Vision Care Claims and TAR Form Completion

Introduction

Purpose

The purpose of this module is to provide an overview of vision claim completion and processing, the authorization process, and *50-3 Treatment Authorization Request* (TAR) form completion requirements. This module discusses the *CMS-1500* claim form and *50-3 TAR* form as they pertain to vision care and offers participants general billing and claim information.

Module Objectives

- Introduce general billing guidelines for the *CMS-1500* claim form
- Identify the provider manual section regarding *CMS-1500* claims and *50-3 TAR* form completion
- Discuss the use of modifiers
- Explain how to determine if authorization is required
- Identify the information required to complete the *50-3 TAR* form
- Discuss the medical justification that is required for TAR approval
- Provider information about how and where to submit the *50-3 TAR* form
- Review the *Adjudication Response* (AR) process

Acronyms

A list of current acronyms is located in the *Appendix* section of each complete workbook.

CMS-1500 Claim Form Guidelines

Providers should bill in the Medi-Cal format with the appropriate modifier(s) required for specified procedures. Claim forms ordered through vendors must include red “drop-out” ink to meet the Centers for Medicare & Medicaid Services (CMS) standards.

Form Submission Methods

Paper Format

Form Completion Instructions

- Do not use punctuation or symbols ($, %, &, /, etc.) except in designated areas.
- Sign (with an original signature) all hard copy claims and follow-up forms using black ink.

Claim Submission Instructions

- Send original claim forms only. Do not send a carbon copy of the claim.
- Separate individual claim forms. Do not staple original claims together.
- Undersized attachments need to be taped to an 8 ½ by 11-inch sheet of white paper using non-glare tape.
- Blue and white claim envelopes can be ordered from the Telephone Service Center (TSC) at 1-800-541-5555.
- Send completed claim forms to:

  California MMIS Fiscal Intermediary
  P.O. Box 15700
  Sacramento, CA 95852-1700

Electronic Format

Please refer to the *Computer Media Claims* (cmc) and *CMC Enrollment Procedures* (cmc enroll) sections in the Part 1 provider manual.

- Claims may be submitted electronically via Computer Media Claims telecommunications (modem) or Internet Professional Claims Submission (IPCS) system through the Medi-Cal Provider website (*www.medi-cal.ca.gov*).
- Electronic claim submission requires a *Medi-Cal Telecommunications Provider and Biller Application/Agreement* (DHS 6153) form be on file with the fiscal intermediary (FI).
- Electronic data specifications and billing instructions are located in the *Medi-Cal CMC Billing and Technical Manual*.
- Claims requiring hard copy attachments may be billed electronically. Attachments must be accompanied by an *Attachment Control Form* (ACF) and mailed or faxed to the FI.
- Claims requiring special processing may not be billed electronically.
- For more information, contact the TSC at 1-800-541-5555.

Claim Timeliness

- Claims must be received by the FI by the last day of the sixth month after the Date of Service (DOS).
- Claims received after this date must include a valid delay reason code to be paid at the maximum allowable rate.

CMS-1500 Claim Form Completion

Refer to *CMS-1500* Completion for Vision Care (cms comp vc) in the Part 2 Provider Manual for assistance in completing the *CMS-1500* claim form.

Note: Do not type in the top inch of the *CMS-1500* claim form. This area is reserved for FI use.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA PICA ← CARRIER →

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) [X] | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): MEDI-CAL ID NUMBER

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

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

4. INSURED'S NAME (Last Name, First Name, Middle Initial): MOTHER'S NAME FOR NEWBORN

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

6. PATIENT RELATIONSHIP TO INSURED: Self, Spouse, Child, Other

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

CITY: PATIENT'S CITY; STATE: ST

8. RESERVED FOR NUCC USE

CITY; STATE

ZIP CODE: PATIENT'S 9-DIGIT ZIP; TELEPHONE (Include Area Code): (PATIENT'S PHONE

ZIP CODE; TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

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

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE CARRIER CODE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes, complete items 9, 9a, and 9d.*: OTHER COVERAGE/AMOUNT

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED NA DATE NA

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

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: ONSET DATE; QUAL.

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: NAME OF REFERRING PROVIDER

17a.; 17b. NPI: NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM FROM DOS TO TO DOS

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): ADDITIONAL JUSTIFICATION PLACED HERE

20. OUTSIDE LAB? YES NO; $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. DIAGNOSIS CODE 1 | B. DIAGNOSIS CODE 2 | C. DIAGNOSIS CODE 3 | D. DIAGNOSIS CODE 4
E. DIAGNOSIS CODE 5 | F. DIAGNOSIS CODE 6 | G. DIAGNOSIS CODE 7 | H. DIAGNOSIS CODE 8
I. DIAGNOSIS CODE 9 | J. DIAGNOSIS CODE 10 | K. DIAGNOSIS CODE 11 | L. DIAGNOSIS CODE 12

22. RESUBMISSION CODE: RESUBMIT CODE; ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: TAR CONTROL NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 QUALIFIER + NDC OR UPN				UNIT QUALIFIER AND QUANTITY							NON-NPI NUMBER
DOS FROM	DOS THRU	POS	DELAY EMER	PROC CODE	MODIFIERS		SERVICE CHARGES	QUANTITY	F P / C H D P	NPI	NPI
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: PATIENT ACCOUNT NUMBER

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

28. TOTAL CHARGE: $ TOTAL CHARGES

29. AMOUNT PAID: $ TOTAL DEDUCTIONS

30. Rsvd for NUCC Use

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

SIGNED; DATE: DATE

32. SERVICE FACILITY LOCATION INFORMATION: NAME AND ADDRESS OF SERVICE FACILITY

a. FACILITY NPI; b. NON-NPI NUMBER

33. BILLING PROVIDER INFO & PH #: (PHONE NUMBER; BILLER ADDRESS

a. BILLER NPI; b. NON-NPI NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org *PLEASE PRINT OR TYPE* CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

Figure 1.1: *CMS-1500* Claim Form

Field Descriptions: 1 thru 8

Box #	Field Name	Instructions
1	Medicaid/Medicare/Other	For Medi-Cal, enter an "X" in the Medicaid box. **Billing Tip**: When billing Medicare crossover claims, check both the Medicaid and Medicare boxes. Refer to the *Medicare/Medi-Cal Crossover Claims: CMS-1500* section (medi cr cms) in the appropriate Part 2 provider manual.
1A	Insured's ID Number	Enter the recipient's 14-digit identification number as it appears on the plastic Benefits Identification Card (BIC) or paper Medi-Cal ID card. **Note**: For Medicare/Medi-Cal crossover claims. Enter Medicare number in this field. **Billing Tip**: Use the Point of Service (POS) network to verify that the recipient is eligible for the services prior to rendering.
2	Patient's Name	The *Patient's Name* field (Box 2) requires commas between each segment of the patient's name: last, first, middle initial (without a period).
3	Patient's Birth Date/Sex	Enter the recipient's date of birth (DOB) in six-digit format (MMDDYY). Enter an "X" in the "M" or "F" box.
4	Insured's Name	Not required by Medi-Cal, except when billing for an infant using the mother's ID. Enter the mother's name in this field when billing for the infant. **Note:** Services rendered to an infant may be billed with the mother's ID for the month of birth and the following month only.
5	Patient's Address/Telephone	Enter the recipient's complete address and telephone number.
6	Patient Relationship to Insured	This field may be used when billing for an infant using the mother's ID by checking the *Child* box.
8	Reserved for NUCC Use	Not required by Medi-Cal

