West Coast Billing Guides

West Coast Reimbursement Support Specialist

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The following information is for general reference only, and is data collected from provider remittance advisements as reported by TearLab customers. If you experience discrepancies from this guide, please contact the TearLab Reimbursement Support Center at RSC@tearlab.com with updated information.

Thank you.

CPT Code 83861, "Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolality" is a covered service by CMS Medicare under the Laboratory Fee Schedule. CLIA Certification is required to perform and bill laboratory tests. The following information is intended as a **reference guide only**. Providers are encouraged to review payor-provider contracts for rate and claim submission requirements.

Reimbursement for Medicare Part B (fee-for-service)

2018 Clinical Laboratory Fee Schedule (CLFS) Rate:

- $22.48 per test/eye ($44.96 per patient)

Sequestration Withhold

- Medicare intermediaries are required to withhold two-percent of the allowable rate for all Medicare covered services.

Medicare CMS Part B Deductible and Coinsurance

- Medicare pays at 100% of CLFS allowable rate.
- Laboratory services are not subject to the Medicare Part B deductible and the patient pays no coinsurance or copayment for covered laboratory testing.
- These rules are not mandatory for Medicare Advantage CMS Part C plans. Check coverage and payment rules for each Medicare Advantage plan for payment rules.

Mandatory Assignment

- Providers are prohibited from collecting payment from a Medicare Part B beneficiary for clinical laboratory tests.
- CLFS payment will be made directly to the provider

Billing CPT Code 83861

Billing rules and payment policies vary by payor such as the use of modifiers, bundling edits, units and reporting a CPT code on single or multiple lines CPT code reporting, etc.

- For **Medicare claim report** CPT Code 83861 QW twice, using two claim lines (one claim line for the left eye (LT) and the second claim line for the right eye (RT)) and enter (1) unit for each test billed (see example below):

	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 Cirrcumstances) CPT (HCPCS)	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL.	J. RENDERING PROVIDER ID #
1.	01	02	16	01	02	16			83861	QW	LT					1		NPI	123456789
2.	01	02	16	01	02	16			83861	QW	RT					1		NPI	123456789

Additional Medicare CMS 1500 form Requirements

- **CMS 1500 Box 17. – Name of Referring Provider or Other Source and NPI number**
  - Enter the provider's individual (Type I) NPI number (see further instructions below):

17.	Name of Referring Provider or Other Source	17a.		
(1)	(2)	17b.	NPI	(3)

(1) *Enter one of the following qualifiers:*
- DN = Referring Provider
- DK = Ordering Provider
- DQ = Supervising Provider

(2) Enter the last and first name of the ordering/referring provider number only. NOTE: Do **not** enter "nicknames", credentials (e.g., "Dr.", "MD", "RPNA", etc.) or middle names (initials) in the Ordering/Referring name field, as their use will cause the claim to fail system edits.

(3) Enter the Type I (individual) NPI number of the ordering/referring provider.

- **CMS 1500 Box 20. – Outside Lab?**
  - Check the "No" box

20. OUTSIDE LAB? $ CHARGES		
☐ YES		
☑ NO		

- **CMS 1500 Box 23. – Prior Authorization**

- Enter your CLIA certificate number. This is a requirement for Medicare FFS, as well as all Medicare Advantage claims.

23. Prior Authorization Number

- **Electronic claims** – Contact your TearLab Reimbursement Advocate. TearLab will provide one-on-one assistance to ensure the CLIA number is transmitting in the required electronic data format, as described below.
- **ANSI 5010 E-claim Crosswalk**

  In loop 2300, Segment REFO2, enter the CLIA Certification number – 10 digits - (Do not enter "CLIA" with the certificate number as this will cause claims to deny as an invalid identification number).

