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Coding and billing manual for Pacific University College of Optometry clinics

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Pacific University

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Abstract
The purpose of this manual is to provide the clinic staff, attending doctors, and students of Pacific University College of Optometry with a basic outline of how to bill some of the more common eye care procedures. This manual will also summarize the general process of billing insurance while pointing out some of the differences between some of the major insurance carriers in which Pacific University College of Optometry is a participant. Examples of claim forms are provided along with a list of some of the more-difficult-to-find diagnosis codes. As the realm of insurance billing and coding is vast and ever changing, this manual is not intended to be all-inclusive or stand the test of time, but will hopefully point the reader in the right direction and provide helpful tips to avoid claim denials. Consultation visits, EIM level determination, vision therapy billing, and low vision billing will not be covered in this manual. Even though most students and attending doctors may not be directly involved in the submission of insurance claims, it is important for all to understand the process and the ramifications of improperly coding procedures and diagnoses for reimbursement.

Degree Type
Thesis

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CODING AND BILLING MANUAL FOR PACIFIC UNIVERSITY
COLLEGE OF OPTOMETRY CLINICS

By
JENNIFER SPRINGSTEAD

A thesis submitted to the faculty of the
College of Optometry
Pacific University
Forest Grove, Oregon
for the degree of
Doctor of Optometry
May 2004

Advisor:
LYNN UESHIRO, OD
Biographies

Jennifer Springstead graduated with honors from Oregon State University where she received a B.S. in General Science. She plans to pursue a clinical career in optometry following receipt of her O. D. degree.
Abstract

The purpose of this manual is to provide the clinic staff, attending doctors, and students of Pacific University College of Optometry with a basic outline of how to bill some of the more common eye care procedures. This manual will also summarize the general process of billing insurance while pointing out some of the differences between some of the major insurance carriers in which Pacific University College of Optometry is a participant. Examples of claim forms are provided along with a list of some of the more-difficult-to-find diagnosis codes.

As the realm of insurance billing and coding is vast and ever changing, this manual is not intended to be all-inclusive or stand the test of time, but will hopefully point the reader in the right direction and provide helpful tips to avoid claim denials. Consultation visits, E/M level determination, vision therapy billing, and low vision billing will not be covered in this manual. Even though most students and attending doctors may not be directly involved in the submission of insurance claims, it is important for all to understand the process and the ramifications of improperly coding procedures and diagnoses for reimbursement.

Key Words
Billing
Coding
Insurance
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First Steps To Proper Billing and Coding

1. When a patient calls to make an appointment, ask if he/ she has any vision insurance he/ she would like billed. If he/ she is an existing patient, ask the patient if his/ her insurance has changed.

It is best to get any insurance information before the appointment to confirm that your office is a plan provider, and to verify the patient's eligibility and benefits.

2. If the patient's reason for coming in sounds more like a medical problem than a refractive problem (i.e., red eyes vs. blurry vision when driving), ask the patient if they have any medical insurance, and recommend billing their medical insurance. Most patients do not realize that most eye problems are medically related so their medical insurance can be billed. Also, most patients do not realize that most eye care providers can treat most medical problems.

Most vision insurance plans only cover routine examinations along with the materials (i.e., frames, lenses, or contact lenses) for refractive diagnoses. Medical insurance plans in general do not cover routine examination. With respect to eye care, they cover the "non-refractive" procedures and must be billed with a medical diagnosis code. Medical insurance is tricky though, because some of the insurance carriers require a referral from a primary care provider before they will agree to cover your services. This is why it is important to ascertain if a referral is required prior to the appointment. If it is an emergency situation and waiting for a referral would put the patient in jeopardy of losing sight or life, an emergency waiver form can be filled out and signed by the patient. (See example of emergency services form on page 40.)

3. Call the insurance carrier or check the insurance carrier's website, before the appointment to verify the patient's eligibility and benefits (i.e., if the benefit has been used in the last 24 months, year, or calendar year, depending on the policy), how often he/ she is eligible for benefits, and if there are any co-payments (co-pay) or maximum allowable amounts for routine plans, and to check for deductibles, office visit co-pays, or required referrals for medical plans.
Document the information along with whom you talked to and the time and day in the patient’s chart. The insurance carriers often have a disclaimer that states the benefits stated by a representative are not a guarantee of payment. However, if information is misquoted by a representative, most carriers will fix the problem in the patient’s favor.

4. When the patient arrives for his/ her appointment, you must have him/ her sign an assignment of benefits form that allows your office to be able to bill the insurance carrier, have the carrier reimburse your office directly, and gives your office permission to release the appropriate information to the insurance carrier for you to file the claim.

(See example of financial policy on page 41.) If the patient declines to sign the assignment of benefits form, the patient must pay for all services and file his/ her own claim in order to be reimbursed from their carrier. Be sure your office’s financial policy is clear to patients that all unpaid charges are the patients’ responsibility. Thus, if for any reason the insurance carrier denies the claim, the patient has been informed that he/ she is responsible for payment of the services and all materials.

If the patient has Medicare and the provider is performing services that are not covered by Medicare, you must have the patient sign an advanced beneficiary notice (ABN) form that will inform the patient that he/ she is responsible for payment of the services. You don’t need a signed ABN for refractions. Otherwise, the patients will not be responsible for the charges and your office will incur a write-off. (See example ABN form on page 42.)

5. Co-payments should be collected on the date of service. Any balance between the amount covered by the insurance and the total charges is usually collected either on the date of service/ order or when the materials are picked up. Co-pays cannot be discounted or waived or it will be considered as fraud by the insurance carriers.

Some insurance carriers (namely, VSP) require the entire patient’s balance be paid on the date of service or when materials are ordered. For Medicare, providers must make every attempt to collect any patient balance or possibly face charges of fraud.
6. If possible, make a copy of the patient's insurance card, front and back, for proof of insurance and the insurance carriers' contact numbers.

It is a good idea to have a copy of the insurance card for auditing purposes. Also, having a hard copy is helpful to refer to in case any information was entered incorrectly on claim forms. Medicare and Medicaid require that a copy of the current card be kept in the patient's chart.
Key Points in Billing Medicare

Medicare/ Aetna (for Oregon, Alaska, Arizona, Hawaii, Nevada, & Washington)
4305 13th Ave SW
Fargo, ND 58103
(800) 316-0238

(The claims address for Medicare depends on the region of the country. There may be differences in coding between the regions.)

Medicare is a government subsidized medical insurance that was established in 1965. The Social Security Administration is responsible for overseeing Medicare. At this time, to be eligible to receive Medicare coverage, a patient must be 65 years or older or have end stage renal disease. Some people under the age of 65 with disabilities are also eligible for Medicare benefits. Medicare coverage is divided into two parts. Part A is for hospital coverage. Medicare Part B is for office visits, which will be discussed in this section. Pacific University College of Optometry is a participant with Medicare Part B, therefore no referrals for services are required.

When in doubt of how to bill a procedure or material to an insurance carrier, it is always best to follow Medicare guidelines. Most insurance carriers have modeled their claims analysis based on Medicare. Medicare reimbursements vary between areas. They are based on relative value units (RVUs). Each procedure is assigned a RVU to which a pre-determined amount is multiplied by to establish the appropriate reimbursement rate.

Routine Services

Routine eye examinations for the purpose of prescribing, fitting, or modifying eyeglasses or contact lenses to correct refractive errors are not covered by Medicare. Thus, refractions (CPT code 92015) are not covered even if the reason it was performed was for a medical purpose. Charges for refractions are the patient’s responsibility and can be collected from the patient at the time of service. A waiver does not need to be signed since refractions are not a covered service. Refractions do not need to be entered on the claim form unless the patient requests it for proof of denial that it is not a covered service. Payment of a refraction will not affect the Medicare deductible.

Coverage for services provided by Medicare depends upon the purpose of the examination, the chief concern, but not the ultimate diagnosis for the patient. If a patient goes to the eye care provider for examination with no specific complaint, Medicare will not cover the services even if a pathological condition was found on examination. For these types of cases (as long as emergent care is not required),
Medicare

further examination for the medical condition can be performed at a separate visit(s) with the patient aware that the condition warrants the chief concern.

Covered services include services that are medically necessary. The services must be related to treatment and/or diagnosis of eye disease, specific illness, symptom, complaint or injury. The chief concern must be medically related to the eye. If no medical diagnosis is confirmed, then the symptoms may be coded (e.g., 379.91 eye pain or 368.10 subjective visual disturbance).

Material Claims

Medicare does not cover glasses or contact lenses for cosmesis. They are the responsibility of the patient. An exception is post-cataract surgery. Medicare will cover one frame and one lens per operated eye after cataract surgery. The code V43.1 (pseudophakia) needs to be used for the diagnosis and not the cataract codes (J66.xx).

Medicare will also cover a frame and a pair of lenses on a reasonable/necessary basis (usually annually) for aphakia (379.31) and congenital aphakia (743.35). Medicare will not cover progressive addition lenses or any specialty tints or coatings. If the patient orders progressive addition lenses, special tints or coatings, or frames that cost more than the allowed amount, etc., he/she must sign an advanced beneficiary notice (ABN) which will inform the patient that he/she will be responsible for the non-covered costs. The modifier -GA can be added to the CPT code to let Medicare know the patient has signed the ABN.

For progressive addition lenses, the cost should be broken down into the allowed amount for the bifocal or trifocal and billed using the appropriate code (V2200-V2299 or V2300-V2399). The difference between the total cost of the lenses and the allowed amount should then be billed using code V2781 with modifier -GA. For frames chosen that are over Medicare’s allowed amount, the allowable should be subtracted from the total and billed with the V2020 code. The balance for the frame should then be billed using the V2025 (deluxe frame) code with the -GA modifier.

Procedure Types

-Eye Examinations

Eye Examinations can be billed using CPT eye codes 92002, 92012, 92004, or 92014 or evaluation and management (E/M) codes (99002, 99003, 99004, 99005, 99012, 99013, 99014, or 99015) which assumes the evaluation was for both eyes. It is not necessary to specify if the patient is monocular when billing these codes, but must be specified
Medicare

when billing certain eye-related procedures or diagnostic tests if only one eye was tested. Medicare will cover exams for any symptom or complaint of eye disease or eye injury.

Some of the main codes not approved for eye exams include:

<table>
<thead>
<tr>
<th>Code Range</th>
</tr>
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<tbody>
<tr>
<td>V50-V50.9</td>
</tr>
<tr>
<td>V70-V70.9</td>
</tr>
<tr>
<td>V72.0-V72.4</td>
</tr>
<tr>
<td>V72.8-V72.9</td>
</tr>
<tr>
<td>V72.7-V72.8</td>
</tr>
</tbody>
</table>

Toxic Medications

Patients on certain medications (ie. Plaquenil, Tamoxifen) must be followed at regular intervals due to their potential for adverse effects on the eye. Use ICD-9 Code V88.6x if the patient is still taking the medication for long term use and Code V67.51 when the patient has completed treatment of the high risk medication for billing these services. Code the V code first, then the code for the systemic condition being treated by the medication (e.g., 714.0 for Rheumatoid Arthritis). If the medication is affecting the eye, use the appropriate code for the side effect (e.g., 362.55 toxic maculopathy) and the E code to identify the drug (e.g., E931.4 antimalarials).