Field Descriptions 9A thru 14

Box #	Field Name	Instructions
9A	Other Insured's Policy or Group Number	Not required for straight Medi-Cal claims. **Note:** For crossover claims, enter the Medi-Cal recipient identification number as it appears on the BIC.
9B	Reserved for NUCC Use	Not required by Medi-Cal
9C	Reserved for NUCC Use	Not required by Medi-Cal
9D	Insurance Plan Name or Program Name	Not required by Medi-Cal
10A	Employment	Complete this field if services were related to an accident or injury. Enter an "X" in the Yes box if the accident/injury is employment related. Enter an "X" in the No box if accident/injury is not employment related. If either box is checked, the date of the accident must be entered in box 14.
10D	Claim Codes (Designated by NUCC)	Enter the amount of recipient's Share of Cost (SOC) for the procedure, service or supply.
11B	Other Claim ID (Designated by NUCC)	Not required by Medi-Cal
11C	Insurance Plan Name or Program Name	If this is a Medicare crossover, enter the Medicare Carrier Code.
11D	Is There Another Health Benefit Plan? Yes or No Box	Enter an "X" in the Yes box if the recipient has Other Health Coverage (OHC). Enter the amount paid (without the dollar sign or decimal point) by the other health insurance in the right side of box 11D. **Billing Tip**: Eligibility under Medicare or a Medi-Cal Managed Care Plan (MCP) is not considered OHC.
13	Insured or Authorized Person's Signature	Not Required However, providers may note the Eligibility Verification Confirmation (EVC) number in this field.
14	Date of Current Illness, Injury, or Pregnancy (LMP) MM/DD/YY (Qual.)	Enter the date of onset of the recipient's illness, the date of accident/injury.

Field Descriptions: 17 thru 20

Box #	Field Name	Instructions
17	Name of Referring Provider or Other Source	Indent to the right of the dotted line and enter the name of the referring provider or other source. For Medi-Cal recipients residing in skilled nursing facilities, intermediate care facilities and intermediate care facilities for the developmentally disabled, enter the facility name.
17A	Unlabeled	Not required by Medi-Cal
17B	NPI	Enter the NPI for the referring provider or other source here. **Note:** Enter the facility's 10-digit NPI.
18	Hospitalization Dates Related to Current Services	*Not Required.*
19	Additional Claim Information (Designated by NUCC)	Use this area for procedures that require additional information, justification or an Emergency Certification Statement. Refer to the policy sections of the manual for Current Procedural Terminology, (CPT) code book/Healthcare Common Procedure Coding System (HCPCS) codes that require additional justification. If the information requested requires additional space than what is provided in Box 19, include a separate attachment on an 8 ½ by 11-inch sheet of paper with the claim. If electronically filing a claim with attachments, enter the Attachment Control Number (ACN) from the *Medi-Cal Claim Attachment Control Form* (ACF).
20	Outside Lab	Leave blank if not applicable. If this claim includes charges for laboratory work performed by a licensed laboratory, enter an "X". "Outside" laboratory refers to a laboratory not affiliated with the billing provider. State in Box 19 that a specimen was sent to an unaffiliated laboratory.

Field Descriptions: 21 thru 24.1

Box #	Field Name	Instructions
21	Diagnosis or Nature of Illness or Injury Relate A-L to service line below (24E)	Enter the ICD indicator “0” for dates of service on or after October 1, 2015. Claims submitted without a diagnosis code do not require an ICD indicator.
21A/ 21B	Diagnosis or Nature of Illness or Injury	Enter all letters and/or numbers of the ICD-10-CM code for the primary diagnosis, including the fourth through seventh characters, if present. (Do not enter decimal point) **Note:** For vision services, enter up to two diagnosis codes in Fields 21A and 21B. Do not enter more than two diagnosis codes. If billing for multiple procedure codes that require different diagnosis codes than what can be entered in Fields 21A and 21B, use a separate claim.
22	Resubmission Code Original Ref. No.	Medicare status codes are required for Charpentier claims. These codes are optional in all other circumstances. **Note:** See provider manual for a list of Medicare Status codes.
23	Prior Authorization Number	For vision care services requiring a TAR, enter the 10-digit TAR Control Number (TCN) followed by the Pricing Indicator (PI). **Billing Tips:** It is not necessary to attach a copy of the TAR to the claim. Recipient and billing information (e.g., procedure codes, modifiers, units, etc.) on the claim must match the TAR. Claims cannot be billed with multiple TCNs. TAR and non-TAR services must be billed on separate claims.
24.1	Claim Line	Information for completing a claim line follows items 24A thru 24J. Refer to the *CMS-1500 Special Billing Instructions for Vision Care* (cms spec vc) section in the Part 2 Vision Care provider manual for more information. **Note:** Do not enter data in the shaded area, except for Box 24C.

Field Descriptions: 24A thru 24G

Box #	Field Name	Instructions
24A	Date(s) of Service	Enter the date(s) the service was rendered in the “From” and “To” boxes in six-digit (MMDDYY) format. When billing for a single date of service, enter the date in the “From” field.
24B	Place of Service	Enter code indicating where the service was rendered. See provider manual for a list of Place of Service codes.
24C	EMG or Delay Reason Code	If there is an exception to the six-month billing limitation, enter the appropriate delay reason code number and include the required documentation. Only one billing limit indicator is allowed per claim and should be entered in the unshaded area, unless the claim also contains an emergency statement. If this occurs, place the delay reason code in the shaded area above the emergency statement indicator. Enter an “X” if an Emergency Certification Statement is attached to the claim or entered in Box 19. Only one emergency indicator is allowed per claim. Place the indicator on the first line of Box 24C line 2.
24D	Procedures, Services or Supplies/Modifier	Enter the procedure code (HCPCS or CPT) and modifier, if appropriate. **Billing Tip**: Do not use Medicare modifiers. If necessary, the procedure description can be entered in the *Additional Claim Information* field (Box 19). A complete list of modifiers accepted by Medi-Cal is found in *the Modifiers: Approved List* section (modif app) in the appropriate Part 2 provider manual.
24E	Diagnosis Pointer	As required by Medi-Cal.
24F	Charges	Enter the usual and customary fee for service(s) in full dollar amount.
24G	Days or Units	Enter the number of medical “visits” or procedures, items or units of service, etc.

Field Descriptions: 24J thru 31

Box #	Field Name	Instructions
24J	Rendering Provider ID Number	Enter the rendering provider's NPI if the provider is billing using a group NPI. **Note:** The rendering provider instructions apply to the following providers: optometrists and ophthalmologists
26	Patient's Account Number	This is an optional field that will help providers to easily identify a recipient on a *Remittance Advice Details* (RAD). Enter the patient's medical record number or account number in this field. A maximum of 10 numbers and/or letters may be used. Whatever is entered here will appear on the RAD. Refer to the RAD example sections in the appropriate provider manual.
28	Total Charge	Enter the full dollar amount, for all services, without the decimal point (.) or dollar sign ($). For example, $100 should be entered as "10000."
29	Amount Paid	Enter the full dollar amount of payment(s) received from the *Other Health Coverage* field (Box 11D) and/or patient's Share of Cost (Box 10D), without the decimal point (.) or dollar sign ($).
31	Signature of Physician or Supplier Including Degrees or Credentials	The claim must be signed and dated by the provider or a representative assigned by the provider, in black ballpoint ink. **Billing Tips:** • Providers that fill another provider's prescription must keep a copy of the prescription in the recipient's medical record, which must be made available for State review if requested. • Signatures must be written, not printed, and should not extend outside the field. Stamps, initials or facsimiles are not accepted.