CLIA Crosswalk – CMS1500 to E-claim Format

Field #	Claim Description	Loop	Segment	Electronic Description
23.	Prior Authorization number	2300	REF01	Reference identification qualifier =**X4**
			REF02	CLIA Certification number

Common Notification Reasons for Medicare Denials

If there is no CLIA number on the claim, Medicare sends RA messages MA 120 and MA 130, which state:

- MA 120 - Did not complete or enter accurately the CLIA number.
- MA 130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim in unprocessable. Please submit the correct information to the appropriate FI or carrier.
- B7 - "This provider was not certified/eligible to be paid for this procedure/service on this date of service."
- The laboratory is not approved for this type of test.

Common Issues for Claim Denial

- Incorrect code used – Always use 83861
- Billing software not configured with X-4 Qualifier in box 23.
- Using the Group NPI instead of individual Physician NPI in box #17.
- Using state issued CLR ID# instead of CLIA # in box 23.

State Medicaid and Managed Medicaid Programs

Congress has granted each statutory authority to establish and manage nearly all aspects of its Medicaid program. This includes but is not limited to provider credentialing and enrollment, coverage and non-coverage policies, claim submission and processing and rules, and determining fee schedule rates for services rendered, etc. Therefore, it is critical to contact your TearLab Reimbursement Support Specialist for assistance.

Commercial, Third Party Payors, Medicare Advantage and Managed Medicaid Plans

Claim submission rules, coverage policies and reimbursement rates may vary by payor-provider contract and patient benefit plans.

- TearLab does track reimbursement rates by client by geographic location. Please contact TearLab's Reimbursement Support Center at rsc@tearlab.com for availability of known reimbursement rates and billing information and assistance.
- TearLab has created a list of known claim submission requirements, e.g., payor rules by state for reporting CPT code 83861 on (1) one claim line versus (2) two, number of units, and use of modifiers, when applicable. Please contact TearLab's Reimbursement Support Center for a copy of this document.

Ordering Diagnostic Tests

All diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary, that is, the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. (42 Code of Federal Regulation 410.32(d))

- Medical record must specify "tear osmolarity test ordered"
- "Test ordered" is insufficient documentation

ICD-10 Diagnosis Coding

Sign and symptom assessment is a key component of dry eye diagnosis. Diagnosis codes that describe symptoms and signs, as opposed to diagnosis, should be reported for billing purposes when a diagnosis has not been established by the physician.

> **"Screening is the testing for disease or disease precursors so that early detection and treatment can be provided for those who test positive for the disease. Screening tests are performed when no specific sign, symptom, or diagnosis is present and the patient has not been exposed to a disease. "The testing of a person to rule out or to confirm a suspected diagnosis because the patient has a sign and/or symptom is a diagnostic test, not a screening. In these cases, the sign or symptom should be used to explain the reason for the test." (**Centers for Medicare and Medicaid Services, Clinical Diagnostic Laboratory Services, January-2013)

Alternatively, if the physician has confirmed a diagnosis based on the results of the diagnostic test, the physician interpreting the test should code that diagnosis. The signs and/or symptoms that prompted ordering the test may be reported as additional diagnoses if they are not fully explained or related to the confirmed diagnosis. Please contact TearLab's Reimbursement Support Center for a list of the most common ICD-10 codes associated with dry eye disease.

- Always code to the highest level of specificity
- TearLab has created a crosswalk list of common ICD-9 to ICD-10 diagnostic codes associated with dry eye disease.
- Please contact your TearLab Reimbursement Advocate of a copy of the ICD-10 Crosswalk

Documentation Requirements

Medicare has several requirements for covering and reimbursing diagnostic tests such as tear osmolarity, which must be documented in the patient's medical record. In addition to general documentation requirements the medical record must include all of the following:

1. The sign or symptom of disease documented as a chief or secondary complaint
2. Medical record must specify "tear osmolarity test ordered."
3. Tear osmolarity test results
4. Treatment/management Plan - the medical action taken as a result of the tear osmolarity test
5. Services provided/ordered must be authenticated by the provider and must be:
    a. Legible handwritten signature at the end of the record; or electronic signature
6. Questionnaires, if used, must be reviewed and ideally signed (legible) by the provider

Request for Supporting Documentation and Audits

The doctor is ultimately responsible for documenting and coding of all services and submitted for reimbursement. All medical records requests should be reviewed by the treating physician before any information is released to the requesting party.