-Minor Surgical Procedures

Punctal Plugs- 68761

This code is appropriate to use for the insertion of either collagen or silicone plugs into one punctum. If more than one plug is being inserted, submit additional 68761-51 codes on separate lines of the CMS-1500 form. Each line should also have the appropriate modifier (E1-E4) specifying which lid the plug was inserted in. The allowance for this code includes the cost of the service along with the cost of the plug.

-Non-surgical Procedures (Special Ophthalmological Services)

Gonioscopy- 92020

Gonioscopy is a covered procedure when reasonable and necessary for the patient. Covered diagnoses include the glaucoma codes (365.xx). Gonioscopy is considered a bilateral procedure.
Medicare

Pachymetry- 76514

Use code 76514 (effective 1/1/04) for this procedure. The restrictions have not been published. At present use code 0025T (until 12/31/03) which is currently limited to once per lifetime and covers the diagnosis of glaucoma suspect [365.00]. This is a bilateral procedure.

Scanning Laser Ophthalmoscopy- 92135

Scanning Laser Ophthalmoscopy includes testing performed with the GDx Nerve Fiber Analyzer, Heidelberg Retina Tomograph, Optical Coherence Tomography, or Retinal Thickness Analyzer. This procedure is covered by Medicare for patients when reasonable and necessary. Acceptable codes for this procedure are the glaucoma codes [365.xx]. This is a unilateral procedure.

Ocular Photography- 92250

Medicare will reimburse for fundus photos in situations where it is reasonable and necessary for the patient to receive these services, i.e., diagnosis of conditions such as degeneration of the macula [362.xx], retinal neoplasms [224.5], choroids disturbances [363.xx], diabetic retinopathy [362.01-362.02], or to identify glaucoma [365.xx], multiple sclerosis and other central nervous system abnormalities. Analysis of the photographs with documentation in the patient's record is required. Medicare considers fundus photography to be a bilateral procedure.

Serial Tonometry- 92100

Serial tonometry is appropriate for determining the diurnal variations of IOP for glaucoma suspects [365.00] or in the medical treatment of acute elevation in IOP and must include at least 3 measurements over during a day. Use code 92100 and submit supporting documentation and progress notes indicating times of measurement. Use one unit of service regardless if pressures were measured unilaterally or bilaterally. This is a bilateral procedure.

Computerized Corneal Topography- 92499

Corneal topography does not yet have its own CPT Code. In this case, 92499 should be used with the words "Corneal Topography" entered in Box 24D of the CMS-1500 form. Corneal topography is not covered by Medicare for measurements that are taken specifically for refractive keratoplasty. Covered diagnoses include keratitis.
Medicare

(370.0-370.9), corneal scars and opacities (371.00-371.05), hereditary corneal degenerations (371.40-371.49), corneal dystrophies (371.50-371.58), keratoconus (371.60-371.62), previous corneal transplant (V42.5), or other corneal deformities (371.70-371.73). This is a unilateral procedure.

Visual Fields- 92081, 92082, 92083

Visual fields are only covered for medically necessary purposes in the diagnosis and treatment of disease, injury, abnormal signs, or abnormal symptoms. The lowest level of visual field testing that is medically necessary must be used. Covered diagnoses for 92081 include ptosis of the lid (374.30-374.34) or dermatochalasis (374.87). Covered diagnoses for 92082 and 92083 are:

<table>
<thead>
<tr>
<th>Code Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>094.83-094.85</td>
<td>095.0</td>
</tr>
<tr>
<td>192.0</td>
<td>194.3</td>
</tr>
<tr>
<td>225.1</td>
<td>234.0</td>
</tr>
<tr>
<td>239.6</td>
<td>242.00-242.01</td>
</tr>
<tr>
<td>348.2</td>
<td>360.23</td>
</tr>
<tr>
<td>361.10-361.12</td>
<td>362.01-362.9</td>
</tr>
<tr>
<td>363.30-363.35</td>
<td>363.40-363.43</td>
</tr>
<tr>
<td>363.70-363.72</td>
<td>363.8</td>
</tr>
<tr>
<td>368.00-368.9</td>
<td>369.00-369.9</td>
</tr>
<tr>
<td>376.00-376.9</td>
<td>377.00-377.9</td>
</tr>
<tr>
<td>446.5</td>
<td>743.20-743.22</td>
</tr>
<tr>
<td>743.55-743.59</td>
<td>743.61</td>
</tr>
<tr>
<td>V45.61-V45.69</td>
<td>V58.69</td>
</tr>
</tbody>
</table>

The CPT Manual states this is a unilateral or bilateral procedure. Medicare considers visual fields to be a bilateral procedure. Check with each insurance carrier as some may consider this to be a unilateral procedure. Analysis of the visual fields with documentation in the patient's record is required.

Bilateral vs. Unilateral Procedures (Diagnostic Tests)

These procedures are considered to be separately billable by Medicare and not included in the examination. Some procedures are considered bilateral (i.e., it is assumed both eyes were tested). Other procedures are considered unilateral (i.e., each eye must be coded separately). Some codes are listed as unilateral or bilateral in the CPT manual. Then the individual insurance carrier determines whether they
Medicare

will reimburse per eye. Check with the insurance carrier on how to they want these services coded.

If procedures are performed on both eyes for CPT codes that apply to evaluation of one eye, bill for each eye separately (on two lines) using the modifiers of -LT and -RT. Of course, if you are only performing the procedure on one eye then for these CPT codes you would need to add the modifiers of -LT or -RT depending on which eye the procedure was performed on. Examples of unilateral procedures include:

76511-76513 76519 92070
92225-92235 92135 76512
92499 (for corneal topography)

Examples of bilateral procedures are:

92020 92283 92100
76514 92283 92250

Claims should be submitted electronically but still can be submitted on CMS-1500 forms if the office is considered to be a small business.

-Required Fields:

1. Check the Medicare box.

1a. The patient’s Medicare Health Insurance Claim Number (HICN) whether Medicare is the primary or secondary payer.

2. The patient’s last name, first name, and middle initial, if any, as shown on the patient’s Medicare card.

3. The patient’s 8-digit birth date (MM/DD/CCYY) and sex.

4. If the patient has insurance primary to Medicare, either through the patient’s or spouse’s employment or any other source, list the name of the insured here. When the insured and the patient are the same, enter the word SAME. If Medicare is primary, leave blank.

5. The patient’s mailing address and telephone number.

6. The patient’s relationship to insured when item 4 is completed.
7. The insured’s address and telephone number. When the address is the same as the patient’s, use the word SAME. Complete this item only when items 4 and 11 are completed.

8. The patient’s marital status and whether employed or a student.

9. The last name, first name, and middle initial of the enrollee in a Medigap policy if it is different from that shown in item 2. Otherwise, use the word SAME. If no Medigap benefits are assigned, leave blank. This field may be used in the future for supplemental insurance plans.

**NOTE:** ONLY PARTICIPATING PHYSICIANS AND SUPPLIERS ARE TO COMPLETE ITEM 9 AND ITS SUBDIVISIONS AND ONLY WHEN THE PATIENT WISHES TO ASSIGN HIS/HER BENEFITS UNDER A MEDIGAP POLICY TO THE PARTICIPATING PHYSICIAN OR SUPPLIER.

Do not list other supplemental coverage in item 9 and its subdivisions at the time a Medicare claim is filed. Other supplemental claims are forwarded automatically to the private insurer if the private insurer contracts with the carrier to send Medicare claim information electronically. If there is no such contract, the beneficiary must file his/her own supplemental claim.

9a. The policy and/or group number of the Medigap insured preceded by MEDIGAP, MG, or MGAP.

**NOTE:** Item 9d must be completed if a policy and/or group number is in item 9a.

9b. The Medigap insured’s 8-digit birth date (MM/DD/CCYY) and sex.

9c. Leave blank if a Medigap PayerID is entered in item 9d. Otherwise, the claims processing address of the Medigap insurer is shown.

9d. The 9-digit PAYERID number of the Medigap insurer. If no PAYERID number exists, then the Medigap insurance program or plan name is shown.

Items 10a thru 10c. Check YES” or "NO" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in item 24. The State postal code must be shown. Any item checked ”YES” indicates there may be other insurance primary to Medicare. Primary insurance information must then be shown in item 11.

10d. Use this item exclusively for Medicaid (MCD) information. If the patient is entitled to Medicaid, this item must show the patient’s Medicaid number preceded by MCD.
11. THIS ITEM MUST BE COMPLETED. BY COMPLETING THIS ITEM, THE
PHYSICIAN/SUPPLIER ACKNOWLEDGES HAVING MADE A GOOD FAITH EFFORT TO
determine whether Medicare is the primary or secondary payer.

If there is insurance primary to Medicare, enter the insured's policy or group number
is entered and then proceed to items 11a - 11c.

If there is no insurance primary to Medicare, the word "NONE" is used and then
proceed to item 12.

11a. The insured's 8-digit birth date (MM/DD/CCYY) and sex if different from item
3.

11b. Employer's name, if applicable. If there is a change in the insured's insurance
status, e.g., retired, enter either a 6-digit (MM/DD/YY) or 8-digit (MM/DD/CCYY)
retirement date preceded by the word "RETIRED."

11c. The 9-digit PAYERID number of the primary insurer. If no PAYERID number
exists, then enter the complete primary payer's program or plan name. If the
primary payer's EOB does not contain the claims processing address, record the
primary payer's claims processing address directly on the EOB.

11d. Leave blank. Not required by Medicare.

12. The patient or authorized representative must sign and enter either a 6-digit
date (MM/DD/YY), 8-digit date (MM/DD/CCYY), or an alphanumeric date (e.g.,
January 1, 1998) unless the signature is on file. In lieu of signing the claim, the
patient may sign a statement to be retained in the provider, physician, or supplier
file. If the patient is physically or mentally unable to sign, a representative may sign
on the patient's behalf. In this event, the statement's signature line must indicate
the patient's name followed by "by" the representative's name, address, relationship
to the patient, and the reason the patient cannot sign. The authorization is effective
indefinitely unless patient or the patient's representative revokes this arrangement.

The patient's signature authorizes release of medical information necessary to
process the claim. It also authorizes payment of benefits to the provider of service or
supplier when the provider of service or supplier accepts assignment on the claim.

Signature by Mark (X). When an illiterate or physically handicapped enrollee signs by
mark, a witness must enter his/her name and address next to the mark.