Field Descriptions: 33 thru 33B

Box #	Field Name	Instructions
33	Billing Provider Info & Phone Number	Enter the provider name, address, nine-digit ZIP code and telephone number. **Note:** The nine-digit ZIP code entered in this box must match the biller's ZIP code on file for claims to be completely reimbursed.
33A	(Blank)	Enter the billing provider's NPI.
33B	(Blank)	Used for atypical providers only. Enter the Medi-Cal provider number for the billing provider. **Note:** Do not submit claims using a Medicare provider number or state license number. Claims from providers and/or billing services that consistently bill with identifiers other than the NPI (or Medi-Cal provider number for atypical providers) will be denied. **Billing Tips**: The Department of Health Care Services (DHCS) assigns a check digit to each provider to verify accurate input of the provider number. The check digit is not a required item. However, including the check digit ensures that reimbursement for the claim is made to the correct provider. Providers should enter their check digit to the right of the Medi-Cal provider number in Box 33B. Providers who do not know their check digit should contact the TSC at 1-800-541-5555.

Vision Modifiers

The use of modifiers is an important part of billing for health care services. Modifiers give additional information for processing claims. Use of a modifier with a CPT or HCPCS code does not ensure reimbursement. Documentation of medical necessity may also be necessary for certain procedure codes.

Refer to the *Modifiers Used with Vision Care Procedure Codes* section (modif used vc) in Part 2 of the *Vision Care* provider manual for a list of modifiers with corresponding procedure codes. For a complete list of modifiers, refer to the *Modifiers: Approved List* section (modif app) of the appropriate Part 2 provider manual. Modifiers not listed in the *Modifiers: Approved List* section are unacceptable for billing Medi-Cal.

Examples of Approved Vision Modifiers

Modifier	Description
22*	Increased procedural services
26*	Professional component
50*	Bilateral procedure
99*	Multiple modifiers/special circumstances
E1	Upper left, eyelid
E2	Lower left, eyelid
E3	Upper right, eyelid
E4	Lower right, eyelid
KX	Specific required documentation on file
LT	Left side (used to identify procedures performed on the left side of the body)
NU	New equipment
RA	Replacement
RB	Replacement as part of a repair
RT	Right side (used to identify procedures performed on the right side of body)
TC	Technical component
SC	Medically necessary service/supply

Required Vision Modifiers

Service or Procedure	Codes or Code Ranges	Required Modifiers	Allowable Modifiers
Removal of foreign body	65210	None	22, 54
Extracapsular cataract removal with insertion of intraocular lens prosthesis	66989, 66991	Not Applicable	AG, ET, PA, PB, PC, SC, UA, UB, U7, 22, 47, 51, 52, 53, 54, 55, 62, 66, 76, 77, 78, 79, 99
Eyelids, excision	67820	None	E1 thru E4, 22, 54
Eyelids, reconstruction	67938	None	E1 thru E4, 22, 54
Closure of the lacrimal punctum	68761	SC†, E1 thru E4†	None
Scanning computerized ophthalmic diagnostic imaging	92132 thru 92134	LT, RT, 50	TC, 26, 99
Extended ophthalmoscopy	92201, 92202	LT, RT, 50	U7, 22, 99
Remote imaging for detection of retinal disease	92227	LT, RT, 50	22, 99
Remote imaging for monitoring and management of retinal disease	92228	LT, RT, 50, 26, TC, 99	22, 99
Imaging of retina for detection or monitoring of disease	92229	LT, RT, 50	SA, U7, 22, 99
Contact lens services	92071, 92072 92310 thru 92312	SC or 22	None
Dark adaptation examination with interpretation and report	92284	TC, 26	SA, U7, 99
Spectacle services, monofocal	92340, 92352	NU, RA	None
Spectacle services, bifocal	92341, 92353	NU, RA	None
Spectacle services, trifocal	92342	RA with KX	None
Repair and refitting spectacles	92370, 92371‡	None	None

Quantity for Unilateral Procedures Billed

CPT codes 92225, 92226, 92230, and 92235 are considered unilateral services. As of December 1, 2012, the quantity allowed per day for CPT codes 92225, 92226, 92230, and 92235 is two procedures, reimbursed at 200 percent when these services are performed on both eyes (bilaterally).

When performed on both eyes as a bilateral procedure, claims must be billed on a single line using modifier 50 (bilateral procedure) with a quantity of "2."

When performed on one eye as a unilateral procedure, claims must be billed with a quantity of "1" and either modifier LT (left side) or RT (right side) to indicate which eye.

The following 90000 series procedure codes are considered bilateral services. A code should be billed only once regardless of whether one or both eyes were involved. In the case of eye surgeries however, this does not apply, and the appropriate code should be used to specify whether the procedure was unilateral or bilateral.

Table of CPT Codes for Bilateral Services

CPT Code	Description
◊92132	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral
◊92133	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve
◊92134	Retina
92227	Remote imaging for detection of retinal disease (e.g., retinopathy in a patient with diabetes) with analysis and report under physician supervision, unilateral or bilateral
◊92228	Remote imaging for monitoring and maintenance of active retinal disease (e.g., diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral

When performed on one eye, these procedures must be billed with a quantity of “1” and either modifier LT (left side) or RT (right side) to indicate which eye. When performed on both eyes, these procedures must be billed on a single line using modifier 50 (bilateral procedure) with a quantity of “1.”

In addition, CPT codes 92227 and 92228 are not reimbursable for the same recipient on the same date of service by any provider in conjunction with codes 92002 thru 92014, 92133, 92134, 92227, 92228, 92250 or E&M codes 99201 thru 99350.

Table of Vision Care Services, Codes and Modifiers

Service or Procedure	Codes or Code Ranges	Required Modifiers	Allowable Modifiers
Out of office call	99056	22	None
Teleophthalmology by store and forward	99241 thru 99243	GQ	None
Frames	V2020, V2025, S0516	NU, RA	None
Spectacle lenses, single vision, glass or plastic	V2100 thru V2121, V2199, V2410	NU, RA	None
Spectacle lenses, bifocal, glass or plastic	V2200 thru V2221, V2299, V2430	NU, RA	None
Spectacle lenses, trifocal, glass or plastic	V2300 thru V2321	RA with KX	None
Variable sphericity lens, other type	V2499	NU, RA	None