When responding to requests for medical records it is critical to provide all documentation relevant to the date(s) of service requested. In most cases simply sending the SOAP (Subject, Objective, Assessment, Plan) note will not be sufficient and may result in denial and/or recoupment of previously paid amounts. The patient's record should be thoroughly reviewed to ensure all supporting documentation is provided. This may include, questionnaires, medication lists, laboratory orders, test results, and even chart notes from previous dates of service. In short, be sure to provide all information used in medical decision making for the date of service documentation has been requested. Remember that handwritten medical records must be legible and signed and dated by the doctor.

Reasons for Audit Failure - Billed Laboratory Services

- A note stating "Ordering Lab" is not sufficient
- Illegible chart notes
- Failure to provide the specified documentation within the required timeframe (Medicare Part B within 45-days from the date of the request)
- Missing treatment plan
- Missing or unsigned chart notes
- Missing order for specific test or medical record does not clearly reflect physicians intent to order
- Documentation does not support medical necessity for billed test
- Use of signature stamp

Resources

TearLab Reimbursement Support Center

Website: www.tearlab.com

TearLab provides its clients with one-on-one assistance

- Financial analysis (CPT 83861)
- ICD-10 Coding
- Payor-Provider contracts
- Billing rules and medical policies
- Payment denials and appeals

Center for Medicare and Medicaid Services (CMS)
Website: www.cms.hhs.gov

Alaska

Payor Name	Lines	Modifier(s)	Units per Line	Average Allowable Per Eye
AARP Medicare Advantage	1	None	2	$9.90
Cigna	1	None	2	$15.14
Aetna	2	RT/LT	2	$14.16
GEHA	1	None	2	$26.32
Medicaid - Optometry	N/A	N/A	N/A	Not Covered
Medicaid - MD/DO (**must apply as independent lab)**	1	None	2	$22.03
Medicare Part B	2	QW,RT/LT	1	$22.66
Premera	1	None	2	$22.71
Tricare - Anchorage Metro Area	1	None	2	$27.04
Tricare - Rest of AK	1	None	2	$27.04
UMR	2	None	1	unknown
United Health Care	1	None	2	$9.90
VSP Primary Care	2	RT/LT	1	$18.86

Arizona

Payor Name	Lines	Modifier(s)	Units per Line	Average Allowable Per Eye/Test
AARP Medicare Advantage	1	QW	2	$9.90
AARP Medicare Complete BHN				$21.21
AARP Medicare Complete HMO				
Aetna	2	RT/LT	1	$20.04
Arizona physicians IPA				
Banner Health (authorization required)	1	QW	2	$18.00
BCBS AZ	2	RT/LT	1	$21.94
BCBS AZ Advantage (carve-out)				Contract rate
CareMore ESAN				
Cigna	2	RT/LT	1	$15.14
Healthcare Partners & Healthcare				

Partners				
Healthchoice Arizona (either format is acceptable)	1 2	QW QW	2 1	$19.49
Healthchoice Generations	1	QW	2	$22.50
HealthNet (All Products)	2	RT/LT	1	$22.54
Health Plan of Nevada	2	RT/LT	1	$23.40
Humana - Commercial *(Lab carve-out was previously obtained by provider. 83861 is typically "bundled" with the office visit)*	2	RT/LT	1	$19.86
Humana - Medicare Advantage	2	RT/LT	1	$19.86
Humana Gold Plus HMO (carve out)				Contracted rate
Medicaid (AHCCCS)	2	RT/LT	1	$19.49
Medicare Part B	2	QW,RT/LT	1	$22.66
Mercy Care Plan (*Prior Authorization is required*)	1	QW	2	$19.64
Meritain Health				
Secure Horizons ESAN (Carve out. Covered ever 365 day. Additional testing requires authorization)				Contacted rate
Tricare	1	None	2	$22.48
UMR				
United Healthcare	1	None	2	$9.90
United Healthcare Dual				
United Healthcare Dual Complete HMO				$19.64
Veterans Administration (carve-out)				Contract rate
VSP **Primary** Care	2	RT/LT	1	$18.86