13. The signature in this item authorizes payment of mandated Medigap benefits
to the participating physician or supplier if required Medigap information is included
in item 9 and its subdivisions. The patient or his/her authorized representative signs
this item, or the signature must be on file as a separate Medigap authorization. The
Medigap assignment on file in the participating provider of service/supplier's office
must be insurer specific. It may state that the authorization applies to all occasions
of service until it is revoked.
14. The patient's 6-digit (MM/DD/YY) or 8-digit (MM/DD/CCYY) date of current illness, injury, or pregnancy. For chiropractic services, enter either a 6-digit (MM/DD/YY) or 8-digit (MM/DD/CCYY) date of the initial treatment or exacerbation of the existing condition.

15. Leave blank. Not required by Medicare.

16. The patient is employed and is unable to work in current occupation, a 6-digit (MM/DD/YY) or 8-digit (MM/DD/CCYY) date must be shown when patient is unable to work. An entry in this field may indicate employment related insurance coverage.

17. The name of the referring or ordering physician must be shown if the service or item was ordered or referred by a physician.

18. The 6-digit (MM/DD/YY) or 8-digit (MM/DD/CCYY) date when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

19. The drug's name and dosage when submitting a claim for Not Otherwise Classified (NOC) drugs.

A concise description of an "unlisted procedure code" or a NOC code if one can be given within the confines of this box. Otherwise an attachment must be submitted with the claim.

All applicable modifiers when modifier -99 (multiple modifiers) is entered in item 24d. If modifier -99 is entered on multiple line items of a single claim form, all applicable modifiers for each line item containing a -99 modifier should be listed as follows: 1=(mod), where the number 1 represents the line item and "mod" represents all modifiers applicable to the referenced line item.

The statement, "Patient refuses to assign benefits" when the beneficiary absolutely refuses to assign benefits to a participating provider. In this case, no payment may be made on the claim.

20. This item is completed when billing for diagnostic tests subject to purchase price limitations.

21. The patient's diagnosis/condition. All physician and non-physician specialties (i.e., PA, NP, CNS, CRNA) must use an ICD-9-CM code number and code to the highest level of specificity. Enter up to four codes in priority order (primary, secondary condition). An independent laboratory must enter a diagnosis only for limited coverage procedures.
Medicare

All narrative diagnoses for non-physician specialties must be submitted on an attachment.


23. The professional review organization (PRO) prior authorization number for those procedures requiring PRO prior approval.

The investigational device exemption (IDE) number when an investigational device is used in an FDA-approved clinical trial.

24a. The 6-digit (MM/DD/YY) or 8-digit (MM/DD/CCYY) date for each procedure, service, or supply. When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in column C.

24b. The appropriate place of service code(s). Identify the location, using a place of service code, for each item used or service performed.

24c. Medicare Carriers must place the correct type of service.

24d. The procedures, services, or supplies using CPT or HCPCS codes.

The specific procedure code must be shown without a narrative description. However, when reporting an "unlisted procedure code" or a NOC code, include a narrative description in item 19 if a coherent description can be given within the confines of that box. Otherwise, an attachment must be submitted with the claim.

24e. The diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Only one reference number per line item. When multiple services are performed, the primary reference number for each service; either a 1, or a 2, or a 3, or a 4 is shown.

24f. The charge for each listed service.

24g. The number of days or units.

24h. Leave blank. Not required by Medicare.

24i. Leave blank. Not required by Medicare.

24j. Leave blank. Not required by Medicare.

24k. The PIN of the performing provider of service/supplier if he/she is a member of a group practice.
Medicare

When several different providers of service or suppliers within a group are billing on the same Form CMS-1500, show the individual PIN in the corresponding line item.

25. The provider of service or supplier Federal Tax I.D. (Employer Identification Number) or Social Security Number.

26. The patient's account number assigned by the provider of service or supplier's accounting system. This field is optional to assist the provider in patient identification.

27. The appropriate block must be checked to indicate whether the provider of service or supplier accepts assignment of Medicare benefits.

28. Total charges for the services (i.e., total of all charges in item 24f).

29. Total amount the patient paid on the covered services only.


31. The signature of the practitioner or supplier, or his/her representative, and either the 6-digit date (MM/DD/YY), 8-digit date (MM/DD/CCYY), or alphanumeric date (e.g., January 1, 1998) the form was signed.

32. The name, address, and zip code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office. Effective for claims received on or after April 1, 2004, the name, address, and zip code of the service location for all services other than those furnished in place of service home - 12.

Effective for claims received on or after April 1, 2004, on the Form CMS-1500, only one name, address and zip code may be entered in the block. If additional entries are needed, separate claim forms must be submitted.

33. The practitioner's/supplier's billing name, address, zip code, and telephone number. The PIN for the performing provider of service/supplier who is not a member of a group practice. Suppliers billing the DMERC will use the National Supplier Clearinghouse (NSC) number in this field.

The group UPIN, including the 2-digit location identifier, for the performing practitioner/supplier who is a member of a group practice.
Key Points in Billing BlueCross BlueShield of Oregon (BCBSO)

Claims Address (excluding Federal Employee Program)
Regence BlueCross BlueShield of Oregon
P.O. Box 30805
Salt Lake City, UT 84130-0805
(503) 225-6619

Federal Employee Program Claims Address
Regence BlueCross BlueShield of Oregon- FEP
P.O. Box 31105
Salt Lake City, UT 84131-0105

Claims may also be submitted electronically. For information on submitting electronic claims, please review the BCBSO website:
http://www.bcbso.com/provider/claims/index.html

BlueCross BlueShield is a private insurance carrier that provides medical and/or vision coverage for its members. The type of coverage a patient has is dependent upon which plan he/she is enrolled. BCBS has several plans within their system. The main plans are the following: Regence BCBSO, Regence HMO Oregon, Regence Life and Health, and Preferred Choice 65. Pacific University College of Optometry (PUCO) is a preferred provider with BCBSO but does not participate in the BCBS HMO plans, which includes Preferred Choice 65 and Regence Life and Health. Members of these plans are allowed to obtain material benefits from a non-participating provider but are not covered for any services.

Many patients under these plans may also be enrolled in the BlueCard Program which links participating providers with other BCBS plans throughout the country. With the BlueCard program, participating providers are allowed to bill their local BCBS for out of state plans. For questions or inquiries on eligibility and claims, the provider would contact their local BCBS. The claim submitted must include the 3-digit alpha prefix from the member's identification card. To determine whether a patient is a BlueCard member, check the ID card for the alpha prefix or the "PPO in a suitcase" logo. (See example card on page 43.) This is a special logo printed on the card since not all PPO members are in the BlueCard program. For BlueCard specific provider questions call 503-225-5393 or 1-800-448-0525.

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Claims for BCBS patients are also submitted on CMS-1500 forms.

- **Required fields:**

  1a- Insured’s Identification Number
  2- Patient’s Name
  3- Patient’s Birth Date and Sex
  4- Insured’s Name
  11- Insured’s Policy Group or FECA number
  17- Name of referring physician or other source (if this is not a referred service, enter the performing physician’s name)
  17a- UPIN for the physician listed in block 17
  21- Diagnosis or Nature of illness or injury, up to 4 in order of relevance. Codes must be carried out to highest possible specificity.
  24a- Date(s) of Service
  24b- Place of Service (for optometric office, use 11)
  24d- Procedures, Services, or Supplies (CPT/HCPCS, modifiers)
  24e- Corresponding diagnosis code(s) referenced from block 21
  24f- Charges (full retail amount)
  24g- Days or Units
  33- Physician’s/ Supplier’s Billing Name, Address, Zip Code, and Phone Number

Blocks 10d, 13, 16, 18, 22, 23, 24h, 24i, 24j, 24k, and 27 should be left blank.

All other blocks on the CMS-1500 form should be filled out as desired or applicable.

BCBSO recommends using the National Correct Coding Initiative’s (NCCI) website to edit and check for correct billing codes. The NCCI web address is: [http://cms.hhs.gov/physicians/cciedits/default.asp](http://cms.hhs.gov/physicians/cciedits/default.asp)

As a supplement to Medicare’s code edits, BCBSO has a PDF file on its website that can also be referenced. 
[http://www.or.regecne.com/provider/claims/trgCCE/index.html](http://www.or.regecne.com/provider/claims/trgCCE/index.html)

**Resubmission of Claims**

If a claim needs to be resubmitted to BCBS due to nonpayment, the provider should first check all available resources to determine the status of the claim. Claims should not be resubmitted earlier than 20 days from the original submission. If the claim is resubmitted on paper, it should be marked “tracer” in the upper right hand corner. If the claim is submitted electronically, it should be marked “tracer” in the remarks section.
BCBSO

For claims that need to be resubmitted due to corrections in coding or charges, there is no waiting period for submission. “Corrected claim” should be written in the upper right hand corner of written submissions or entered in the remarks field for electronic claim submission.

Routine Vision Care Coverage

BCBSO offers many different plans for vision coverage. In some cases, employers of large companies will design their own benefit plans with BCBSO. The main preferred provider vision plans are summarized on the following tables. (Note: The plan name is listed on the bottom right side of the page.) For all other plans, the website or customer service representative will be able to tell you what benefits are available to the patient when you call for eligibility.

Medical Vision Care Coverage

For most medically related vision care with BCBSO, a referral is required from the patient’s primary care provider to be seen. Ask the customer service representative when calling on the benefits for the patient if a referral is required. The waiver for emergency services can be signed in urgent care situations.
## Vision Plan

### Benefits

This is a benefit summary only. For a complete list of benefits and the limitations and exclusions that apply to them, please refer to the benefits booklet or the group master contract.

<table>
<thead>
<tr>
<th>Providers</th>
<th>Regence BlueCross BlueShield of Oregon Full Service Vision Panel</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Examination</strong></td>
<td>Your plan will pay for one examination every 24 months for you and your eligible dependents age 19 and over after a $0 copayment when performed by a Regence BlueCross BlueShield of Oregon Full Service Vision Panel provider. Examinations for children under 19 years of age are covered every 12 months.</td>
</tr>
<tr>
<td><strong>Lenses</strong></td>
<td>Your plan will pay up to the maximum allowance for one pair of lenses every 24 months for you and your eligible dependents age 19 and over and every 12 months for children under 19 years of age.</td>
</tr>
<tr>
<td>➢ Single vision lenses</td>
<td>$89</td>
</tr>
<tr>
<td>➢ Bifocal vision lenses</td>
<td>$125</td>
</tr>
<tr>
<td>➢ Trifocal vision lenses</td>
<td>$158</td>
</tr>
<tr>
<td><strong>Frames</strong></td>
<td>Your plan will pay up to $75 for frames every 24 months for you or your eligible dependents when necessary to accommodate newly prescribed lenses.</td>
</tr>
<tr>
<td><strong>Contact Lenses</strong></td>
<td>Your plan will pay for contact lenses in two different ways (depending on the reason contacts are prescribed). Whatever the reason, your plan will pay up to the maximum allowance for one pair of lenses every 24 months for you and your eligible dependents age 19 and over and every 12 months for children under 19 years of age.</td>
</tr>
<tr>
<td>1. If an enrollee selects contact lenses as an alternative to lenses and frames, the plan will pay up to:</td>
<td></td>
</tr>
<tr>
<td>➢ Single vision lenses</td>
<td>$164</td>
</tr>
<tr>
<td>➢ Bifocal vision lenses</td>
<td>$200</td>
</tr>
<tr>
<td>➢ Trifocal vision lenses</td>
<td>$233</td>
</tr>
<tr>
<td>2. Contact lenses are paid for in full if they are necessary after cataract surgery. In addition, this vision plan will pay for contact lenses if they are the only means to correct vision to 20/70 or better.</td>
<td></td>
</tr>
</tbody>
</table>

**Please Note:**

➢ If you choose a provider who is not participating, benefits will be paid at 70% of actual or participating provider contracted charges.