Table of Vision Care Services, Codes and Modifiers

Service or Procedure	Codes or Code Ranges	Required Modifiers	Allowable Modifiers
Contact lens	V2500, V2501, V2510, V2511, V2513, V2520, V2521, V2523, S0500, S0512, S0514	NU, RA	None
Contact lens	V2599§	LT, RT	None
Low vision aids	V2600, V2610, V2615	NU, RA	None
Prosthetic eye	V2623, V2627 thru V2629	NU, RA	None
Polishing/resurfacing of ocular prosthesis	V2624	SC	None
Enlargement of ocular prosthesis	V2625	SC	None
Reduction of ocular prosthesis	V2626	SC	None
Deluxe lens feature	V2702	NU, RA	None
Antireflective coating, per lens	V2750	NU, RA	None
Scratch resistant coating, per lens	V2760	NU, RA	None
Mirror coating, any type, solid, gradient or equal, any lens material, per lens	V2761	NU, RA	None
Polarization, any lens material, per lens	V2762	NU, RA	None
Occluder lens	V2770	NU, RA	None
Progressive lens, per lens	V2781	NU, RA	None
Lens, index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbonate, per lens	V2782	NU, RA	None
Lens, index greater than or equal to 1.66 plastic or greater than or equal to 1.80 glass, excludes polycarbonate, per lens	V2783	NU, RA	None
Lens, polycarbonate or equal, any index, per lens	V2784	NU, RA	None
Miscellaneous vision service	V2799	NU, RA	None

CMS-1500 Billing Example

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA PICA CARRIER

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) [X] TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 90000000A95001

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

3. PATIENT'S BIRTH DATE MM DD YY: 06 21 62 SEX M [X] F

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

5. PATIENT'S ADDRESS (No., Street): 1234 MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other

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

CITY: ANYTOWN STATE: CA

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 958235555 TELEPHONE (Include Area Code): (916) 555-5555

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. D1D1D1D B. D2D2D2D C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10	01	21				11		V2020	NU		50 00	2		NPI	
2	10	01	21				11		92340	NU		100 00	4		NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED *Jane Doe* DATE 10/30/21

32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.

33. BILLING PROVIDER INFO & PH # (916) 555-5555

JANE SMITH
1027 MAIN STREET
ANYTOWN CA 958235555

a. 0123456789 b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org *PLEASE PRINT OR TYPE* CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

Figure 2.1: Example, Single Vision Lenses from *CMS-1500*

Note: When billing with multiple modifiers, each CPT/HCPCS and appropriate modifier must be placed on individual claim lines to ensure accurate payment.

Learning Activity 1

Collagen Plugs

Using this information, complete the claim form and include appropriate modifiers:

Procedure Information

- On December 28, 2021, temporary collagen plugs were inserted in both the right and left lower lids of the patient in the office (CPT code 68761).
- On January 21, 2022, after noticing improvement of symptoms with the temporary collagen plugs, the patient returned for permanent placement of silicone-punctual plugs in lower right and lower left **eyelids.**

Billing Information

Date of Service 12/28/21

- Diagnostic closure of the lacrimal punctum, by absorbable temporary plug, one or more closures, includes office visit. CPT code 68761 requires modifier SC (Medically necessary service). Charges are $48.84
- Diagnosis code(s) and ICD Indicator

Date of Service 01/21/22

- Closure of the lacrimal punctum; by plug, each (CPT 68761), each billed on separate claim lines for the lower right and lower left eyelids.
- Modifiers E4 (lower right), E2 (lower left). Charges are $125.47 each closure.
- Diagnosis code(s) and ICD Indicator.

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

PHYSICIAN OR SUPPLIER INFORMATION

Figure 3.1: Partial Example, Collagen Plugs *CMS-1500* Claim Form

Learning Activity 2

Trifocal Replacement

Using this information, complete the claim form and include appropriate modifiers.

Procedure Information

- On January 22, 2022, a current trifocal patient comes into the office for trifocal replacement (CPT code 92342).

Billing Information

Date of Service January 22, 2022

- Replacement trifocal lenses (CPT code 92342)
- Modifier's RA (replacement) and Modifier KX (documentation on file patient is current trifocal wearer)
- Diagnosis(s) codes and ICD Indicator 0
- Charges are $100.00

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.
15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. B. C. D.
E. F. G. H.
I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

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

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO
28. TOTAL CHARGE $
29. AMOUNT PAID $
30. Rsvd for NUCC Use

Figure 4.1: Partial Example, Trifocal Replacement *CMS-1500* Claim Form.

DO NOT STAPLE IN BAR AREA

MEDI-CAL CLAIM ATTACHMENT CONTROL FORM

STATE OF CALIFORNIA DEPARTMENT OF HEALTH SERVICES

DO NOT WRITE IN THIS SPACE

ATTACHMENT CONTROL NUMBER 99999999999

VOID

PROVIDER NUMBER : (REQUIRED)

PROVIDER NAME : ______

PROVIDER ADDRESS : ______

______

(PLEASE PRINT IN BLACK OR BLUE INK TO COMPLETE THIS FORM)

FOR F.I. USE ONLY

1 2 3 4

RETURN THIS FORM WITH ATTACHMENTS TO:

FISCAL INTERMEDIARY
P.O. BOX 526022
SACRAMENTO, CA 95852

PROVIDER SIGNATURE DATE

X______ ______

USE THIS FORM AS A COVER SHEET FOR PAPER DOCUMENTATION TO SUPPORT THE ELECTRONICALLY SUBMITTED CLAIM.
FOR FURTHER INFORMATION REGARDING USE OF THE ATTACHMENT CONTROL FORM SEE THE PROVIDER MANUAL.

FORM NUMBER ACF-001

Figure 4.2: ACF Example

Additional Forms (Attachments)

Medi-Cal Claim Attachment Control Form (ACF)

Under HIPAA rules, an electronic 837 v.5010 claim cannot be rejected (denied) because it requires an attachment. CA-MMIS has been modified to process paper attachments submitted in conjunction with an electronic 837 v.5010 claim. The ACF validates the process of linking paper attachments to electronic claims.

For each electronically submitted claim requiring an attachment, a single and unique ACF must be submitted via mail or fax. Information receivers are required to use the 11-digit ACN from the ACF to populate the paperwork (PWK) segment of an 837 HIPAA transaction.

Attachments must be mailed or faxed to the address below:

California MMIS Fiscal Intermediary
P.O Box 526022
Sacramento, CA 95852-6022
Fax: 1-866-438-9377

Attachment Policies

- All attachments must be received within 30 calendar days of the electronic claim submission in order to be matched to the electronic claim.
- The original ACF must accompany the attachments.
- Paper attachments cannot be matched after 30 calendar days from the electronic claim submission.
- To ensure accurate processing, only one ACN value will be accepted per single electronic claim and only one set of attachments will be assigned to a claim.

Denied Claim Reasons

- If an 837 v.5010 electronic transaction is received that requires an attachment and there is no ACN, the claim will be denied.
- If no ACF or a non-original ACF is submitted, the attachments or documentation will be returned with a rejection letter to the provider or submitter.
- Photocopies of the ACF will not be accepted.
- Providers should submit the ACF with their NPI in the Provider Number field.

ACF Order/Reorder Instructions

- To order ACF documents, call TSC at 1-800-541-5555.
- To reorder forms, complete and mail the hard copy reorder form.

For further instructions, refer to the *Forms Reorder Request: Guidelines* section (forms reo) in the Part 2 provider manual or visit the Medi-Cal Providers website.

Note: ACFs and envelopes are provided free of charge to all providers submitting 837 v.5010 electronic transactions.