California

Payor Name	Lines	Modifier(s)	Units per Line	Average Allowable Per Eye/Test
AARP Medicare Advantage	1	QW	2	$9.90
Aetna	2	RT/LT	1	$18.63
Alameda Alliance	1	None	2	$17.13
Anthem Blue Cross	1	None	2	$14.53
Blue Shield of CA	1	None	2	$18.16
California Health and Wellness	1	None	2	$17.80
CalOptima	1	QW	2	$20.29
Cigna HealthCare CA	1	QW	2	$15.54
GEHA	1	None	2	$19.57
Health Partners	2	RT/LT	1	$17.17
HealthNet of California	2	RT/LT	1	$22.50
Health Plan of San Joaquin	1	None	2	$12.64
Hill Physicians	2	RT/LT	1	$21.38- $22.23

Humana (Commercial)	2	RT/LT	1	Bundled
Humana Gold	2	RT/LT	1	$22.50
Humana Medicare Advantage	2	RT/LT	1	$22.26
Mail Handlers				$19.57
Medi-Cal (Xerox) *Supplemental application required (DHCS 6209)*	1	None	2	$18.17
Medicare Part B	2	QW, RT/LT	1	$22.66
Memorial Healthcare Foundation FFS	2	LT/RT	1	$22.09
Monarch FFS (authorization required)	1	RT/LT	2	$ 9.71
Partnership Health of CA	1	None	2	$17.82
Prospect Medical	1	QW	2	$18.03
Rail Road Medicare	1	QW	2	$22.77
SCAN Health Plan	1	QW	2	$17.82
Sharp (Carve-out required)	2	QW, LT, RT	1	$22.50
Tricare - Anaheim/Santa Ana	1	None	2	$26.21
Tricare - Los Angeles	1	None	2	$24.74
Tricare - Marin/Napa/Solano	1	None	2	$27.16
Tricare - Oakland/Berkeley	1	None	2	$27.16
Tricare - San Francisco	1	None	2	$27.16
Tricare - San Mateo	1	None	2	$27.16
Tricare - Santa Clara	1	None	2	$27.16
Tricare - Ventura	1	None	2	$24.49
Tricare - Rest of CA	1	None	2	$24.49
United HealthCare	1	None	2	$ 9.90
UMR	1	None	2	Unknown
VSP Primary Care	2	QW, RT/LT	1	$18.86

Colorado

Payor Name	Lines	Modifier(s)	Units per Line	Average Allowable Per Eye/Test
AARP Medicare Advantage	1	QW	2	$ 9.26
Aetna Medicare Advantage	2	RT/LT	1	$14.10
Aetna PPO	2	RT/LT	1	$14.39
Anthem Blue Cross	2	QW, LT/RT	1	unknown
Ameriben	1	QW	2	$21.04
BCBS of CO	2	RT/LT	1	$ 9.47
Cigna	2	RT/LT	1	$11.11
Cofinity	2	RT/LT	1	$15.12
Corsource	2	RT/LT	1	$14.15
EMBS	1	None	2	$18.51
Humana - Commercial	2	RT/LT	1	$11.33
Humana - Medicare Advantage	2	RT/LT	1	$11.33

Medicaid (OD's not currently recognized as a rendering provider)	1	None	2	$18.27
Medicare Part B	2	QW, RT/LT	1	$22.66
Rocky Mountain Health Plan	1	None	2	$22.50
Secure Horizons	2	RT/LT	1	$23.54
Tricare	1	None	2	$20.60
UMR (subsidiary of UHC)	1	None	2	$9.90
United HealthCare	1	None	2	$ 9.90
Veterans Administration (VA)	2	RT/LT	1	$22.80
VSP Primary Care	2	RT/LT	1	$18.86

