

CAUTION: Read the [ICD-9 Policy Holding Library](#) page about policy in this document.

contact lens ex

1

Contact Lenses Example: CMS-1500

This example will help providers bill for contact lenses on the *CMS-1500* claim form. Refer to the *Contact Lenses* section of this manual for policy information. Refer to the *CMS-1500 Completion for Vision Care* section of this manual for instructions to complete claim fields not explained in the following example. For additional claim preparation information, refer to the *Forms: Legibility and Completion Standards* section of this manual.

Billing Tips: When completing claims, do not enter the decimal points in ICD-9-CM codes or dollar amounts, or dollar signs with the charges. If requested information does not fit neatly in the *Reserved for Local Use* field (Box 19) of the claim, type it on an 8½ x 11-inch sheet of paper and attach it to the claim.

Contact Lenses

Figure 1. Contact lenses.

This is a sample only. Please adapt to your billing situation.

In this example, the doctor has received authorization from the Department of Health Care Services (DHCS) Vision Services Branch (VSB) for the contact lens evaluation (CPT-4 code 92312) and replacement of a pair of soft or hydrophilic contact lenses (HCPCS code V2520) for a patient with aphakia. Authorization for these services is indicated by the 10-digit TAR Control Number (TCN) followed by the Pricing Indicator (PI) in the *Prior Authorization Number* field (Box 23).

CPT-4 code 92312 (prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, both eyes) with modifier SC (medically necessary service/supply) and HCPCS code V2520 (contact lens, hydrophilic, spherical, per lens) with modifier RA (replacement) are entered in the *Procedures, Services, or Supplies* field (Box 24D).

Because the optometrist is billing for one contact lens evaluation and two contact lenses, “1” and “2” are entered in the *Days or Units* field (Box 24G) respectively, for the corresponding procedure codes. Enter the usual and customary charges in the *Charges* field (Box 24F).

Enter “11” in the *Place of Service* field (Box 24B) to indicate that services were rendered in an office. ICD-9-CM code 379.31 (aphakia) is entered in the *Diagnosis or Nature of Illness or Injury* field (Box 21).

The long term care facility’s name and National Provider Identifier (NPI) are entered in the *Name of Referring Provider or Other Source* (Box 17) and *NPI* (Box 17a) fields to indicate that the recipient meets the Optional Benefits Exclusion exemption. Although CPT-4 code 92312 remain a covered benefit for all eligible recipients based on medical necessity, this information is required on the claim for the reimbursement of HCPCS code V2520. Refer to the *Optional Benefits Exclusion* section in this manual for additional information.

Refer to the *Contact Lenses* and *TAR Completion for Vision Care* sections in this manual for policy and required authorization information.

Refer to the *Modifiers for Vision Care Services* section in this manual for a list of required modifiers and their corresponding procedure codes.

<div style="text-align: right;">PICA <input type="checkbox"/></div> <div style="text-align: left;">1500</div> <h2 style="text-align: center;">HEALTH INSURANCE CLAIM FORM</h2> <p style="text-align: center;">APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</p>																																																																																																																																																																																																																																																																																																																																																											
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25. FEDERAL TAX I.D. NUMBER			SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gmt claims, see 10-900) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 250.00		29. AMOUNT PAID \$		30. BALANCE DUE \$ 250.00																																																																																																																																																																																																																																																																																																																																														
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 <i>Jane Doe</i> DATE 09/30/09					32. SERVICE FACILITY LOCATION INFORMATION a. NPI			33. BILLING PROVIDER INFO & PH # (916) 555-5555 JANE SMITH 1027 MAIN STREET ANYTOWN CA 958235555 a. 0123456789 b.																																																																																																																																																																																																																																																																																																																																																			

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Figure 1. Contact Lenses.