California MMIS
Fiscal Intermediary

P.O. Box 13029
Sacramento, CA 95813-4029

1.800.541.5555

Date:

ATTACHMENT CONTROL FORM REJECT LETTER

This letter is to inform you that the coversheet or Attachment Control Form (ACF) you submitted does not meet Medi-Cal standards. It has been rejected for the following reason(s):

________ **Invalid ACF**
(Only original ACFs provided by California Department of Health Care Services (DHCS) will be accepted)

________ **Missing ACF**
(Paper attachments submitted without ACF)

________ **Supporting documentation missing**
(ACF received without paper attachments)

________ **Invalid Attachment Control Number (ACN) on ACF**
(Pre-imprinted CANNOT be altered or unreadable)

________ **Other:** ____

Please resubmit your electronic claim if:

The resubmitted ACF has an Attachment Control Number (ACN) that differs from your original electronic claim form or;

More than 30 days have passed since you originally submitted your electronic claim.

Mail attachments to: California MMIS Fiscal Intermediary
P.O. Box 526022
Sacramento, CA 95852

If you have any questions regarding this notice or submitting attachments, please call the Telephone Service Center (TSC) at 1-800-541-5555.

Sincerely,

California Medicaid Management Information System Fiscal Intermediary

Figure 5.1: ACF Rejection Letter

Authorizations (TAR)

Authorization is required for medically necessary contact lenses and contact lens evaluations, low vision aids, prosthetic eyes and non-Prison Industry Authority (PIA) covered items. Providers must request authorization on a *50-3 TAR* form from the Vision Services Branch (VSB) of DHCS. This form can be ordered by calling the TSC at 1-800-541-5555.

Documentation Requirements

Medical Justification

It is the provider's responsibility to provide all necessary documentation and justification for TAR processing. Information regarding proper medical justification is found in the *Contact Lenses, Eye Appliances, Eyeglass Lenses, Low Vision Aids, Prosthetic Eyes* and *TAR Completion for Vision Care* sections in the Part 2 Medi-Cal Vision Care manual.

Medical Necessity

Providers must justify that the services they are requesting are medically necessary. The Medi-Cal program definition of medical necessity limits the provision of health care services to those that are reasonable and necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain.

Authorization may be granted when the services requested are reasonably expected to:

- Restore lost function
- Minimize deterioration of existing functions
- Provide necessary training in the use of orthotic or prosthetic devices
- Provide the capability of self-care, including feeding, toilet activities and ambulation
- When failure to achieve such goals would result in loss of life or significant disability

STATE USE ONLY

SERVICE CATEGORY

5

CONFIDENTIAL PATIENT INFORMATION

1 FOR F.I. USE ONLY

CCN

F.I. USE ONLY 40 41 42 43

TREATMENT AUTHORIZATION REQUEST

STATE OF CALIFORNIA DEPARTMENT OF HEALTH SERVICES

(PLEASE TYPE) FOR PROVIDER USE (PLEASE TYPE)

VERBAL CONTROL NO. | TYPE OF SERVICE REQUESTED 2 DRUG OTHER | REQUEST IS RETROACTIVE? YES NO | IS PATIENT MEDI-CARE ELIGIBLE? YES NO | PROVIDER PHONE NO. ( ) | PROVIDER FAX NO. ( )

PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS:

PLEASE TYPE YOUR NAME AND ADDRESS HERE

PROVIDER NAME AND ADDRESS

3. PROVIDER NUMBER

FOR STATE USE

33 PROVIDER; YOUR REQUEST IS:

APPROVED AS REQUESTED | DENIED | DEFERRED

APPROVED AS MODIFIED (ITEMS MARKED BELOW AS AUTHORIZED MAY BE CLAIMED) | JACKSON VS RANK PARAGRAPH CODE

BY

MEDI-CAL CONSULTANT

34 I.D. # 35 DATE 44 REVIEW COMMENTS INDICATOR

COMMENTS/EXPLANATION

NAME AND ADDRESS OF PATIENT

4 PATIENT NAME (LAST, FIRST, M.I.)

5 MEDI-CAL IDENTIFICATION NO. CHECK DIGIT 6

STREET ADDRESS

7 SEX AGE 8 DATE OF BIRTH

CITY, STATE, ZIP CODE

PHONE NUMBER AREA ( )

PATIENT STATUS: HOME | BOARD & CARE | SNF / ICF | ACUTE HOSPITAL

DIAGNOSIS DESCRIPTION: | ICD-9-CM DIAGNOSIS CODE

MEDICAL JUSTIFICATION:

RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003 (b)

36 1 2 3 4 5 6

LINE NO.	AUTHORIZED Y/N	APPROVED UNITS	SPECIFIC SERVICES REQUESTED	UNITS OF SERVICE	NDC/UPN OR PROCEDURE CODE	QUANTITY	CHARGES
1	9	10			11	12	$
2	13	14			15	16	$
3	17	18			19	20	$
4	21	22			23	24	$
5	25	26			27	28	$
6	29	30			31	32	$

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

SIGNATURE OF PHYSICIAN OR PROVIDER | TITLE | DATE

AUTHORIZATION IS VALID FOR SERVICES PROVIDED 37 FROM DATE 38 TO DATE

TAR CONTROL NUMBER

PI

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE PATIENT'S ELIGIBILITY IS CURRENT BEFORE RENDERING SERVICE.

50-3 03/07

SEND TO FIELD SERVICES (F.I. COPY)

SEE YOUR PROVIDER MANUAL FOR ASSISTANCE REGARDING THE COMPLETION OF THIS FORM.

Figure 6.1: *50-3 TAR* Form

50-3 TAR Form Completion

To determine if a procedure requires authorization and for step-by-step instructions for completing a *50-3 TAR* form, refer to the *TAR Completion for Vision Care* (tar comp vc) section in Part 2 of the Medi-Cal *Vision Care* provider manual.

If you are unsure if a procedure requires authorization, contact the TSC at 1-800-541-5555.

Field Descriptions: 1 thru 5

Locator #	Form Field	Instructions
1	State Use Only	*Leave blank.*
1A	FI Use Only	*Leave blank. For FI use only.*
1B	Verbal Control Number	Enter a fax number to receive an AR for this TAR by fax. An AR will be mailed if the fax number is invalid or the AR is unable to be faxed via normal processing.
2	Type of Service Requested/Retroactive Request/Medicare Eligibility Status	Mark the appropriate box. If the request is retroactive, please indicate the date of service in the *Medical Justification* field.
2A	Provider Phone Number	Enter the telephone number and area code of the requesting provider.
2B	Provider Fax Number	Enter the fax number and area code of the requesting provider.
2C	Provider Name and Address	Enter provider name and address, including the nine-digit ZIP code.
3	Provider Number	Enter the 10-digit NPI number.
4	Patient Name, Address, and Telephone Number	Enter recipient information.
5	Medi-Cal Identification Number	When entering only the recipient's identification number from the BIC, begin in the farthest left position of the field. Do not enter any characters (dashes, hyphens or special characters) in remaining blank positions of the *Medi-Cal Identification Number* field or in the *Check Digit* field. The county code and aid code must be entered just above the recipient Medi-Cal Identification No. box.