➢ The maximum allowances are subject to change without notice.

### Limitations and Exclusions

#### Services And Supplies Not Covered

➢ Treatment of eyes or special procedures such as orthoptics and vision training.

➢ Charges for fashion eyewear features such as flintglass, blended, coated, tinted (except tints #1 and #2), or oversize lenses.

➢ Additional charges for partially covered frames.

➢ Any extra charge for lenses with prisms, prism segs, slab-off, and other special-purpose vision aids.

➢ Replacement of lenses and frames at a time the covered person is not otherwise eligible for new lenses and frames.

➢ The maximum allowances are subject to change without notice.
# Vision Plan

## Benefits

This is a benefit summary only. For a complete list of benefits and the limitations and exclusions that apply to them, please refer to the benefits booklet or the group master contract.

### Providers

| Regence BlueCross BlueShield of Oregon Full Service Vision Panel |

### Examination

Your plan will pay for one examination every 24 months for you and your eligible dependents age 19 and over. Examinations for children under 19 years of age are covered every 12 months.

Your plan will pay up to the maximum allowance for one pair of lenses every 24 months for you and your eligible dependents age 19 and over and every 12 months for children under 19 years of age.

### Lenses

- Single vision lenses: $89
- Bifocal vision lenses: $125
- Trifocal vision lenses: $158

### Frames

Your plan will pay up to $75 for frames every 24 months for you or your eligible dependents when necessary to accommodate newly prescribed lenses.

Your plan will pay for contact lenses in two different ways (depending on the reason contacts are prescribed). Whatever the reason, your plan will pay up to the maximum allowance for one pair of lenses every 24 months for you and your eligible dependents age 19 and over and every 12 months for children under 19 years of age.

1. If an enrollee selects contact lenses as an alternative to lenses and frames, the plan will pay up to:
   - Single vision lenses: $164
   - Bifocal vision lenses: $200
   - Trifocal vision lenses: $233

2. Contact lenses are paid for in full if they are necessary after cataract surgery. In addition, this vision plan will pay for contact lenses if they are the only means to correct vision to 20/70 or better.

### Please Note:

- If you choose a provider who is not participating, benefits will be paid at 70% of actual or participating provider contracted charges.
- The maximum allowances are subject to change without notice.

## Limitations and Exclusions

### Services And Supplies Not Covered

- Treatment of eyes or special procedures such as orthoptics and vision training.
- Charges for fashion eyewear features such as flintglass, blended, coated, tinted (except tints #1 and #2), or oversize lenses.
- Additional charges for partially covered frames.
- Any extra charge for lenses with prisms, prism segs, slab-off, and other special-purpose vision aids.
- Replacement of lenses and frames at a time the covered person is not otherwise eligible for new lenses and frames.
- The maximum allowances are subject to change without notice.
# Vision Plan

## Benefits

This is a benefit summary only. For a complete list of benefits and the limitations and exclusions that apply to them, please refer to the benefits booklet or the group master contract.

### Providers

Regence BlueCross BlueShield of Oregon Full Service Vision Panel

### Examination

Your plan will pay for one examination every 24 months for you and your eligible dependents age 19 and over after a $15 copayment when performed by a Regence BlueCross BlueShield of Oregon Full Service Vision Panel provider. Examinations for children under 19 years of age are covered every 12 months.

### Lenses

- **Single vision lenses** $89
- **Bifocal vision lenses** $125
- **Trifocal vision lenses** $158

### Frames

Your plan will pay up to the maximum allowance for one pair of lenses every 24 months for you and your eligible dependents age 19 and over and every 12 months for children under 19 years of age.

### Contact Lenses

Your plan will pay up to $75 for frames every 24 months for you or your eligible dependents when necessary to accommodate newly prescribed lenses.

#### Contact Lenses

1. If an enrollee selects contact lenses as an alternative to lenses and frames, the plan will pay up to:
   - **Single vision lenses** $164
   - **Bifocal vision lenses** $200
   - **Trifocal vision lenses** $233

2. Contact lenses are paid for in full if they are necessary after cataract surgery. In addition, this vision plan will pay for contact lenses if they are the only means to correct vision to 20/70 or better.

### Please Note:

- If you choose a provider who is not participating, benefits will be paid at 70% of actual or participating provider contracted charges.
- The maximum allowances are subject to change without notice.

## Limitations and Exclusions

### Services And Supplies Not Covered

- Treatment of eyes or special procedures such as orthoptics and vision training.
- Charges for fashion eyewear features such as flintglass, blended, coated, tinted (except tints #1 and #2), or oversize lenses.
- Additional charges for partially covered frames.
- Any extra charge for lenses with prisms, prism segs, slab-off, and other special-purpose vision aids.
- Replacement of lenses and frames at a time the covered person is not otherwise eligible for new lenses and frames.
- The maximum allowances are subject to change without notice.
Key Points in Billing For the Oregon Health Plan (OHP)

The Oregon Health Plan is a government-subsidized health insurance that is operated by the state of Oregon. It is a form of Medicaid (federal medical assistance program for the disabled or unemployed). Eligibility, benefits, and the name of the plan for Medicaid plans vary from state to state. OHP contracts out to different insurance carriers to manage their claims (e.g., ODS Health Plans, VSP Care Oregon, Tuality Health Alliance, etc...). PUCO accepts contracted plans through the Office of Medical Assistance Programs (OMAP, sometimes referred to as “open card”) and VSP Care Oregon. Verification of eligibility and benefits can be checked by OMAP’s automated provider service line and VSP’s provider service line, respectfully.

Office of Medical Assistance Programs
500 Summer St. NE, E35
Salem, OR 97301-1077
Phone: (800) 336-6076 for Provider Services
Automated Information Service (AIS) eligibility line: (800) 522-2508

VSP Care Oregon
PO Box 99700
Sacramento, CA 95899-7100
(800) 615-1883

Forms

Claims are submitted on the CMS-1500 forms (formerly known as HCFA-1500 forms). For clients who have Medicare/Medical Assistance Program, optometrists and ophthalmologists must bill Medicare first. Medicare will then forward the claim to OMAP. In rare cases where the doctor needs to submit a claim to OMAP for a Medicare patient, he/she will need to use the OMAP 505 form. For a list of situations in which the doctor would have to submit the claim to OMAP, please refer to the provider guide.

If an error is made in billing and payment has been made, corrections can be made and resubmitted on an Individual Adjustment Request Form (OMAP 1036). Do not submit a new claim. If OMAP has not made any form of payment, a new corrected claim form should be submitted unless otherwise indicated on the EOB (Explanation of Benefits) form. Copies of each of these forms can be found in the sample forms section at the end of the manual (pages 45-47).
CMS-1500 Form

Each patient must be billed on a separate form. If more procedures are provided than the allowed spaces, a new form must be completely filled out for that patient with the totals for each page listed separately.

- required fields
  1a (8 digit alphanumeric Medical Care Recipient ID)
  2 (patient's name as it appears on his/her medical card)
  21 (ICD-9-CM code number(s) listed in priority order to highest degree of specificity)
  24A (numeric date of service)
  24B (location where service was provided; usually 3 - practitioner's office)
  24C (type of service, ie. S - Optician, F - Optometrist, 1 - Ophthalmologist)
  24D (CPT, HCPCS, or OMAP unique procedure codes)
  24E (a single reference number for the diagnosis codes listed in field 21)
  24F (usual and customary charge for procedure/ item)
  24G (number of units provided or number of days from field 24A)
  28 (Total for all charges on this form)
  30 (Amount due - subtract only payments made by other insurance or resource, not co-payments or write-offs)
  33 OMAP provider number to whom the check should be sent

- required fields when applicable
  9 (other health insurance coverage, if no payment is received from this source, the 2 letter reason code must be the 1st entry in this box; list of codes can be found on page 29 of OMAP provider manual)
  10a-c (complete if injury is involved)
  10d (if the procedure was an emergency, enter "Y")
  17 (referring provider's name)
  17a (referring provider's OMAP number or UPIN)
  23 (for prior authorized services, enter 9 digit PA number; do not bill for prior and non-prior authorized services on the same form)
  24K (if a billing provider is listed in field 33, enter the OMAP performing provider number here)
  26 (patient's account number may be entered here and will show on the Remittance Advise)
  29 (if another insurance or resource has paid on this claim, enter the amount of payment here)

As of February 2003, the Oregon Health Plan has divided coverage between its Standard plan and Plus plan. Patients with OHP Plus benefits (usually children under the age of 19, pregnant women, members of federally recognized Native
American tribes, the elderly, clients with disability waivers, etc... are still eligible for routine vision services and material benefits and are usually not required to pay co-pays for these services. For patients with OHP Standard benefits (adults who meet financial eligibility requirements), routine vision services are no longer available. The insurance cards are sent to the members every month and reflect the benefit package. It is important to make a copy of the patient's current insurance card for the month in which they are receiving services.

Routine Benefits Available with OHP Plus

It is the provider's responsibility to check for eligibility of routine services for the member. Adults (19 years and older) are eligible for routine services every 24 months. Children under 19 years of age are allowed to have services and materials provided before the eligibility period is renewed if it is documented as medically necessary.

If a patient is ineligible for routine services but wants to pay out of pocket, the patient must sign a waiver stating the provider has the right to bill him/her for these services. (See OHP Waiver on page 44.) Routine vision services include a comprehensive (92004, 92014) or intermediate (92003, 92012) exam for the purpose of prescribing glasses and materials, which include one pair of spectacles (frame and lenses).

Patients enrolled in the Open Medical Card must order their spectacles through SWEEP Optical. The frames and lenses are covered as a package, thus OHP will not cover the cost of lenses if a patient wants to use a personal frame. The provider usually has a selection of frames in stock from SWEEP Optical for the patient to choose from so the fitting measurements can be made. The provider is then allowed to bill OMAP a fitting charge for measurement of anatomical characteristics (pupillary distance, bifocal segment height, etc...), writing up the lab specifications order, and adjusting of the glasses at the dispensing visit. The spectacles must be dispensed before billing OMAP unless the patient has expired or several documented attempts were made to contact the patient and he/she still failed to return for the dispense. The acceptable fitting codes are 92340-92353.

