye exam. Refractions may be provided on the same date of service as the basic eye exam and billed as a separate procedure.

If visual field examinations, fundus photography, and laser scanning are performed on the same date of service as an eye exam, visual field examinations, fundus photography, and laser scanning are considered content of service of that eye exam unless medical necessity is shown.

Visual field examinations and laser scanning are not allowed on the same date of service. Both procedures are limited to a total of four times per 365 days if medical necessity is present. (Laser scanning is limited to four per year for each eye. An LT or RT modifier is required when billing laser scanning.)

Visual field testing must be medically necessary to establish a diagnosis, monitor a course of treatment, or determine if a change in therapeutic plan is necessary because of a progression of a disease. Furthermore, the lowest level of testing medically necessary should be used. Glaucoma is the most frequent diagnosis associated with visual field testing. Visual field testing may be medically necessary in a glaucoma suspect or a patient with glaucoma, mild damage, and good control only once every year. Visual field testing may be necessary in patients with moderate glaucoma and good control once a year. Field testing may be necessary in mild, moderate, or advanced glaucoma and borderline control two times a year. Finally, visual field testing in patients with advanced damage or uncontrolled glaucoma may be necessary up to four times a year.

Fundus photography and visual field examinations are considered content of service of an eye exam when performed on the same date of service unless the diagnosis on the claim clearly supports medical necessity for the procedure.

8400. MEDICAID Updated 08/08

Eye Exams continued

Laser scanning is appropriate once a year to follow preglaucoma patients or those with mild damage. Patients with moderate damage may be followed with either scanning or visual field testing. Using scanning **and** visual field testing is not allowed. Patients with moderate damage may be followed with two tests per year. If the glaucoma is uncontrolled, more than two tests per year (up to the limit of four tests) may be necessary. Finally, in advanced damage visual field testing is preferred instead of laser scanning.

Corneal topography is allowed no more than one time per year with prior authorization. Medical necessity must be shown by one of the following diagnosis codes: 371.46, 371.48, 371.60, 371.61, 371.62, 996.51, and V42.5. Corneal topography is noncovered for preparation or continued care of Laser-Assisted in Situ Keratomileusis (LASIK) surgery or basic fitting or refitting of contact lenses.

LASIK surgery is noncovered.

Documentation
Documentation in the beneficiary's medical record must support the service billed in the course of a postpayment review. Refer to Section 2700 of the *General Benefits Provider Manual* for KMAP documentation requirements.

Eyeglasses
All frames must include a one-year warranty.

Back-up eyeglasses are noncovered and should not be billed to KMAP.

Eyeglasses may initially be ordered on the same date a KBH vision exam is performed.

The fitting of new eyeglasses is considered content of service of the charge for the glasses and cannot be billed separately.

Eyeglasses are covered up to no more than three sets of lenses and three pairs of frames per 365 days for KBH beneficiaries. Replacement parts may be covered.

Eyeglasses are covered up to no more than one set of lenses and one pair of frames per 1,460 days (four years) for non-KBH beneficiaries.

If only one lens or just frames are issued to the non-KBH participant after the four-year limitation, ~~the medical card will be updated. However,~~ the patient remains eligible to receive the other lens and/or frames. The provider needs to verify with the KMAP Customer Service Center at 1-800-933-6593 to determine if the beneficiary qualifies for further coverage before billing the KMAP beneficiary. Minor repairs to eyeglasses may be covered.

8400. MEDICAID Updated 01/09

Eyeglasses continued:

The date of receipt of the prescription (ordering date) is considered the date of service. The provider may bill KMAP before the actual dispensing of the glasses since the intent to render service has been confirmed by the acceptance of the prescription.

Optometrists and ophthalmologists who provide eyeglass dispensing services to non-KMAP beneficiaries must offer this service to KMAP beneficiaries. This policy is monitored on a postpayment basis.

If a beneficiary chooses eyeglass frames or lenses that exceed KMAP's allowed amount, the beneficiary is responsible for the entire expense of the frames or lenses. Do not bill KMAP for these services.

Eyeglasses for post cataract surgery patients are covered when provided within one year following the cataract surgery.

~~Photochromatic tint is covered with medical necessity. All other tints are noncovered. Medical necessity is reviewed on a postpayment basis. If a beneficiary chooses a tint that is not medically necessary, the beneficiary is responsible for the expense of the tint.~~

All ~~types of~~ sunglasses, transition lenses, tints (including photochromatic), progressive lenses, safety glasses, and athletic glasses are noncovered.