Field Descriptions: 7 thru 10A

Locator #	Form Field	Instructions
7	Sex and Age	Use the capital “M” for male or “F” for female. Enter the age of the recipient in the *Age* box.
8	Date of Birth	Enter the recipient’s date of birth in a six-digit format (mmddyy). If the recipient’s full date of birth is not available, enter the year of the recipient’s birth preceded by “0101.”
8A	Patient Status (Optional)	Mark the appropriate box.
8B	Diagnosis Description and ICD-9-CM Diagnosis Code	Always enter the English description of the diagnosis and its corresponding code from the ICD-10-CM codebook.
8C	Medical Justification	Provide sufficient medical justification for the consultant to determine whether the service is medically justified. If one of the following special handling descriptors is required due to claim limitations, enter it in this field: 1. Exceeded Billing Dollar Amount 2. Exceeded Billing Frequency Limit 3. Usage is for Non-Standard Diagnosis If necessary, attach additional information. **Note:** For authorization of services with a date of service prior to the date of TAR submission, enter the Date of Service here.
9	Authorized Yes/No	*Leave blank.* This information will be indicated on the *Adjudication Response* (AR).
10	Approved Units	*Leave blank.* This information will be indicated on the AR.
10A	Specific Services Requested	Indicate the name of the procedure, item or service. If HCPCS codes V2600, V2610, V2615 or V2799 are submitted, a detailed description of the item must be provided.

Field Descriptions: 10B thru 39A

Locator #	Form Field	Instructions
10B	Units of Service	Indicate the units of service requested. **Note:** The number of units requested may differ from the approved units.
11	NDC/UPC or Procedure Code	Enter the anticipated code (five-character HCPCS, five-digit CPT [followed by a two-digit modifier, when necessary]).
12	Quantity	*Not required.* The *Units of Service* field is adequate.
12A	Charges	Indicate the dollar amount of your usual and customary charge for service(s) requested.
13 thru 32	Additional Lines 2 thru 6	Additional TAR Lines. Up to six drugs or supplies may be requested on one TAR.
32A	Patient's Authorized Representative (if any) Enter Name and Address	If applicable, enter the name and address of the recipient's authorized representative, representative payee, conservator, legal representative or other representative handling the recipient's medical and/or personal affairs.
33 thru 36	For State Use	*Leave blank.* Consultant's determination and comments will be entered on the AR.
37 thru 38	Authorization is Valid for Services Provided	*Leave blank.* Consultant will indicate valid dates of authorization for this TAR on the AR.
39	TAR Control Number	*Leave blank.* Consultant will assign a TAR Control Number (TCN) and Pricing Indicator (PI) on the AR.
39A	Signature of Physician or Provider	Form must be signed and dated by the optometrist, physician or authorized representative.

TAR Form Submission

Submission Method

The *50-3 TAR* form and associated documentation should be mailed or faxed.

Mail	Fax
Department of Health Care Services Vision Services Branch MS 4604 P.O. Box 997413 Sacramento, CA 95899-7413	(916) 440-5640

Authorization Findings

Adjudication Response

Providers no longer receive TAR adjudication results on the *50-3 TAR* form. Instead, providers receive an AR by fax with the following information, as appropriate:

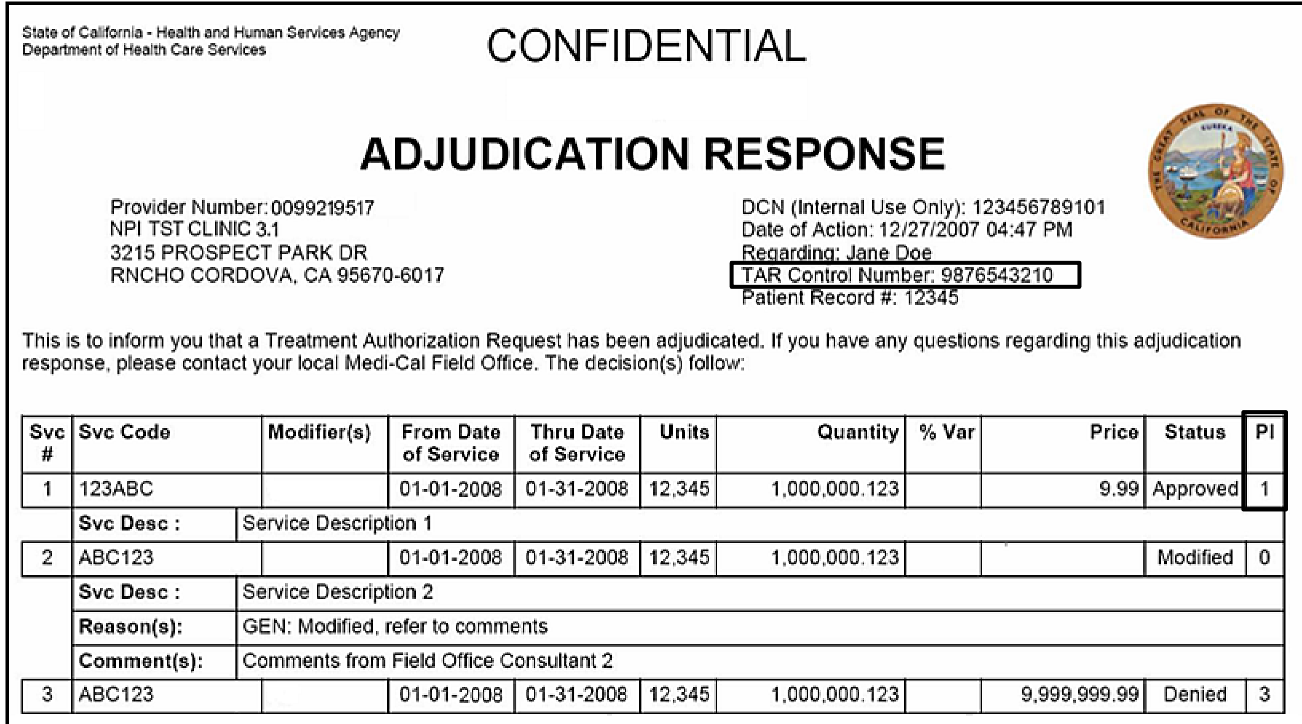
- The status of the requested services
- Information required to submit a claim for TAR-approved services
- The reason(s) for the decision(s) if the service(s) is deferred or denied
- TAR decisions resulting from an approved or modified appeal
- The TAR consultant's request for additional information, if necessary

Providers should keep a copy of the AR for resubmitting a deferred paper TAR, or when requesting an update or correction to a previously approved or modified paper TAR.

TCN and Pricing Indicator

The last column on the AR contains the Pricing Indicator (PI) number.

When submitting claims, the PI number should be included as the last (11th) digit of the TCN. Failure to use the PI when billing will cause the claim to be denied.



State of California - Health and Human Services Agency
Department of Health Care Services

CONFIDENTIAL

ADJUDICATION RESPONSE

Provider Number: 0099219517
NPI TST CLINIC 3.1
3215 PROSPECT PARK DR
RNCHO CORDOVA, CA 95670-6017

DCN (Internal Use Only): 123456789101
Date of Action: 12/27/2007 04:47 PM
Regarding: Jane Doe
TAR Control Number: 9876543210
Patient Record #: 12345

This is to inform you that a Treatment Authorization Request has been adjudicated. If you have any questions regarding this adjudication response, please contact your local Medi-Cal Field Office. The decision(s) follow:

Svc #	Svc Code	Modifier(s)	From Date of Service	Thru Date of Service	Units	Quantity	% Var	Price	Status	PI
1	123ABC		01-01-2008	01-31-2008	12,345	1,000,000.123		9.99	Approved	1
	Svc Desc :	Service Description 1								
2	ABC123		01-01-2008	01-31-2008	12,345	1,000,000.123			Modified	0
	Svc Desc :	Service Description 2								
	Reason(s):	GEN: Modified, refer to comments								
	Comment(s):	Comments from Field Office Consultant 2								
3	ABC123		01-01-2008	01-31-2008	12,345	1,000,000.123		9,999,999.99	Denied	3

Figure 8.1: Example of the AR with PI.