- 92340- fitting of spectacle (excluding aphakia); single vision
- 92341-" ; bifocal
- 92342-" ; multifocal
- 92352- fitting of spectacle prosthesis for aphakia; single vision
- 92353-" ; multifocal
Repairs can be billed when replacing parts through SWEEP. The repair codes are 92370 and 92371. The delivery invoice number must be documented somewhere in the patient’s records. Keep in mind that all the frames have a limited warranty, so parts may not be covered. The turn-around time for spectacle orders placed through SWEEP is seven days. Orders can be placed on the web. Paper claims are still accepted by fax or mail but are subject to a small fee for processing.

Materials Benefit with VSP Care Oregon

If the insurance plan is contracted out (i.e., VSP Care Oregon), the patient may choose a frame from the Value Package selection. This insurance does not allow the patient to pay the difference in ordering more expensive eyewear, contact lenses, or additional coatings. In this case, the provider can bill the insurance for the glasses and the dispensing fee. Patients on the contracted plan can opt to select from SWEEP Optical for their glasses.

Specialty Materials

Some exceptions are made for specialty eyewear in certain cases. For example, high index lenses are covered if the power is greater than +/- 10 diopters or requires more than 10 diopters of prism. Nonprescription spectacles are provided for emmetropes who are legally blind (20/200 or worse BCVA in better eye or less than 20 degrees of visual field in better eye) for the purpose of protection. Tinted or photochromic lenses are covered for patients with documented albinism or pupillary defects.

Medically indicated contact lenses may be covered if the patient has a refractive error of 9 diopters or greater in any meridian, keratoconus, 3 diopters or more of anisometropia, nystagmus, irregular astigmatism, or aphakia. Proper documentation is needed in the patient’s record and on the authorization request of why glasses cannot be worn or are not as effective due to the listed condition. Adults (age 21 and older) must have prior authorization for contact lenses and services except in the case of keratoconus. (See section on prior authorizations below.) Fitting of contacts is limited to once every 24 months with replacement of a pair of lenses every 12 months. Contact lenses must also be ordered through SWEEP optical.

Non-covered materials include (but are not limited to) two pairs of spectacles, bifocal or trifocal segments other than 28mm wide, anti-reflective coatings, low vision aids, ultraviolet coatings, progressives/blended lenses, aniseikonic lenses, or sunglasses.
Medical benefits available with OHP Plus

If the patient requires a medical eye exam, it may be necessary to get a referral from the primary care doctor prior to the examination. Since Pacific University College of Optometry is a participating provider, no referral is needed to provide medical care. Most non-routine/medical procedures require documented proof that the patient has a condition that requires the procedure.

Some also require a prior authorization before the services are performed. If a prior authorization is not obtained in a non-emergent situation before services are rendered, OHP and the patient will not be responsible for the charges. Prior authorizations do not guarantee payment or eligibility, it allows the claim to be reviewed for payment determination and not automatically rejected. To obtain a prior authorization, the provider must submit in writing a request to the OMAP office. The request must include: patient’s name and ID number, provider’s name and provider number, a description of the needed item/service including procedure code, cost of acquiring the item (if applicable), a statement with medical relevance showing the need for the service/item (including diagnosis codes) and reasons why other options are inappropriate; any additional clinical information that may support or aid in simplifying the review process, and the provider’s signature. OMAP will review the request and if accepted, send the provider a nine digit prior authorization [PA] number that must be entered in field 23 of the HCFA-1500 form.
Diagnosis Codes

ICD-9 Codes

All services and materials that are billed to insurance carriers must be in reference to the patient's relevant condition or diagnosis. Since 1988, Medicare has required providers to use the ICD-9 coding system to submit claims for Medicare reimbursement. All other major insurance carriers have followed suit in requiring ICD-9 codes for billing purposes. ICD-9 stands for the International Classification of Diseases, ninth edition. There are thousands of codes that cover a very wide range of possible diagnoses. Codes are constantly being reviewed, updated, and added. The codes range from 3 digit (non-specific) to 5 digit (high specificity) codes. Physicians should always bill using the most specific code possible. If definite diagnoses have not yet been determined, there are also codes available to document the patient's symptoms or reason for the visit. Code the diagnosis/reason/symptom that relates to the primary reason for the visit first. Code the underlying disease first where specified (e.g., Diabetes Mellitus).

Most of the diagnostic eye codes can be found in 360.00-369.99. Some codes are more challenging to find since they are located in the systemic section (e.g., congenital cataract [743.3x], herpes simplex dendritic keratitis [054.42]) or the same code is used for multiple diagnoses (e.g., 373.12 meibomianitis or internal hordeolum). Also, some diagnoses have multiple names, so if you look under the wrong name, you may not be able to find the code (e.g., 362.58 macular pucker listed for epiretinal membrane, cellophane maculopathy, or macular fibrosis).

Finding ICD-9 Codes

There are two ways to look up diagnoses listed in the ICD-9-CM book. The book is divided into two sections. The first half lists diagnoses in alphabetical order by their name. While this section is useful to get right to the desired code, you have to make sure you use the same name for the code that the book does. This section also only gives the three to five digit code without any descriptors, definitions, exclusions and special coding requirements. If you are using this section to find a code, you should then cross reference the code in the second section, codes listed by category (codes are listed in numerical order). This section is nice in that it gives all the details listed above, but sometimes it may take a little longer to find the specific code you want. The eye codes are listed in the Nervous System and Sense Organs section under the heading Disorders of the Eye and Adnexa (360-379). After each main heading, examples, inclusions and exclusions may be given along with special coding instructions if applicable. The subject of the main heading is then broken down into the fourth or fifth digit classifications for higher specificity. Definitions of the
condition may also be listed and can be found after the "DEF:" abbreviation. Other abbreviations used in the ICD-9-CM book are NOS (not otherwise specified) and NEC (not elsewhere classified). Congenital Anomalies are listed in their own section (743).

V Codes

V codes are used in conjunction with the ICD-9 coding system and are alternate diagnosis codes that cover services such as routine care, family history, pre-operative care, post-operative care, etc... In other words, they cover the situations when a diagnosis or concern is not due to a disease or injury. Some V codes can be used as primary diagnosis codes. They can be found in the ICD-9-CM book in their own sections after the numerical section.

E Codes

E codes are supplemental codes for the classification of external causes or injury or poisoning. These codes are always used as secondary or tertiary diagnosis codes to identify the cause of the injury, poisoning or other adverse effect. E codes can be referenced in two different sections of the ICD-9-CM book. The first section is located in the middle of the book (after the alphabetical listing) and is listed as an alphabetical table of drugs and chemicals followed by an alphabetical index of external causes. The second section is found in the back and is listed by classification in numerical order. This second section also contains descriptors, inclusions and exclusions for each code.

***The following codes that are listed in this section include the main (and also some of the more difficult to find) ocular related diagnoses. Not all of these codes are listed to the highest specificity and are marked as such with "[unspec.]" written after the descriptor or with "xx" for the fourth and fifth digit. The more specific classifications can then be referenced in the ICD-9 Coding book.***
### Refractive/ Accommodative/ VF Defect

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V65.5</td>
<td>Emmetropia</td>
</tr>
<tr>
<td>367.10</td>
<td>Myopia</td>
</tr>
<tr>
<td>367.00</td>
<td>Hyperopia</td>
</tr>
<tr>
<td>367.21</td>
<td>Astigmatism (regular)</td>
</tr>
<tr>
<td>367.22</td>
<td>Astigmatism (irregular)</td>
</tr>
<tr>
<td>367.40</td>
<td>Presbyopia</td>
</tr>
<tr>
<td>367.53</td>
<td>Accommodative spasm</td>
</tr>
<tr>
<td>367.31</td>
<td>Anisometropia</td>
</tr>
<tr>
<td>367.32</td>
<td>Aniseikonia</td>
</tr>
<tr>
<td>367.51</td>
<td>Central scotoma</td>
</tr>
<tr>
<td>368.43</td>
<td>Sector or arcuate VF defect</td>
</tr>
<tr>
<td>368.44</td>
<td>Other localized VF defect</td>
</tr>
<tr>
<td>368.45</td>
<td>Generalized contraction/constriction</td>
</tr>
<tr>
<td>368.46</td>
<td>Homonymous bilateral VF defect</td>
</tr>
<tr>
<td>368.47</td>
<td>Heteronymous bilateral VF defect</td>
</tr>
</tbody>
</table>

### Lids/ Lashes/ Lacrimal

<table>
<thead>
<tr>
<th>ICD-9 Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>743.62</td>
<td>Lid coloboma</td>
</tr>
<tr>
<td>333.81</td>
<td>Blepharospasm</td>
</tr>
<tr>
<td>351.80</td>
<td>Myokymia; face, lid</td>
</tr>
<tr>
<td>373.00</td>
<td>Blepharitis</td>
</tr>
<tr>
<td>373.11</td>
<td>External hordeum</td>
</tr>
<tr>
<td>373.12</td>
<td>Internal hord./ melbomianitis</td>
</tr>
<tr>
<td>373.20</td>
<td>Chalazion</td>
</tr>
<tr>
<td>373.31</td>
<td>Eczema of the lid</td>
</tr>
<tr>
<td>373.32</td>
<td>Allergic dermatitis of the lid</td>
</tr>
<tr>
<td>373.33</td>
<td>Xeroderma of the lid</td>
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<td>Lid inflammation (unspec.)</td>
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<td>373.20</td>
<td>Lagophthalmos (unspec.)</td>
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<tr>
<td>373.30</td>
<td>Posis (unspecified)</td>
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<td>373.32</td>
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<td>373.55</td>
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<td>373.15</td>
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<td>373.20</td>
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<td>373.30</td>
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<td>373.78</td>
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<td>373.50</td>
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<td>756.00</td>
<td>Floppylid (face structure)</td>
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<td>921.00</td>
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### Binocular Dysfunction

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<tr>
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<td>378.31</td>
<td>Hypertropia</td>
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<td>378.32</td>
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<td>378.83</td>
<td>Convergence insufficiency</td>
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<td>378.84</td>
<td>Convergence excess</td>
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<td>378.85</td>
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<tr>
<td>378.51</td>
<td>CN III palsy (partial)</td>
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<tr>
<td>378.52</td>
<td>CN III palsy (total)</td>
</tr>
<tr>
<td>378.53</td>
<td>CN IV palsy</td>
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<td>378.54</td>
<td>CN VI palsy</td>
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<tr>
<td>379.71</td>
<td>Brown's syndrome</td>
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<tr>
<td>368.20</td>
<td>Diplopia</td>
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<td>368.31</td>
<td>Suppression</td>
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<tr>
<td>368.32</td>
<td>Simultaneous percept. w/o fusion</td>
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<td>Anomalous retinal correspondence</td>
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### Iris/ Ciliary Body