Polycarbonate lenses are covered with medical necessity. Polycarbonate lenses are billed using one of the following options:

- V2784 (Lens, polycarbonate or equal, any index, per lens). This code is NOT in addition to and cannot be billed with any other lens codes.
- S0580 (Polycarbonate lens), list this code in addition to the basic code for the lens. If using S0580, providers should bill this code in addition to the appropriate lens code.

Codes V2784 and S0580 cannot be billed together. Polycarbonate lenses are noncovered for convenience or cosmetic reasons. Modifier 22 is no longer required. If a beneficiary chooses polycarbonate lenses when medical necessity does not exist, the beneficiary is responsible for the entire cost of the lens.

8400. MEDICAID Updated 05/07

Contact Lenses:

Prior authorization is required at all times for contact lens services. Backdating a prior authorization is not allowed. Providers must obtain a prior authorization approval from KMAP before dispensing contacts. The following beneficiary information must be provided with a prior authorization request:

- Eyeglass lens prescription and the visual acuity achieved with this correction in both eyes
- Visual acuity without correction
- Type of contact lenses to be fitted
- Date of original fitting
- Reason for refitting, if applicable
- Medical necessity for contact lenses
- Outline of adaptation procedures
- Probability of need for supplemental eyeglass lenses
- Approximate cost to KMAP

Contact lenses and replacements are covered with prior authorization for the following (medical necessity must be present):

- Monocular aphakia
- Bullous keratopathy
- Keratoconus
- Corneal transplant
- Anisometropia of more than three diopters of difference that is causing vision distortion and cannot be corrected with glasses
- Anisekonia of more than three diopters of difference that is causing vision distortion and cannot be corrected with glasses

Contact lens adaptation includes six months of care.

Contact lens replacement includes neutralization per lens.

Contact lenses are noncovered for cosmetic purposes or for athletic participation. Contact sunglasses, colored or tinted of any kind, are noncovered.

Contact lens fitting is allowed once per lifetime when contacts are first prescribed. Subsequent fittings will be considered if a new type of contact lens is being prescribed and fitted.

8400. MEDICAID Updated 08/08

Blepharoplasty and Blepharoptosis

Blepharoplasty and Blepharoptosis procedures require prior authorization. The beneficiary must meet the following criteria:

- Margin Reflex Distance (MRD) must be 1.0 or less in the best eye.
- Full Flash Photo light reflex must be performed to identify papillary center resting tangent.
- Visual field loss must be 10-15 degrees above dead center in the best eye for beneficiaries 14 years of age and older. Submit with request visual field loss of both eyes (taped and untapped).
- Prior vision history and expected outcomes of surgery must be submitted with request.
- If best eye does not meet the above criteria, the surgery is not allowed except in beneficiaries under 10 years of age.
- For coverage of one eye, the same criteria applies unless person only has one functional eye.
- For coverage of both eyes, the best eye must meet all of the above criteria.
- All of the above information must be submitted at the time the prior authorization request is made. Requests cannot be processed without all of the above information.

Vision Therapy

Orthoptic and/or pleoptic training (also referred to as vision therapy) is a noncovered KMAP benefit. No services are payable arising from the assessment, planning, implementation, or evaluation of vision therapy.

Emergency Medical Services for Aliens (SOBRA)

In addition to inpatient hospital and emergency room hospital, emergency services performed in outpatient facilities and related physician, lab, and x-ray services will be allowed for the following places of service: office, outpatient hospital, Federally Qualified Health Clinics, state or local public health clinics, rural health clinics, ambulance, and lab for SOBRA claims. Inpatient hospital reimbursement will not be limited to 48 hours. Follow-up care will not be allowed once the emergent condition has been stabilized.

Refer to Section 2040 of the *General Benefits Provider Manual* for specific information.

APPENDIX I

PROCEDURE CODES AND NOMENCLATURE

Updated 05/07

The following codes represent an all inclusive list of vision services billable to the Kansas Medical Assistance Program (KMAP). Procedures not listed here are considered noncovered.

~~**MODIFIER**~~

~~22 Polycarbonate lens~~

COVERAGE INDICATORS

KBH - KAN Be Healthy participation is required.
~~INV - Manufacturer's invoice must accompany claim.~~
~~NC - Non covered Kansas Medical Assistance Program service.~~
PA - Prior authorization is required.
C - Covered KMAP service.

