**Durable Medical Equipment (DME)**

Payable Diagnosis Codes (all other codes will be denied):

- **V43.1** (pseudophakia): 1 frame & 2 lenses per operated eye.
- **379.31** (aphakia): 1 frame & 2 lenses per year or on a reasonable and necessary basis.
- **743.35** (congenital aphakia): 1 frame and 2 lenses per year or on a reasonable and necessary basis.

Billing for Frames:

First: Bill for the basic frame using V2020 and Medicare’s allowed amount for the fee.

Then: For frame overages (deluxe frame), bill on a separate line using V2025.

The fee is the difference between Medicare’s allowed amount and your usual and customary charge for the frame.

Billing for Standard Lenses:

For 1 or 2 lenses, use the correct HCPCS code (V21xx, V22xx, or V23xx) on separate lines for each eye.

Use modifier RT and/or LT modifier(s) for one lens at your usual and customary charge for the lens.

Not: Modifier 50 cannot be used when billing materials.

Billing for Progressive Lenses:

First: Bill for standard lenses (see above).

Then: When billing for only 1 lens, bill V2781 with a quantity of 1 and a RT or LT modifier.

When billing for 2 lenses, bill V2781 with a quantity of 2 without a modifier.

Billing for Lens Extras:

When billing only 1 lens, bill the correct HCPCS code(s) (V27xx) with a quantity of 1 and a RT or LT modifier.

When billing for 2 lenses, bill the correct HCPCS code(s) (V27xx) with a quantity of 2 without a modifier.

Applicable Modifiers:

- RT, LT, GA, EY and KX. Detail lines with GA and EY modifiers must be submitted on separate claim forms.

For Glasses After Cataract Surgery:

Include the surgeon’s name (17), NPI (17b), date(s) of surgery (19) and modifier RT and/or LT (24d).

**Punctal Occlusion by Plug**

- **68761**
  - Temporarily or permanently.
  - Payment is per plug.
  - Supply of plug is included in the allowed amount.
  - Requires E modifier(s).
  - Each plug must be listed on separate lines.
  - Use a quantity of 1.
  - Global period = 10 days.
  - Use a 25 modifier on the exam if it is separate and identifiable from the punctal plug. Established patients.

**Foreign Body Removal**

- **65210, 67938, 65220, 65222, 65205**
  - Payment is per eye.
  - Requires RT or LT modifier(s).
  - Each eye must be listed on separate lines.
  - Use a quantity of 1.
  - Global period = 0 days.
  - 67938: 10 day global period (includes all related services).
  - Use a 25 modifier on the exam if it is separate and identifiable from the foreign body removal. Established patients.
### Glaucoma

**Step One:** Bill the type of glaucoma (365.10 - 365.65).

- 365.10 Open-angle glaucoma, unspecified
- 365.11 Primary open-angle glaucoma
- 365.12 Low/normal tension glaucoma
- 365.13 Pigmentary glaucoma
- 365.20 Primary open angle glaucoma, unspecified
- 365.23 Chronic/primary angle-closure glaucoma
- 365.31 Steroid induced glaucoma
- 365.52 Pseudoexfoliation glaucoma
- 365.63 Glaucoma associated with ocular inflammations
- 365.63 Glaucoma associated with vascular disorders
- 365.65 Glaucoma associated with ocular trauma

**Step Two:** Determine the severity of the glaucoma in the worse eye (365.7x).

- 365.70 Glaucoma stage, unspecified
- 365.71 Mild stage glaucoma
- 365.72 Moderate stage glaucoma
- 365.73 Severe stage glaucoma
- 365.74 Indeterminate stage glaucoma

**Note:** Documentation of stage is required.

### CMS 1500 Claim Form

Medicare replaced the CMS 1500 claim form version 08/05 with version 02/12 effective April 01, 2014.

**Important Changes**

- **Box 17 - Name of the Referring or Ordering Physician**
  - Enter the name of the ordering or referring physician.
  - Enter a qualifier to the left of the dotted line to identify an ordering or referring role as follows:
    - DN – Referring Provider (a physician who requests an item or service)
    - DK – Ordering Provider (physician who orders non-physician services)

- **Box 21 - Patient’s Diagnosis/Condition**
  - Enter the patient’s diagnosis/condition of specificity for the date of service in priority order.
  - The “ICD Indicator” identifies the ICD code being reported as follows:
    - 9 – ICD-9 CM diagnosis
    - 10 – ICD-10 CM diagnosis

**Reminder:** Do not report ICD-10-CM codes for claims with dates of service prior to the effective date.

**Box 24E - Diagnosis Code Reference Number**

- Enter the diagnosis code reference letter as shown in Box 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed enter the primary reference letter for each service and it will be a letter from A to L.

### Modifiers

- **24** Unrelated E&M service/same doctor/during post-op.
- **25** Separate, identifiable E&M service/same doctor/same day as procedure. Use to unbundle some services. Established patients.
- **26** Professional component.
- **51** Multiple procedures on same day, same session.
- **52** Reduced services.
- **54** Surgical care. Used by surgeon.
- **55** Post-op care only (use with codes 66821, 66982, 66983 and 66984).
- **59** Distinct procedural service (use separate resource service.
- **79** Unrelated procedure or service same day as procedure.
- **125** Payment adjustment due to submission/billing error.
- **E1** Left upper.
- **E2** Left lower.
- **E3** Right upper.
- **E4** Right lower.
- **EY** Physician didn’t order. Used for materials.
- **GA** Services not covered by Medicare. ABN on file.
- **GK** Reasonable and necessary when a piece of equipment is upgraded.
- **GL** Medically unnecessary upgrade at no charge.
- **GP** Services delivered to another patient.
- **GW** Service not related to hospice.
- **GZ** Services expected to be denied. ABN not on file.
- **KX** Use with certain material codes if physician determines it is medically necessary.
- **TC** Technical component.

### Epilation

- **67820**
  - Payment is per eyelid.
  - Requires E modifier(s).
  - Each eyelid must be listed on separate lines.
  - Use a quantity of 1.
  - Global period = 0 days.
  - Use a 25 modifier on the exam if it is separate and identifiable from the epilation. Established patients.