Knowledge Review

1. What is the 11-digit TCN used in the AR document when submitting a claim for Service #1?

____

See the Appendix for the Answer Key.

Billing Tips

Claim Submission

Providers bill Medi-Cal for TAR-authorized services (medically necessary contact lenses and examinations, low vision aids, prosthetic eyes and other non-PIA covered items) only after receiving the approved AR from the VSB. If the TAR approval process causes a delay in submitting claims, providers may request an extension of the usual six-month billing limit by entering the appropriate delay reason code in the *EMG (Delay Reason)* field (Box 24C) of the claim.

To submit a claim for services authorized by a TAR, complete these steps:

- Ensure that the procedure codes, modifiers and dates of service on the claim match those shown on the approved AR. The cumulative number of units billed (for each procedure) against a particular TAR must not exceed the number of units approved by the TAR.
- Enter the 10-digit TCN and one-digit PI from the AR in the *Prior Authorization Number* field (Box 23) on the *CMS-1500* claim form.
- Enter the TCN on all claims for services authorized on one TAR, even if the services are billed on separate claims.

Billing Policies

- **Multiple TARs/Separate Claims**

  Items or procedures approved on separate TAR forms must be billed on separate claim forms. Items covered on two TARs must not be combined on a single claim. Do not bill TAR-approved and non-TAR items on the same claim.

- **Copies of TARs**

  Providers must not submit copies of TARs with claims as proof of authorization. Instead, providers should accurately and legibly copy the entire 11-digit TCN and PI in the *Prior Authorization Number* field on the claim form. Omissions, errors or illegibility will cause claim denial. Providers may submit copies of TARs with appeals and *Claims Inquiry Forms* (CIFs) to show that there is an error in the TAR information.

- **Corrections**

  Providers may request the Vision Services Section (VSS) to correct or modify recipient information on a TAR within a year of the TAR's original approval date. The DHCS consultant will not change the recipient's Medi-Cal ID number, Social Security Number (SSN), name, date of birth or sex if the TAR is more than one year old.

- **Mismatched Data**

  If a claim is denied because recipient data on the claim does not match the recipient data on the AR, providers may request claim reconsideration by attaching a copy of an AR to a CIF.

Navigating to Reference Materials

The Medi-Cal Providers website homepage can be accessed by opening an internet browser, typing *mcweb.apps.prd.cammis.medi-cal.ca.gov* in the address bar and pressing **Enter**.

To access provider communities and their associated reference materials, navigate to Publications from the Providers drop-down menu.

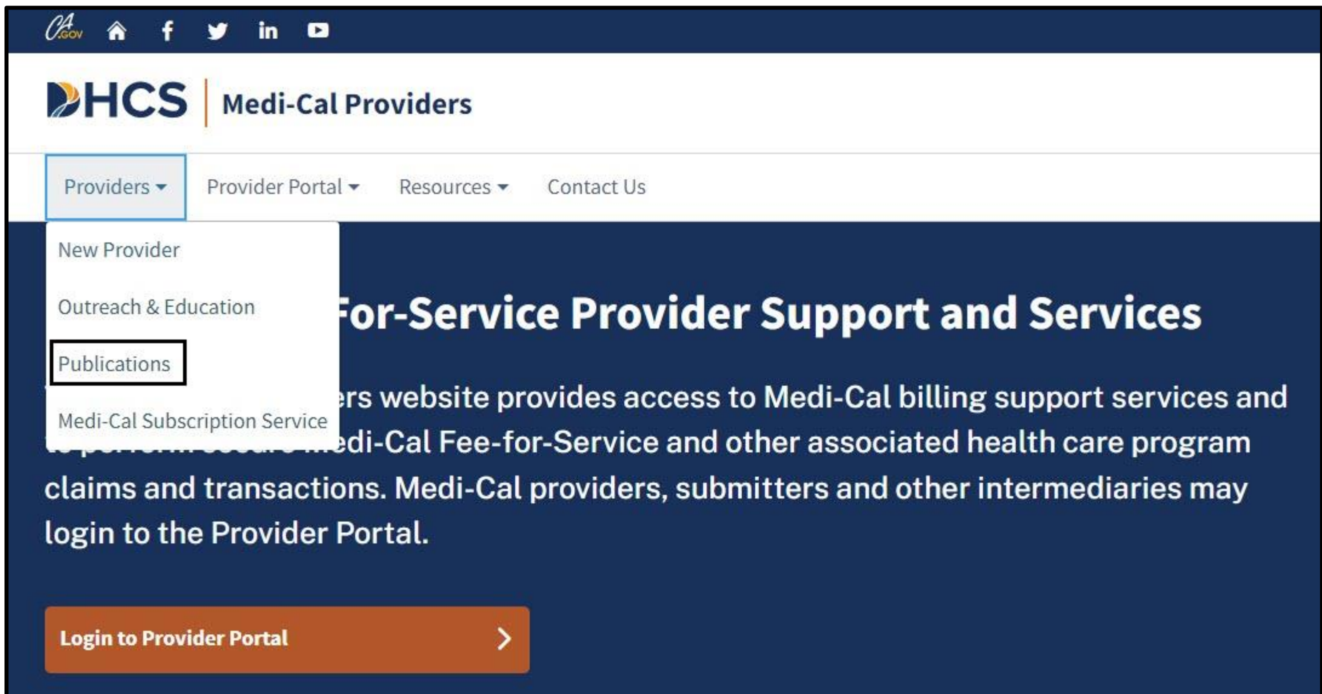


Figure 9.1: The Publications tab under the Medi-Cal Providers drop-down menu.

Provider communities are services with published materials. Under the Communities, a link for Vision Care is displayed.