Refer to Section 8400 of this manual for additional benefits and limitations.

COV.	PROCEDURE CODE	NOMENCLATURE
		PROFESSIONAL SERVICES
		EYE EXAMINATIONS
C	92002	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
C	92004	Comprehensive, new patient, one or more visits
C	92012	Ophthalmological services: medical examination and evaluation with initiation or continuation of diagnostic and treatment program; intermediate, established patient
C	92014	Comprehensive, established patient, one or more visits
C	92015	Determination of refractive state
C	92020	Gonioscopy (separate procedure)
C	92081	Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (e.g., tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)
C	92082	Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (e.g., at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)

COV.	PROCEDURE CODE	NOMENCLATURE Updated 12/07
		EYE EXAMINATIONS continued
C	92083	Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (e.g., Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)
C	92100	Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (e.g., diurnal curve or medical treatment of acute elevation of intraocular pressure)
C	92135	Scanning computerized ophthalmic diagnostic imaging, posterior segment (e.g. scanning laser) with interpretation and report, unilateral
C	92140	Provocative tests for glaucoma, with interpretation and report, without tonography
C	92250	Fundus photography with interpretation and report
C	92285	External ocular photography with interpretation and report for documentation of medical progress (e.g., close-up photography, slit lamp photography, goniophotography, stereo-photography)
C, PA	92025	Computerized corneal topography, unilateral or bilateral, with interpretation and report
		LENSES, FRAMES, AND MATERIALS
C	V2020	Frames, purchases
C	V2100	Sphere, single vision, plano to plus or minus 4.00, per lens
C	V2101	Sphere, single vision, plus or minus 4.12 to plus or minus 7.00d, per lens
C	V2102	Sphere, single vision, plus or minus 7.12 to plus or minus 20.00d, per lens
C	V2103	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens
C	V2104	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 2.12 to 4.00d cylinder, per lens
C	V2105	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens
C	V2106	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens
C	V2107	Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00d sphere, 0.12 to 2.00d cylinder, per lens
C	V2108	Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens
C	V2109	Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens

COV.	PROCEDURE CODE	NOMENCLATURE Updated 05/07
		LENSES, FRAMES, AND MATERIALS continued
C	V2110	Spherocylinder, single vision, plus or minus 4.25 to 7.00d sphere, over 6.00d cylinder, per lens
C	V2111	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens
C	V2112	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25d to 4.00d cylinder, per lens
C	V2113	Spherocylinder, single vision, plus or minus 7.25 toplus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens
C	V2114	Spherocylinder, single vision sphere over plus or minus 12.00d, per lens
C, PA	V2115	Lenticular (myodisc), per lens, single vision
C, PA	V2118	Aniseikonic lens, single vision
C, PA	V2121	Lenticular lens, per lens, single
C, PA,~~KBH~~	V2199	Not otherwise classified single vision lens
C	V2200	Sphere, bifocal, plano to plus or minus 4.00d, per lens
C	V2201	Sphere, bifocal, plus or minus 4.12 to plus or minus 7.00d, per lens
C	V2202	Sphere, bifocal, plus or minus 7.12 to plus or minus 20.00d, per lens
C	V2203	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens
C	V2204	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 2.12 to 4.00d cylinder, per lens
C	V2205	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens
C	V2206	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens
C	V2207	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 0.12 to 2.00d cylinder, per lens
C	V2208	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens
C	V2209	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens
C	V2210	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, over 6.00d cylinder, per lens
C	V2211	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens
C	V2212	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25 to 4.00d, cylinder, per lens
C	V2213	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens
C	V2214	Spherocylinder, bifocal, sphere over plus or minus 12.00d, per lens
C,PA	V2215	Lenticular (myodisc), per lens, bifocal
C,PA	V2218	Aniseikonic, per lens, bifocal
C	V2219	Bifocal seg width over 28mm