***Premier Eyecare**: The QW modifier must be in the first position.*
For example: 83861QWRT and 83861QWLT

Hawaii

Payor Name	Lines	Modifier(s)	Units per Line	Average Allowable Per Eye/Test
AARP Complete UHC	2	RT, LT, QW	1	unknown
AARP Medicare Advantage Plan	1	QW	2	$9.90
AARP Medicare Complete Choice (Group#77007 &70000)	2	RT, LT, QW	1	unknown
AARP Medicare Essential PPO (Group# 77003 & 7008)	2	RT, LT, QW	1	unknown
Aetna	2	RT, LT	1	$31.78
Aetna Medicare				$22.12
Aetna Medicare Advantage				$26.54
AlohaCare Med Advantage Plan	1	RT,LT	1	$24.76
AlohaCare Quest Plan	1	RT, LT	1	$16.98
Blue Card Hawaii				$30.32
Hawaii Mainland Administrators (HMA, Inc)				$24.19
Hawaii Medical Assurance Assoc. (HMAA)	1	None	2	$23.77
HMSA Advantage	2	None	1	$30.20
HMSA BCBS HI	1	None	2	$15.13
HSMA Akamai	2	None	1	$22.23
HMSA HMO	2	None	1	$29.02
HMSA-Quest				$26.16
HPAC				$28.93
HPH				$28.95
Humana - Commercial	2	RT, LT, QW	1	$22.18
Humana - Medicare Advantage	2	RT,LT,QW	1	$22.48
Humana Advantage-MDX	2	RT,LT, QW	1	unknown

Humana Medicare Advantage PPFS	2	RT, LT, QW	1	$22.46
Medicaid-Community Plan	1	None	2	$23.58
Medicare Part B	2	RT,LT, QW	1	$22.66
Ohana Medicare Advantage	2	QW. LT, RT	1	$22.50
Premier Eyecare-QEXA (QW first position)	2	QW, RT,LT	1	$23.58
Premier Eyecare-Medicare (QW first position)	2	QW, RT,LT	1	$22.48
Tricare Prime	1	None	2	$28.94
UHA				$27.25
United Health Care	1	None	2	$9.90
United Health Care-Community Plan				$22.19
VSP Primary Care	2	RT/LT	1	$18.86

Idaho

Payor Name	Lines	Modifier(s)	Units per Line	Average Allowable Per Eye/Test
AARP Medicare Advantage	1	QW	2	$9.90
Aetna	2	RT/LT	1	$21.52
Anthem Blue Cross of California	2	RT/LT	1	$14.53
BCBS Idaho	1	None	2	$25.27
BCBS Regence ID	1	None	2	$22.71
Cigna	1	QW	2	$15.23
Deseret Mutual	2	None	1	unknown
Medicaid	1	None	2	$20.29
Medicare Part B	2	QW, RT/LT	1	$22.66
Pacific Source	2	RT/LT	1	$20.29
Premera	1	None	2	$22.71
Select Health Advantage	1	None	2	$18.78
Tricare	1	None	2	$20.61
United HealthCare	1	None	2	$ 9.90
VSP Primary Care	2	RT/LT	1	$18.86

Montana

Payor Name	Lines	Modifier(s)	Units per Line	Average Allowable Per Eye/Test
AARP Medicare Advantage	1	QW	2	$9.90
Blue Cross Blue Shield of Montana	2	RT/LT	1	$30.00
Cigna (O.D not covered)	1	QW	2	$15.23

Medicaid	1	None	2	$38.74
Medicare Part B	2	QW, RT/LT	1	$22.21
Tricare	1	None	2	$20.23
United HealthCare	1	None	2	$9.90
UHC TriCare	2	RT/LT	1	Unknown
Veterans Choice Health Plan *(pre-authorization required)*	1	None	2	Unknown
VSP Primary Care	2	RT/LT	1	$18.86