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<thead>
<tr>
<th>E07.00</th>
<th>Primary iritis (acute)</th>
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<tr>
<td>364.02</td>
<td>Recurrent iritis (acute)</td>
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<td>364.05</td>
<td>Hypopyon</td>
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<td>364.1</td>
<td>Chronic iritis (unspec.)</td>
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<tr>
<td>364.41</td>
<td>Hyphema</td>
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<td>364.42</td>
<td>Rubeosis iridis</td>
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<td>364.53</td>
<td>Pigment dispersion syndrome</td>
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<tr>
<td>364.77</td>
<td>Resection of chamber angle</td>
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<tr>
<td>364.6</td>
<td>Idiopathic cysts of uvea</td>
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<td>364.71</td>
<td>Posterior synchiae</td>
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<td>364.72</td>
<td>Anterior synchiae</td>
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<tr>
<td>364.75</td>
<td>Pupillary abnormalities</td>
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<td>364.76</td>
<td>Iridodyalysis</td>
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<td>743.46</td>
<td>Iris coloboma</td>
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### Globe

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<thead>
<tr>
<th>E07.00</th>
<th>Purulent endophthalmitis</th>
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<tbody>
<tr>
<td>360.21</td>
<td>Degenerative myopia</td>
</tr>
<tr>
<td>360.30</td>
<td>Hypotony of eye</td>
</tr>
<tr>
<td>360.41</td>
<td>Phthisis bulb</td>
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<tr>
<td>360.42</td>
<td>Absolute glaucoma</td>
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<tr>
<td>360.50</td>
<td>Retained intraocular magnetic FB</td>
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<tr>
<td>360.60</td>
<td>Retained intraocular nonmag. FB</td>
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<td>267.11</td>
<td>Orbital granuloma</td>
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### Lens/ Cataracts

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<tr>
<th>E07.00</th>
<th>Pre-senile cataract (unspec.)</th>
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<tr>
<td>366.10</td>
<td>Senile cataract (unspec.)</td>
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<tr>
<td>366.11</td>
<td>Pseudoexfoliation</td>
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<td>366.12</td>
<td>Incipient cataract</td>
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<td>366.13</td>
<td>Ant. Subcap. Polar</td>
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<tr>
<td>366.14</td>
<td>Post. Subcap. Polar</td>
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<tr>
<td>366.15</td>
<td>Cortical senile</td>
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<td>366.16</td>
<td>Nuclear sclerosis</td>
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<td>366.17</td>
<td>Mature cataract</td>
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<td>366.20</td>
<td>Traumatic cataract (unspec.)</td>
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<tr>
<td>366.45</td>
<td>Drug-induced cataract</td>
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<tr>
<td>366.53</td>
<td>Cat. assoc. w/ physical cause</td>
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<tr>
<td>367.30</td>
<td>Acquired aphakia</td>
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### Pupils/ Nystagmus

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<tr>
<th>E07.00</th>
<th>Abnormal pupillary fcn</th>
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<tr>
<td>379.40</td>
<td>Anisocoria</td>
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<td>379.42</td>
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<td>379.43</td>
<td>Mydriasis</td>
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<td>379.45</td>
<td>Argyll Robertson pupil</td>
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<td>379.46</td>
<td>Adie's pupil</td>
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<tr>
<td>379.49</td>
<td>Hippus/ pupillary paralysis</td>
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<tr>
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<td>Nystagmus (unspec.)</td>
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<tr>
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<td>Congenital nystagmus</td>
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<td>379.52</td>
<td>Latent nystagmus</td>
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<td>337.90</td>
<td>Homer's syndrome</td>
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### Symptoms/ Signs

<table>
<thead>
<tr>
<th>E07.00</th>
<th>Pain in/around eye</th>
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<tbody>
<tr>
<td>379.91</td>
<td>Swelling in eye</td>
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<tr>
<td>379.92</td>
<td>Redness/ discharge of eye</td>
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<tr>
<td>368.80</td>
<td>Blurred vision</td>
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<tr>
<td>368.10</td>
<td>Subjective visual disturbance</td>
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<tr>
<td>368.11</td>
<td>Sudden visual loss</td>
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<tr>
<td>368.12</td>
<td>Transient visual loss</td>
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<td>Visual discomfort</td>
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### Color Vision

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<td>Tritan defect</td>
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<td>368.54</td>
<td>Achromatopsia</td>
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<td>368.55</td>
<td>Acquired color deficiencies</td>
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<td>368.61</td>
<td>Congenital night blindness</td>
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<td>368.63</td>
<td>Acquired night blindness</td>
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<td>368.83</td>
<td>Abnormal dark adapt. curve</td>
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<td>Dermatological/ Neoplastic Conditions</td>
<td>ICD-9 Codes</td>
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<td>78.00 molluscum contagiosum</td>
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<td>053.20 herpes zoster opththalmicus</td>
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<td>053.21 herpes zoster keratoconjunctivitis</td>
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<tr>
<td>190.00 malignant neoplasm of uvea/ lens</td>
<td>053.22 herpes zoster iridocyclitis</td>
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<tr>
<td>190.10 malignant neoplasm of orbit</td>
<td>054.41 herpes simplex keratoconjunctivitis</td>
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<tr>
<td>190.20 malignant neoplasm of lacrimal gland</td>
<td>054.42 herpes simplex dendritic keratitis</td>
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<td>054.43 herpes simplex disciform keratitis</td>
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<td>054.44 herpes simplex iridocyclitis</td>
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<td>091.52 syphilitic iridocyclitis</td>
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<td>130.10 toxoplasmosis conjunctivitis</td>
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<td>250.0x diabetes mellitus w/o ocular complication</td>
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<td>Personal history of malignant neoplasm, eye</td>
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<td>V14.x</td>
<td>Personal history of allergy to medicinal agents</td>
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<td>V15.81</td>
<td>Noncompliance with medical treatment</td>
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<td>V16.8</td>
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<td>Family history of diabetes</td>
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<td>Family history of blindness</td>
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<td>V19.1</td>
<td>Family history of other eye disorders</td>
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<td>V26.3</td>
<td>Genetic counseling</td>
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<td>Observation of newborn/infant for suspected condition not found</td>
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<td>Other eye problems</td>
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<td>Organ or tissue replaced by transplant</td>
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<td>S/p prosthetic globe</td>
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<td>V43.1</td>
<td>Pseudophakia</td>
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<td>V45.61</td>
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<td>V45.69</td>
<td>S/p eye surgery</td>
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<td>Acquired absence of organ, eye</td>
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<td>Other specific conditions influencing health status</td>
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<td>Plastic surgery for cosmetic appearance</td>
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<td>Aftercare of cosmetic surgery</td>
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<tr>
<td>V52.2</td>
<td>Fitting/adjustment of artificial eye</td>
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<td>V53.1</td>
<td>Fitting/adjustment of eyeglasses or contact lenses</td>
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<td>V57.21</td>
<td>Occupational therapy</td>
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<td>V57.4</td>
<td>Orthoptic training</td>
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<tr>
<td>V57.89</td>
<td>Other rehab procedure, multiple training or therapy</td>
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<tr>
<td>V58.3</td>
<td>Attention to surgical dressings/ sutures</td>
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<tr>
<td>V58.42</td>
<td>S/p surgery-neoplasm</td>
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<td>V58.43</td>
<td>S/p surgery-injury or trauma</td>
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<td>V58.69</td>
<td>Current use of high risk medication (ie, Plaquenil)</td>
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<tr>
<td>V58.71</td>
<td>S/p surgery-sense organs</td>
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<td>V58.77</td>
<td>S/p surgery-skin and subcutaneous tissue</td>
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<td>V64.1</td>
<td>Surgical procedure not carried out due to contraindication</td>
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<tr>
<td>V65.2</td>
<td>Malingering</td>
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<td>V65.43</td>
<td>Counseling on injury prevention</td>
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<td>V65.5</td>
<td>Feared condition not demonstrated, &quot;worried well&quot;</td>
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<td>V67.2</td>
<td>Exam following chemo therapy</td>
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<tr>
<td>V67.51</td>
<td>Completed use of high risk med (Plaquenil, etc)</td>
</tr>
<tr>
<td>V68.2</td>
<td>Request for expert advice</td>
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<tr>
<td>V70.3</td>
<td>Exam for administrative purposes</td>
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<td>V70.7</td>
<td>Exam of clinical trial participant</td>
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<td>V71.8</td>
<td>Observation for specific suspected condition, ruled out</td>
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<tr>
<td>V71.9</td>
<td>Observation for suspected condition, without symptoms</td>
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<td>Pre-op exam</td>
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<td>V74.4</td>
<td>Screening for bacterial conjunctivitis</td>
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<td>V76.89</td>
<td>Special screening for other malignant neoplasm</td>
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<td>Screening for Diabetes Mellitus</td>
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<td>Screening for glaucoma</td>
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<td>Screening for other eye conditions</td>
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<td>Screening for Rheumatoid Arthritis</td>
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<td>Special screening for other specific conditions</td>
</tr>
<tr>
<td>V83.89</td>
<td>Other genetic carrier status</td>
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</tbody>
</table>
E914  Foreign body accidentally entering eye/ adnexa
E924.1  Caustic/ corrosive substance (acid, cleaner, lye)
E926.2  Exposure to radiation: visible or ultraviolet light source
E928.4  Exposure to radiation: laser
E942.0  Cardiovascular meds: rhythm regulators (amiodarone)
E946.5  Agent affecting eye: eye drugs
E947.8  Other: silicone oil, contrast media

Medications as the cause
E931.4  Plaquenil (hydroxychloroquine)
E932.9  Tamoxifen (anti-estrogen agent for breast cancer)
E933.1  Mexate (methotrexate/ cancer drug/ intraocular)
E942.0  Amiodarone (cardiac rhythm regulators)
E946.6  Steroids (ENT; e.g., prednisone)
E946.5  Steroids (ophthalmic preparation)
Procedure Codes

CPT Codes

CPT stands for Current Procedural Terminology, which codes for procedures and services performed by physicians. CPT codes are five digit codes which insurance carriers require to bill for the procedures and services provided. Any qualified physician is allowed to use the codes listed under specific specialty groups if that service or procedure was rendered. The procedure or service that has been provided must have adequate documentation in the patient’s record.

General ophthalmological services (sometimes referred to as eye codes) are the main codes used for routine vision care. These office visit codes can be used with refractive or medical diagnoses depending on the type of insurance that is billed. They are categorized by new (9200x) versus established (9201x) patients and intermediate (9202x) versus comprehensive (9203x) examinations. New patients are defined as any patient that has not received professional services from the physician or another physician of the same specialty in the same group practice for the past three years. To determine the appropriate level for eye code documentation, examination of a certain number of exam elements must be met. Exam elements include:

- Confrontation Visual Fields
- Eyelids and Adnexa
- Ocular Motility
- Pupils/ Iris
- Cornea

- Anterior Chamber Evaluation
- Lens
- Intra-ocular Pressure
- Retina (vitreous, macula, periphery, blood vessels)
- Optic Nerve

For **intermediate level** (92002-92012) requirements, a new or worsening chief concern is required, documentation of history of present illness, brief past medical history and ocular history and at between 4-7 exam elements. [If less than 4 exam elements have been performed or documented, use E/M Code 99211.]

