

MEDICARE QUICK-REFERENCE

Billing Medicare (DMERC) for Glasses

Payable Diagnosis Codes (all other codes will be denied)

- V43.1 (pseudophakia) 1 frame and 2 lenses per operation
- 379.31 (aphakia) 1 frame and 2 lenses per year or once on a reasonable and necessary basis.
- 743.35 (congenital aphakia) 1 frame and 2 lenses per year or once on a reasonable and necessary basis.

Billing for Standard Lenses (two options)

1. For 2 lenses, bill the correct HCPCS code (V21xx, V22xx, or V23xx code) on one line in a quantity of 1, and the fee for two lenses at your usual and customary (U&C) fee. (Note: Modifier 50 cannot be used when billing two lenses on the same line. You must use a quantity of 2.)
2. For 1 or 2 lenses billed on separate lines, bill the correct HCPCS code, modifier 50, and the fee for one lens at your U&C fee.

Billing for Progressives

- First: Bill for standard lenses (see above) on one line. Modifier 50 cannot be used when billing two lenses on the same line. You must use a quantity of 1.
- Then: Bill on a separate line for progressive lenses and modifier 50 (1 lens) or a quantity of 2 (2 lenses). The fee is the difference between your U&C fee for standard lenses and progressives for one or two lenses.

Billing for Frames

- First: Bill for the base amount for billing (DMEPOS and Medicare allowed amount for the fee).
- Then: For frame overage, bill the frame on a separate line using V2025. The fee is the difference between your U&C fee for the frame and Medicare's allowed amount for the frame.

Applicable Modifiers (RT, LT, GA, etc. and see Medicare Manual for definitions).

For Glasses or Contact Surgery, include the surgeon's name, UPIN/NPI, date(s) of surgery, and RT and/or LT.

All codes billing in this category require a description. (Example: V2799).

For a complete list of "DMEPOS" codes, visit: <https://www.moridianmedicare.com/dme/news/manual/codes>

Billing Medicare for Contact Management - 66821, 66982, 66983, 66984

- Code 66984 indicates post-operative care of the surgeon, name and UPIN and NPI, and RT and/or LT (Example: 66984-RT) (CPT 17-99999 Form):
- Code 66982 indicates second surgery during the post-operative care of another surgery (Example: 66982-RT) (CPT 17-99999 Form):
- Date of service must be the date of surgery.
- Diagnosis code(s) must be the pre-surgery diagnosis and must match the diagnosis that the surgeon billed for (Example: 366.16). Note: Some states allow the use of V43.1. Check with your Carrier for specific rules.
- Procedure code(s) must match the procedure that the surgeon billed for (Example: 66984).
- Care summary date is usually 90 days after surgery but is 180 days after the surgeon releases care.
- Care report date is no more than 90 days after the date of surgery and is **always** after the assumed date.

Bilateral Services (two eyes)

Always use quantity of 1.

- Applicable modifiers for bilateral services (one eye only).
- 76514/TC/26 6516/TC/26 76514/TC/26
- 92020 92020/TC/26
- 92082/TC/26 92082/TC/26 92100/TC/26
- 92250/TC/26 92283/TC/26 92285/TC/26
- 92286/TC/26 92025/TC/26

Unilateral Services (one eye)

Always use quantity of 1.

- Applicable modifiers-50 (one line) **OR** RT or LT (two lines).
- 65205 92225 68810
- 68840 65210 92226
- 65220 67938 68801
- 92070 92135 92136
- 65222 76519/26