Nevada

Payor Name	Lines	Modifier(s)	Units per Line	Average Allowable Per Eye/Test
AARP Medicare Advantage	1	QW	2	$ 9.90
Aetna Medicare Advantage	2	RT/LT	1	$ 21.95
AmeriGroup	2	RT/LT	1	$ 22.54
BCBS FEP	2	RT/LT	1	$ 10.54
Caremore	n/a	n/a	n/a	Unknown
Clark County Employees	2	RT/LT	1	$ 14.97
Culinary Health	n/a	n/a	n/a	Not Covered
GEHA	n/a	n/a	n/a	Unknown
Health Plan of Nevada	1	None	2	$ 22.09
Humana - Commercial	n/a	n/a	n/a	Bundled
Humana - Medicare Advantage	1	None	2	$ 22.54
Medicaid - Optometry	n/a	n/a	n/a	Not Covered
Medicaid - MD/DO	1	None	2	$ 21.41
Medicaid (Managed Care)	2	RT/LT	1	$ 21.41
Medicare Part B	2	QW, RT/LT	1	$ 22.66
Sierra Health and Life	2	RT/LT	1	$ 18.17
Tricare	1	None	2	$ 22.96
United HealthCare	1	None	2	$ 9.90
Ventian UMR	2	RT/LT	1	$ 18.17
VSP Primary Care	2	RT/LT	1	$ 18.86

New Mexico

Payor Name	Lines	Modifier(s)	Units per Line	Average Allowable Per Eye/Test
AARP Medicare Advantage	1	QW	2	$9.90
Aetna	2	RT/LT	1	$20.04
BCBS	2	RT/LT	1	$23.58
Cigna	2	RT/LT	1	$15.54

Humana (commercial & Medicare Advantage) Carver out required	2	RT/LT	1	$11.33
Medicaid (State of New Mexico)	2	QW, RT/LT	1	$15.75
Medicare Part B	2	QW, RT/LT	1	$22.66
Molina HealthCare (Medicaid)	1	QW	2	$18.86
Presbyterian Centennial Care (Medicaid)	2	QW, RT/LT	1	$24.07
Presbyterian Health	2	RT/LT	1	$15.90
Tricare - Tri-West - CHAMPUS	1	None	2	$21.07
United Healthcare	1	None	2	$9.90
VSP Primary Care	2	RT/LT	1	$18.86

Oregon

Payor Name	Lines	Modifier(s)	Units per Line	Average Allowable Per Eye/Test
AARP Medicare Advantage	1	None	2	$9.90
Aetna	2	RT/LT	1	$20.04
Atrio Health Plans	2	RT/LT	1	$21.03
BCBS FEP	2	RT/LT	1	$21.88
BCBS Regence Oregon	1	None	2	$21.88
Blue Cross Premera	1	None	2	$14.15
Cigna	2	RT/LT	1	$14.15
HealthNet	2	RT/LT	1	$20.28
HealthNet - Medicare Advantage	2	RT/LT	1	$19.64
Intercommunity Health Network	2	RT/LT	1	$23.40
LifeWise	2	None	1	unknown
Medicaid	n/a	n/a	n/a	Not Covered
Medicare (Noridian)	2	QW, RT/LT	1	$22.66
ODS Companies	1	None	2	$26.00
Oregon Health Coop	1	None	2	unknown
Pacific Source- Commercial	1	None	2	$27.25
Pacific Source-Medicare Advantage	2	RT, LT, QW	1	$27.25
Providence Health Plan	2	RT/LT	1	$23.40
Tricare - Portland Metro	1	None	2	$20.43
Tricare - Rest of OR	1	None	2	$20.43
UMR	1	None	2	Unknown
United Healthcare	1	None	2	$9.90