For **comprehensive level** (92004-92014) requirements, include the chief concern, history of present illness, brief past medical and ocular history, along with at least 8 or more elements. Patients that fall under this level of examination almost always have a dilated fundus evaluation. If the patient is not dilated, state in the record the medical contraindication for not dilating. To be able to count the retinal evaluation for level determination, the patient must be dilated.
Office visits can also be billed using Evaluation and Management (E/M) Codes (99201-05, 99211-15) for medical diagnoses or by using Consultation Codes (99241-45) if the patient was referred to you.

This manual does not go into detail on how to determine which of these codes to use or when it is appropriate. Please refer to the CPT book for complete explanations.

Bundled elements are other elements performed during the examination that are considered to be part of the office visit code and not separately billable as special testing. Bundled elements include:

<table>
<thead>
<tr>
<th>Element</th>
<th>Description</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amsler Grid</td>
<td>lens opacity measurements</td>
<td>macular testing</td>
</tr>
<tr>
<td>keratometry</td>
<td>laser interferometry</td>
<td>glare testing</td>
</tr>
<tr>
<td>exophthalmometry</td>
<td>tear film adequacy</td>
<td>contrast sensitivity</td>
</tr>
<tr>
<td>tonometry</td>
<td>brightness acuity test</td>
<td>corneal sensation</td>
</tr>
<tr>
<td>slit lamp exam</td>
<td>pseudoisochromatic plates</td>
<td>pressure patching</td>
</tr>
<tr>
<td>stereo testing</td>
<td>Park's 3-step</td>
<td>scleral indentation</td>
</tr>
<tr>
<td>lensometry</td>
<td>palpation for lymphadenopathy</td>
<td>lid eversion</td>
</tr>
<tr>
<td>blood pressure</td>
<td>dilation and irrigation</td>
<td>globe repositioning</td>
</tr>
<tr>
<td>Jones Test</td>
<td>carotid auscultation</td>
<td>forced ductions</td>
</tr>
<tr>
<td>Seidel Test</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Refractions (92015) are always considered to be separate from the examination and should be billed out when giving an Rx.

The CPT book is broken down into sections by specialty. Most of the eye related procedures can be found in the surgery or medicine section. An alphabetical index is also available in the back of the book.

Modifiers

Modifiers are two digit or two letter add-ons that can be attached to the end of the CPT codes to provide additional information about the service or procedure without changing the definition of the code. Modifiers can describe location, if a service has been reduced or increased, if more than one physician was involved, etc… A list of the modifiers including descriptors is located in Appendix A of the CPT book.
CPT Codes

General Ophthalmological Services
92002  medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
92004  ; comprehensive, new patient, one or more visits
92012  ; intermediate, established patient
92014  ; comprehensive, established patient, one or more visits

Special Ophthalmological Services
92015  determination of refractive state
92020  gonioscopy, bilateral
92060  sensorimotor examination with multiple measurements of ocular deviation w/ interpretation and report
92065  orthoptic and/or pleoptic training, with continuing medical direction and evaluation
92070  bandage contact lens, fitting of contact lens for treatment of disease, including supply of lens
92081  visual field examination, unilateral or bilateral, with interpretation and report; limited examination
         (ie. tangent screen, Autopt, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7)
92082  visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination
         (ie. at least 2 isopters on Goldmann perimeter or Humphrey suprathreshold automatic diagnostic test)
92083  visual field examination, unilateral or bilateral, with interpretation and report; extended examination
         (ie. Goldmann visual fields with at least 3 isopters plotted and static determination w/ central 30, or
         quantitative, automated threshold perimetry, Humphrey visual field analyzer full threshold programs 30-2, 24-2
         or 30/60-2)
92100  serial tonometry (separate procedure) w/ multiple measurements of IOP over an extended time period
         with interpretation and report, same day
92135  scanning computerized ophthalmic diagnostic imaging (eg. scanning laser) with interpretation and report,
         unilateral
92140  provocative tests for glaucoma, with interpretation and report, without tonography
92225  ophthalmoscopy, extended, with retinal drawing, with interpretation and report; initial
92226  ophthalmoscopy, extended, with retinal drawing, with interpretation and report; subsequent
92250  fundus photography with interpretation and report
92283  color vision examination, extended (ie. anomaloscope; excluding pseudoisochromatic plates)
92284  dark adaptation examination with interpretation and report
92286  external ocular photography with interpretation and report for documentation of medical progress
92230  fluorescein angiography with interpretation and report
92235  fluorescein angiography (including multiframe imaging) with interpretation and report
92260  ophthalmodynamometry
92499  unlisted ophthalmological service or procedure (use for corneal topography) use descriptor in box 19
78516  A-scan, ophthalmic biometry
78519  A-scan, ophthalmic w/ IOL power calculation
78512  B-scan, ophthalmic

Removal of Foreign Body
65205  external eye, conjunctival superficial
65210  conjunctival embedded (including concretions), subconjunctival, or scleral nonperforating
65220  corneal, without slit lamp
65222  corneal, with slit lamp

Cornea- removal or destruction
65430  scraping of cornea, diagnostic, for smear and/or culture
65435  removal of corneal epithelium; with or without chemocauterization
65500  multiple punctures of anterior cornea (eg. for corneal erosion, tattoo)
### Eyelids- Excision or Reconstruction
- **67800** excision of chalazion; single
- **67801** multiple, same lid
- **67805** multiple, different lids
- **67820** correction of trichiasis; epilation, by forceps only
- **67938** removal of embedded foreign body, eyelid
- **67840** excision of lesion of eyelid (except chalazion) without closure or with simple direct closure

### Injections
- **67500** retrobulbar injection; medication (separate procedure, does not include supply of medication)
- **67515** injection of therapeutic agent into Tenon's capsule
- **68200** subconjunctival injection
- **11900** intralesional injection (i.e. chalazion), up to and including 7 lesions

### Other Procedures
- **68760** closure of the lacrimal punctum; by thermocauterization, ligation, or laser surgery
- **68761** closure of the lacrimal puncta by plug, each
- **68801** dilation of lacrimal punctum, with or without irrigation
- **76514** determination of corneal thickness (i.e. pachymetry) w/ interpretation and report, bilateral
- **68020** incision of conjunctiva, drainage of cyst

### Contact Lens Services
- **92310** Fix and fitting of contact lens with medical supervision of adaptation, bilateral; exclud. aphakia
- **92311** unilateral, for aphakia
- **92312** bilateral, for aphakia
- **92313** corneoscleral lens
- **92325** modification of contact lens, with medical supervision of adaptation
- **92326** replacement of contact lens

### Spectacle Services
- **92340** fitting (includes taking measurements, ordering, and dispensing) of spectacles; single vision, exclud. aphakia
- **92341** bifocal, exclud. aphakia
- **92342** multifocal, exclud. bifocal or aphakia
- **92352** fitting of spectacles for aphakia; single vision
- **92353** multifocal
- **92354** fitting of spectacle mounted low vision aids; one element system
- **92355** telescopic or compound lens system
- **92370** repair and refitting of spectacles; exclud. aphakia
- **92371** for aphakia
MODIFIERS

21. Prolonged service: identifies lengthy service where time main factor. Informational modifier only, does not affect payment.

22. Unusual Service: identifies greater than usual service (usually surgery), complex or difficult due to adhesions, bleding, unusual approach, lengthy case, etc. Requires paper claim and report. Payment affect: Increase usual fee.

23. Unusual Anesthesia: identifies a procedure that is normally performed with no anesthetic or by local, but in this case general anesthesia was required. Payment affect: Medicare does not adjust payment, informational only.

24. Unrelated E&M visit in the post-op period. Allows payment for a visit in the post-op period of surgery when condition is unrelated to the surgery.

25. Significantly identifiable visit on the same day as minor procedure. Allows payment for both a visit and minor procedure, unbundles beware.


32. Mandated service: Insurance Company or workers compensation requested evaluation. Could be 2nd opinion for surgery required by coverage.

50. Bilateral service: When procedure performed on both eyes or sides of body. Payment affect: one side paid at full allowance, 2nd side at 50%. Use on Medicare & Medicaid billing only.

51. Multiple procedure: Appended to 2nd, 3rd, 4th, etc. surgical procedures. Payment affect: Med: 100%, 50% thru 5th procedure. Others: 100%, 50%, 25%, 10%.

52. Reduced service: When less than the procedure (CPT) as described is performed. Visual field on one eye, rather than both. Payment affect: varies per procedure.


54. Surgical Care Only: Refers to intra-op portion of global surgery. Used when post-op care transferred elsewhere. Payment affect: Ophthomology allowance is 80% usual procedure. Medicare includes pre-op portion (-56) in this designation and does not recognize pre-op separately.

55. Post-Op Care: Refers to post-op portion of global surgery. Used when assuming part or all of 90 day post-op period. Payment affect: Ophthalmology allowance is 20% of usual procedure, pro-rated for less than 90 days or split.

57. Decision for Surgery: Appended to visit when surgery to occur within 24 hours and was not planned until that date.

58. Staged Procedure: Related procedure performed by same physician/group in the post-op period of another surgery, that was either planned as staged or went from a lesser procedure to greater. Payment affect: Procedure allowed at full & usual. Starts new post-op period.

59. Distinct Procedural Service: “unbundling” modifier. Allows separate payment for a procedure normally bundled or mutually exclusive of another. Or, used to identify a separate service on same day. Requires documentation to support.

62. Two Surgeons: When 2 surgeons perform same surgical procedure, but may be of different specialty. (i.e., dermatologist and ophtalmologist) Payment affect: each surgeon should get ½ of 125%, as this supercedes assistant surgeon billing.
Repeat Procedure/Same Physician/Same Day: Medicare uses mostly for multiple radiology procedures on same day. May work for repeat VF for taped and untaped. Both should be paid and allowed at full & usual.

Return to OR: surgical procedure performed by same physician/group in the post-op of another as an unexpected complication. Payment affect: claim paid at 80% of usual as it allows for intra-op portion only. No new post-op period, retains the original surgery's global.

Unrelated Procedure in Post-Op: unrelated as to eye, or condition or type of surgery. Cannot be related to original surgery. Payment affect: allowed at full & usual.

Surgical Assistant: Payment affect: Medicare 16% of usual, others 20-25%. Only allowed on certain procedures complex enough to be authorized for assistant surgeons.

Surgical Assistant: Used when no qualified resident available in a teaching setting. Requires statement on op report. Payment affect: Medicare 16% of usual, others 20-25%. Only allowed on certain procedures complex enough to be authorized for assistant surgeons.

Right or Left to identify eye. No payment affect. Recommended due to nature of specialty. Medicare requires on cataracts.

Medical necessity waiver signed by patient agreeing to patient. Called “ABN” by Medicare (Advance Beneficiary Notice). If denied, it will be patient responsibility.

Explains that service provided to a Medicare patient is non-covered. For instance, cosmetic or refractive surgery and refractive. Will deny as patient responsibility.

Explains that service is considered not medically necessary, but that no ABN was signed. Will deny as provider write-off.