COV.	PROCEDURE CODE	NOMENCLATURE Updated 05/07
		LENSES, FRAMES, AND MATERIALS continued
C	V2220	Bifocal add over 3.25d
C,PA	V2221	Lenticular lens, per lens, bifocal
C,~~PA,KBH~~	V2299	Specialty bifocal (by report)
C	V2300	Sphere, trifocal, plano to plus or minus 4.00d, per lens
C	V2301	Sphere, trifocal, plus or minus 4.12 to plus or minus 7.00d per lens
C	V2302	Sphere, trifocal, plus or minus 7.12 to plus or minus 20.00, per lens
C	V2303	Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens
C	V2304	Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 2.25 to 4.00d cylinder, per lens
C	V2305	Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens
C	V2306	Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens
C	V2307	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 0.12 to 2.00d cylinder, per lens
C	V2308	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens
C	V2309	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens
C	V2310	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, over 6.00d cylinder, per lens
C	V2311	Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens
C	V2312	Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25 to 4.00d cylinder, per lens
C	V2313	Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens
C	V2314	Spherocylinder, trifocal, sphere over plus or minus 12.00d, per lens
C,PA	V2315	Lenticular (myodisc), per lens, trifocal
C,PA	V2318	Aniseikonic lens, trifocal
C	V2319	Trifocal seg width over 28mm
C	V2320	Trifocal add over 3.25d
C,PA	V2321	Lenticular lens, per lens, trifocal
C	V2399	Specialty trifocal (by report)
C,PA	V2410	Variable asphericity lens, single vision, full field, glass or plastic, per lens
C,PA	V2430	Variable asphericity lens, bifocal, full field, glass or plastic, per lens
C,PA	V2499	Variable asphericity lens, other type
~~NC~~, C	V2710	~~Special grinding, pair~~ Slab off prism, glass or plastic, per lens
C	V2715	Prism, per lens
C	V2760	Scratch resistant coating, per lens

COV.	PROCEDURE CODE	NOMENCLATURE Updated 01/09
		LENSES, FRAMES, AND MATERIALS continued
C	V2782	Lens, index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbonate, per lens
C	V2783	Lens index greater than or equal to 1.66 plastic or greater than or equal to 1.80 glass, excludes polycarbonate, per lens
C	V2784	Lens, polycarbonate or equal, any index, per lens
~~C~~	~~V2744~~	~~Tint, photochromatic, per lens~~
C, PA	V2799	Vision service miscellaneous
C	92370	Repair and refitting spectacles; except for aphakia
C	S0580	Polycarbonate lens
		CONTACT LENS
		ADAPTATION
C, PA	92070	Fitting of contact lens for treatment of disease, including supply of lens
C, PA	92310	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia
C, PA	92311	Corneal lens for aphakia, one eye
C, PA	92312	Corneal lens for aphakia, both eyes
C, PA,	92313	Corneoscleral lens
C, PA	92314	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens, both eyes, except for aphakia
C, PA	92315	Corneal lens for aphakia, one eye
C, PA	92316	Corneal lens for aphakia, both eyes
C, PA	92317	Corneoscleral lens
C, PA	92325	Modification of contact lens (separate procedure), with medical supervision of adaptation
C, PA	92326	Replacement of contact lens
C, PA	V2500	Contact lens, PMMA, spherical, per lens
C, PA	V2501	Contact lens, PMMA, toric or prism ballast, per lens
C, PA	V2502	Contact lens, PMMA, biofocal, per lens
C, PA	V2503	Contact lens, PMMA, color vision deficiency, per lens
C, PA	V2510	Contact lens, gas permeable, spherical, per lens
C, PA	V2511	Contact lens, gas permeable, toric, prism ballast, per lens
C, PA	V2512	Contact lens, gas permeable, bifocal, per lens
C, PA	V2513	Contact lens, gas permeable, extended wear, per lens
C, PA	V2520	Contact lens, hydrophilic, spherical, per lens
C, PA	V2521	Contact lens, hydrophilic, toric, or prism ballast, per lens

COV.	PROCEDURE CODE	NOMENCLATURE Updated 05/07
		CONTACT LENS continued
C, PA	V2522	Contact lens, hydrophilic, bifocal, per lens
C, PA	V2523	Contact lens, hydrophilic, extended wear, per lens
C, PA	V2530	Contact lens, scleral, gas permeable, per lens (for contact lens modification, see 92325)
C, PA	V2531	Contact lens, scleral, gas permeable, per lens (for contact lens modification, see 92325)
C, PA	S0500	Disposable contact lens, 1 unit = 1 lens
		ARTIFICIAL EYES
		(Includes both professional and material charges)
C	V2623	Prosthetic, eye, plastic, custom
C	V2624	Polishing/resurfacing of ocular prosthesis
C	V2625	Enlargement of ocular prothesis
C	V2626	Reduction of ocular prosthesis
C	V2627	Scleral cover shell
C	V2628	Fabrication and fitting of ocular conformer

FORMS SECTION

CMS-1500

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.