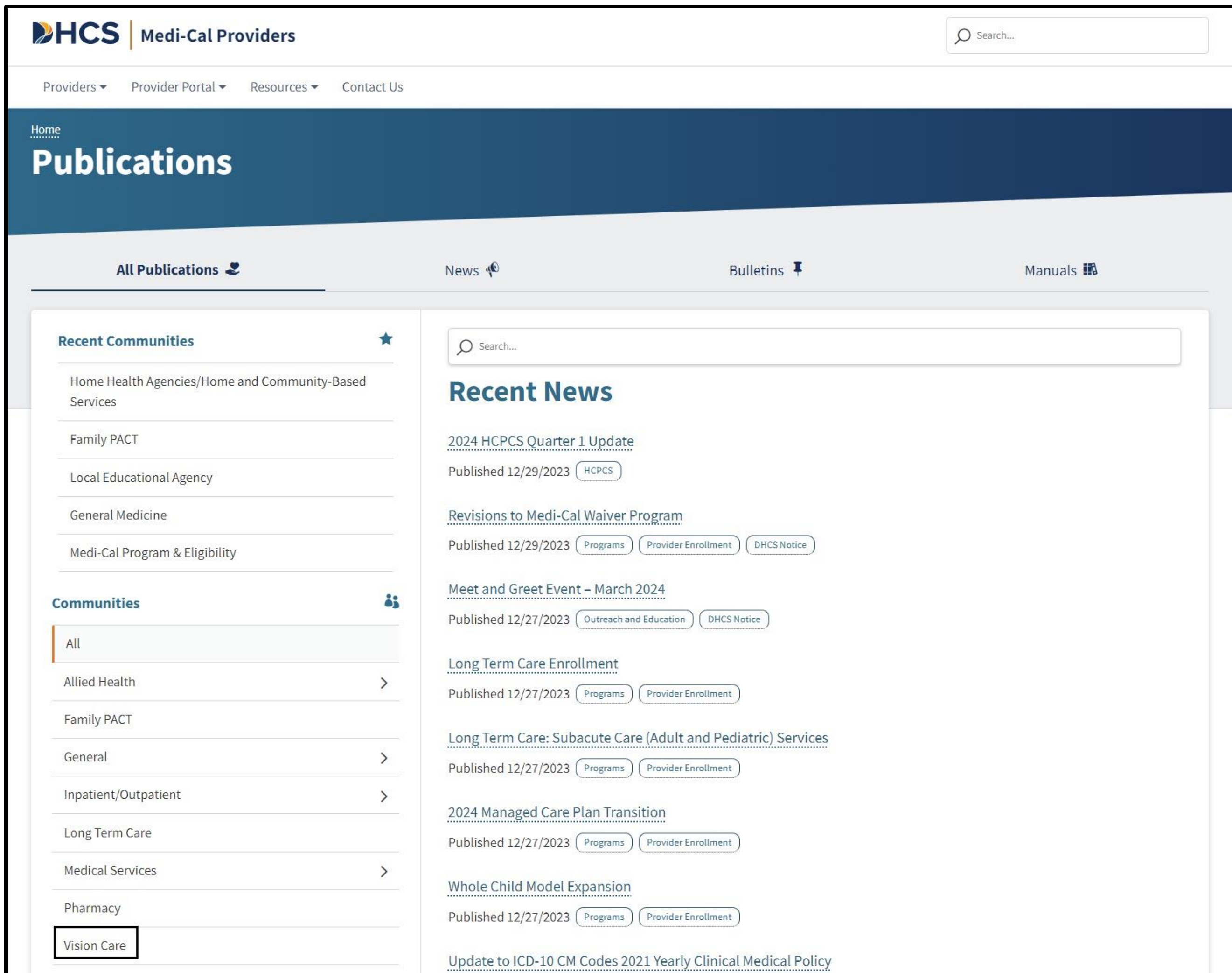


Figure 9.2: The Vision Care Community link under Communities.

The Vision Care community homepage will show recent news articles for the community. Using the navigation bar at the top, both bulletins and manuals can be displayed.

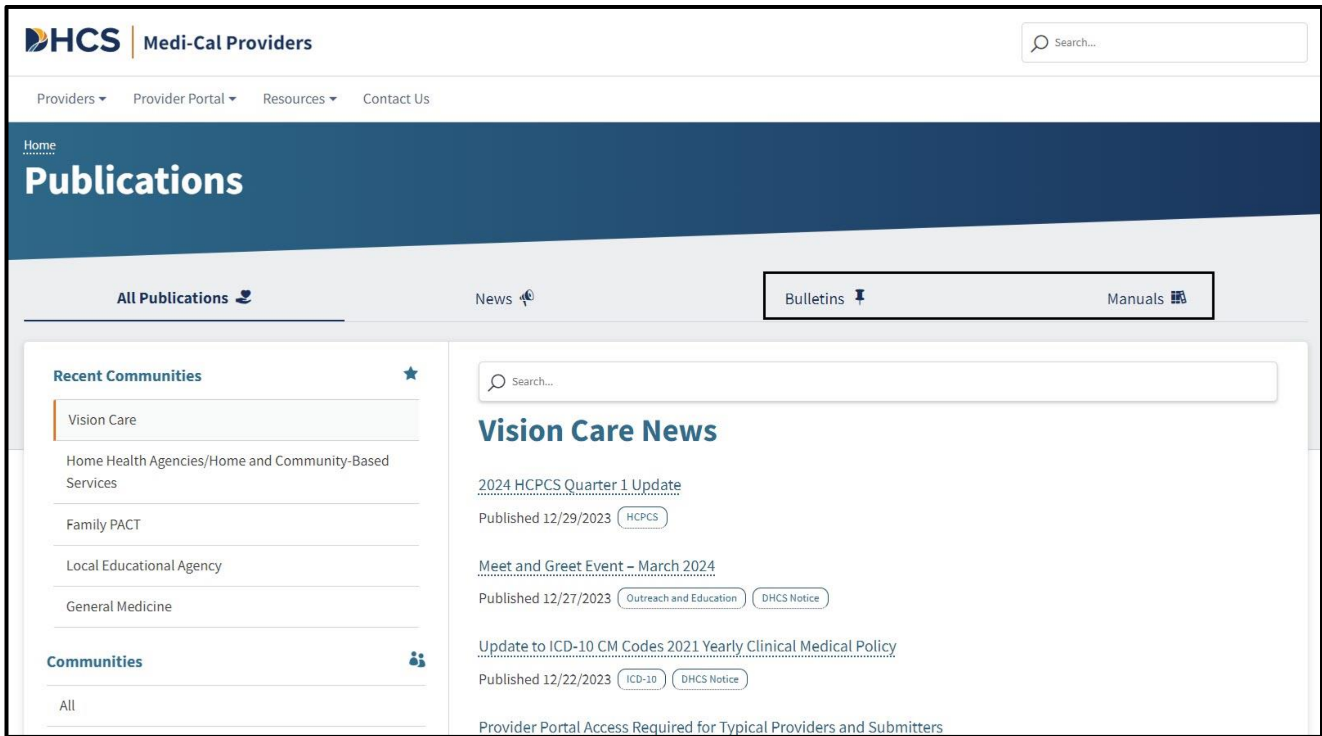


Figure 9.3: Vision Care Community page navigation links.

Resource Information

References

Provider Manual References

The following reference materials provide Medi-Cal program and eligibility information.

Part 1

Computer Media Claims (cmc)
CMC Enrollment Procedures (cmc enroll)

Part 2

CMS-1500 Completion for Vision Care (cms comp vc)
CMS-1500 Special Billing Instructions for Vision Care (cms spec vc)
CMS-1500 Submission and Timeliness Instructions (cms sub)
CMS-1500 Tips for Billing (cms tips)
Forms Reorder Request: Guidelines (forms reo)
Medicare/Medi-Cal Crossover Claims: CMS-1500 (medi cr cms)
Modifiers: Approved List (modif app)
TAR Completion for Vision Care (tar comp vc)

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
*	Check the CPT book for guidelines in using this modifier.
†	Use modifier SC with CPT code 68761 to indicate the use of temporary collagen punctual plugs. Use modifiers E1 thru E4 for permanent plugs.
‡	CPT codes 92370 and 92371 are used to bill frame repair, including parts, under Medi-Cal.
◊	Split-billable and must be billed with the appropriate modifiers (26, TC). To bill for both, enter one modifier on one line and the corresponding modifier on second line.
§	HCPCS code V2599 is used to bill bandage contact lenses only under Medi-Cal