Medicare modifiers to identify lid. No payment affect.
Sample Forms
Emergency Medical Eye Care Statement

To: All insurance companies/carriers, employers, and medical service providers involved with my care,

At the time I sought out emergency eyecare services, it was my belief that waiting to receive care would result in a worsening of my condition. When I considered the change in my vision and/or the appearance of my eyes, I believed that immediate evaluation and treatment by an eye specialist was the only prudent course of action.

Signed ______________ Date ____________
PLEASE READ THE FOLLOWING CAREFULLY:

PAYMENT FOR EACH VISIT IS REQUESTED AS YOU LEAVE. Materials will be ordered when payment is received. We welcome the opportunity to discuss any aspect of our fees and financial policy.

I authorize Pacific University College of Optometry Family Vision Centers to release any medical information necessary for continuation of care or processing of claims for me or my child for up to one year from this date. I also understand that this information cannot be released without this consent (except in a medical emergency, for an audit, or with a court order) and that I have the right to revoke my consent (in writing) at any time. I authorize the Pacific University College of Optometry and the Pacific University Family Vision Centers to make customary and constructive use, exercising due discretion, for education, scientific, and professional purposes, of information, photographs, and other materials pertinent to and in consideration of my examination and treatment procedures. I authorize the release of payment for medical benefits to my physician and assume responsibility for all charges.

Signature (circle one: Patient Parent Legal Guardian)  Today's Date
NOTE: You need to make a choice about receiving these health care items or services.

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, Medicare probably will not pay for -

**Items or Services:**

**Because:**

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (Estimated Cost: $__________), in case you have to pay for them yourself or through other insurance.

**PLEASE CHOOSE ONE OPTION. CHECK ONE BOX. SIGN & DATE YOUR CHOICE.**

- **Option 1. YES.** I want to receive these items or services.
  
  I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

- **Option 2. NO.** I have decided not to receive these items or services.
  
  I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

**Date** 
**Signature of patient or person acting on patient's behalf**

**NOTE:** Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.
<table>
<thead>
<tr>
<th>ID NO</th>
<th>GROUP NO</th>
<th>GC PLAN</th>
<th>BS PLAN</th>
<th>DATE ISSUED</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>015101471</td>
<td>350</td>
<td>851</td>
<td>02/25/2003</td>
</tr>
</tbody>
</table>

**Subscribed Dependents**

<table>
<thead>
<tr>
<th></th>
<th>Name</th>
<th>M/RX</th>
<th>Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Doe, John C.</td>
<td>M</td>
<td>RX</td>
</tr>
<tr>
<td>02</td>
<td>Doe, Jane A.</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>03</td>
<td>Doe, James D.</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>04</td>
<td>Doe, Sarah M.</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

**Comments**

- Medical Preauthorization Required
  - RX $10 Gen/$15 Pref/$25 Non-Pref
  - PPO Plan

**FOR ELIGIBILITY, BENEFITS, OR CLAIMS QUESTIONS**

- Call 1-800-826-9813
- Portland (503)220-3849

**FOR PREAUTHORIZATION QUESTIONS**

- Call 1-800-824-8563

**FOR MEDICAL CLAIMS, SEND TO**

- Your local Blue Cross and/or Blue Shield Plan
- www.or.regence.com/pebb

**SEND ALL OTHER CLAIMS TO**

- P.O. Box 1271
- Portland, OR 97207-1271

This card is for information only and does not certify eligibility or guarantee benefits.
OREGON HEALTH PLAN
PATIENT RESPONSIBILITY WAIVER

The following services are not covered benefits under the Oregon Health Plan:

Medical and/or surgical services

Condition/Diagnosis

I, ____________________________

(Patient name and OHP Identification number)

understand that the services listed above, for the condition listed above, are not covered for payment by ____________________________ (Health Plan Name) or the Office of Medical Assistance Programs under the Oregon Health Plan. If I or my dependent chooses to obtain the services listed above on this date, I agree to be personally responsible for paying the financial charges for these services. The estimated amount that I may be responsible for is $________, not to exceed $________.

PATIENT OR RESPONSIBLE PARTY SIGNATURE ____________________________ DATE _____________

WITNESS ____________________________ DATE _____________

*If you have Medicare, you may have additional appeal rights. Contact ____________________________ (Health Plan Name) Customer Service at ____________________________ (Phone Number) for further information.
HEALTH INSURANCE CLAIM FORM

1. MEDICARE
2. MEDICAID
3. CHAMPUS
4. CHAMPVA
5. HEALTH PLAN
6. BLK LUNG
7. PECA
8. OTHER

1a. INSURED’S E.I.D. NUMBER

1b. INSURED’S E.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
   M  F

4. PATIENT’S ADDRESS (No., Street)

5. PATIENT’S STATUS
   Single  Married  Other

6. PATIENT’S RELATIONSHIP TO INSURED
   Self  Spouse  Child  Other

7. PATIENT’S ACCOUNT NO.
   8188

8. PATIENT’S ACCOUNT NO. (FOR PROGRAM IN ITEM 1)

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

10. IS PATIENT’S CONDITION RELATED TO:
   a. EMPLOYMENT? (CURRENT OR PREVIOUS)
      YES  NO
   b. AUTO ACCIDENT? (PLACE (State))
      YES  NO
   c. OTHER ACCIDENT?
      YES  NO

11. INSURED’S POLICY GROUP OR FECA NUMBER
    00

12. PATIENT’S ADDRESS
    CITY
    STATE
    ZIP CODE

13. OTHER ACCIDENT? (PLACE (State))

14. INSURED’S ADDRESS
    CITY
    STATE
    ZIP CODE

15. dates patient unable to work in current occupation
    FROM  TO

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
    FROM  TO

17. INSURED’S ADDRESS
    CITY
    STATE
    ZIP CODE

18. MEDICARE RESUBMISSION CODE
    0

19. OTHER INSURED’S ADDRESS

20. INSURED’S ADDRESS
    CITY
    STATE
    ZIP CODE

21. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
    FROM  TO

22. MEDICARE RESUBMISSION CODE
    0

23. PRIOR AUTHORIZATION NUMBER

24. DATE(S) OF SERVICE
    FROM
    TO

25. FEDERAL TAX I.D. NUMBER
    SSN

26. PATIENT’S ACCOUNT NO.
    00

27. ACCEPT ASSIGNMENT?
    YES  NO

28. TOTAL CHARGE
    $0.00

29. BALANCE DUE
    $0.00

30. INSURED’S ADDRESS
    CITY
    STATE
    ZIP CODE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER
    (INCLUDING DEGREES OR CREDENTIALS)
    (I certify that the statement on the reverse apply to this bill and I am a part thereof)
**PATIENT NAME (SUBSCRIBER) INFORMATION**

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)  
2. PATIENT'S DATE OF BIRTH  
3. INSURED'S NAME (Last Name, First Name, Middle Initial)  

**PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)**  

4. PATIENT'S SEX  
5. INSURED'S ID NO. (Include all letters & Numbers)  
6. INSURED'S GROUP NO. (If Group Name)  
7. PATIENT'S RELATIONSHIP TO INSURED  
   - SELF  
   - SPOUSE  
   - CHILD  
   - OTHER  

**TELEPHONE NO.**

8. OTHER HEALTH INSURANCE COVERAGE. Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number  

**10. WAS CONDITION RELATED TO:**
   - A. PATIENT'S EMPLOYMENT  
   - B. ACCIDENT  
   - AUTO  

**SIGN**

11. INSURED'S ADDRESS (Street, city, state, zip code)  

12. PATIENT'S D.O.B. OR AUTHORIZED PERSON'S SIGNATURE (Read last name before signing)  
   - I authorize the release of any medical information necessary to process this claim and request payment of Medicare benefits to myself or to the Party who accepts assignment below  

**SIGN**

13. I authorize payment of Medicare benefits to undersigned physician or supplier for service described below  

**DATE**

14. DATE OF  
15. DATE FIRST CONSiBTED YOU FOR THIS CONDITION  
16. DATE PATIENT ABLE TO RETURN TO WORK  
17. DATE PATIENT ABLE TO RETURN TO WORK  
18. DATES OF TOTAL DISABILITY  
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g., PUBLIC HEALTH AGENCY)  
20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES  
   - ADMIITTED  
   - DISCHARGED  

**PHYSICIAN OR SUPPLIER INFORMATION**

21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)  
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE?  
   - YES  
   - NO  

23. A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE 1, 2, 3, ETC. OR DX CODE  
   - A. EPDOT  
   - B. FAMILY PLANNING  

**24.**

- DATE OF SERVICE  
- PLACE OF SERVICE  
- PROCEDURE CODE (CPT)  
- DIAGNOSIS CODE  
- CHARGES BILLED MEDICARE  
- PROVIDER NUMBER  

**25.**

- SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS) (CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)  
   - YES  
   - NO  

**26.**

- ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY)  
   - YES  
   - NO  

**27.**

- TOTAL CHARGE  

**28.**

- INSURANCE OTHER THAN MEDICAID/MEDICARE  
   - YES  
   - NO  

**29.**

- YOUR SOCIAL SECURITY NO.  

**30.**

- PHYSICIAN OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & PHONE NO.  
   - MEDICAID BILLING INVOICE  
   - MEDICAL PRACTITIONER CLAIMS  
   - CGMP 505 (Rev. 11/99)
**Individual Adjustment Request**

☑ Complete this form to request an adjustment.
☑ Please keep your copy.

1. **Please Adjust (Indicate situation below)**
   - [ ] Underpayment - Request additional payment
   - [ ] Overpayment - Please deduct from subsequent payment

2. **To facilitate processing please attach the following**
   - ✔ Claim (copy)
   - ✔ Remittance Advice (copy)
   - ✔ Financial planner (N.H. only):

3. **Return To:**
   - Office of Medical Assistance Programs
   - Department of Human Services
   - P.O. Box 14952
   - Salem OR 97309

Please enter the following data from your Remittance Advice:

4. **Internal Control Number**

5. **Client I.D. Number**

6. **Client Name**

7. **Provider Number**

8. **Provider Name**

9. **Remittance Advice Date**

10. **Description**
    - [ ] Place of Service
    - [ ] Type of Service
    - [ ] Quantity/Unit
    - [ ] NDC/Procedure Code
    - [ ] Revenue Code (if applicable)
    - [ ] Insurance Payment/Patient Liability
    - [ ] Drug Name (Pharmacy Only)
    - [ ] Billed Amount
    - [ ] Other

11. **Line No.**

12. **Service Date**

13. **Wrong Information**

14. **Right Information**

15. **Remarks**

16. **Provider's Signature**

17. **Date**

Distribution: White - OMAP; Canary - Provider
References


Cottle, Elizabeth, CPC. Casey Eye Institute. Portland, Oregon.

Regence BlueCross BlueShield of Oregon website. http://www.or.bcbs.com


Ueshiro, Lynn, OD. Pacific University College of Optometry. Forest Grove, Oregon.