Utah

Payor Name	Lines	Modifier(s)	Units per Line	Average Allowable Per Eye/Test
AARP Medicare Advantage	1	None	2	$9.90
Aetna	2	RT/LT, QW	1	$ 18.86
Altuis	1	None	2	$22.03
BCBS	2	RT, LT, QW	1	$14.98-$19.16
BCBS Regence	2	RT/LT	1	$ 20.95
Deseret Mutual	2	No modifier on line one. Modifier 59 on line two.	1	unknown
Cigna	1	None	2	$9.00-$11.29
EMI	**2**	RT, LT, QW	1	$20.29
Humana - Commercial	**1**	**RT/LT**	**2**	**Bundled**
Humana - Medicare Advantage	1	RT/LT	2	$ 19.90
IHC	1	None	2	$20.29
Medicaid	n/a	n/a	n/a	Not Covered
Medicare Part B	2	QW, RT/LT	1	$ 22.66
Medicare Complete	1	QW	2	$ 9.25
Meritain Health	2	None	1	unknown
PEHP	1	None	2	$18.52
Select Health Adv.	1	None	2	$18.78
Tricare - Tri-West - CHAMPUS	1	None	2	$ 20.70
UMR	2	None	2	$14.15
University of Utah Health Plans (U of U)	1	QW	2	$32.50
United HealthCare	1	QW	2	$ 9.90
VSP Primary Care	2	RT/LT	1	$ 18.86

Washington

Payor Name	Lines	Modifier(s)	Units per Line	Average Allowable Per Eye/Test
AARP Medicare Advantage	1	None	2	$9.90
AARP UHC Medicare Complete				
Aetna	2	RT,LT	1	$20.04
AmeriBen	1	QW	2	$21.04
Ameritas	2	RT,LT, QW	1	$14.53
Anthem Blue Cross	2	RT,LT, QW	1	$14.53
Asuris Northwest Health				
Blue Cross/Blue Shield Fed. Emp.	1	QW	1	$16.09
Blue Cross/Blue Shield Highmark	2	RT,LT	1	$15.90
Blue Cross Premera	1	None	2	$22.71

Blue Cross Regence	2	RT,LT	1	$22.71
Carpenters Trust of Western WA	2	RT,LT	1	unknown
Cigna	2	RT,LT	1	$18.86
Community Health Plan	2	RT,LT	1	$22.54
EBMS				Based on individual patient benefits
First Choice Health				Based on individual patient benefits
$24.00	2	RT,LT	1	
Group Health Options				$19.73
Health Alliance Advantage				
Health Alliance Commercial				
Health Comp				Based on individual patient benefits
Humana Medicare Advantage & Commercial (**MUST** request a "carve out" for CPT code 83861)	2	LT, RT, QW	1	$22.50
HMA	2	RT,LT	1	$22.54
Idaho Medicaid	2	LT,RT	1	$20.29
Medicaid (***only covered for those patients that are QMB eligible***)	2	LT, RT, QW	1	$18.00
Medicare Part B	2	RT,LT, QW	1	$22.66
Meritain Health	2	RT,LT	1	unknown
Pacific Underwriters (PURMS)				Based on individual patient benefits
Providence Health Plan				$18.31
Regence BCBS	2	RT/LT	1	$22.74
Soundpath **(Medicare Advantage Plan)**		Pending email reply		
Tricare - Seattle	1	None	2	$18.76
Tricare - Rest of WA	1	None	2	$18.90
United Healthcare	1	None	2	$9.90
VSP Primary Care	2	RT/LT	1	$18.86

Wyoming

Payor Name	Lines	Modifier(s)	Units per Line	Average Allowable Per Eye/Test
AARP Medicare Advantage	1	None	2	$9.90
Medicaid	n/a	n/a	n/a	Not Covered
Medicare Part B	2	QW, RT/LT	1	$22.66
Tricare - Tri-West - CHAMPUS	1	None	2	$20.63
VSP Primary Care	2	RT/LT	1	$18.86

Puerto Rico

st
1 Coast Medicare
Humana Medicare Advantage (Gold)
Constellation Health (certification not required)
Molina Health Plan Medicaid
MMM

14. DATE OF CURRENT: MM DD YY / ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
01 01 2015		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Dr John Doe	17a. / 17b. NPI XXXXXXXXX	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. ICD 10 2. 3. 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER: CLIA 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. #
01 01 2015 01 01 2015	11		83861	QW LT	A	$ $$			NPI	XXXXXXXXX
01 01 2015 01 01 2015	11		83861	QW RT	A	$ $$			NPI	XXXXXXXXX

Medical Card Service (MCS) Commercial

- When billing two units on one line, double your fee in box 24F, so that the amount reflects the two units that are being billed.

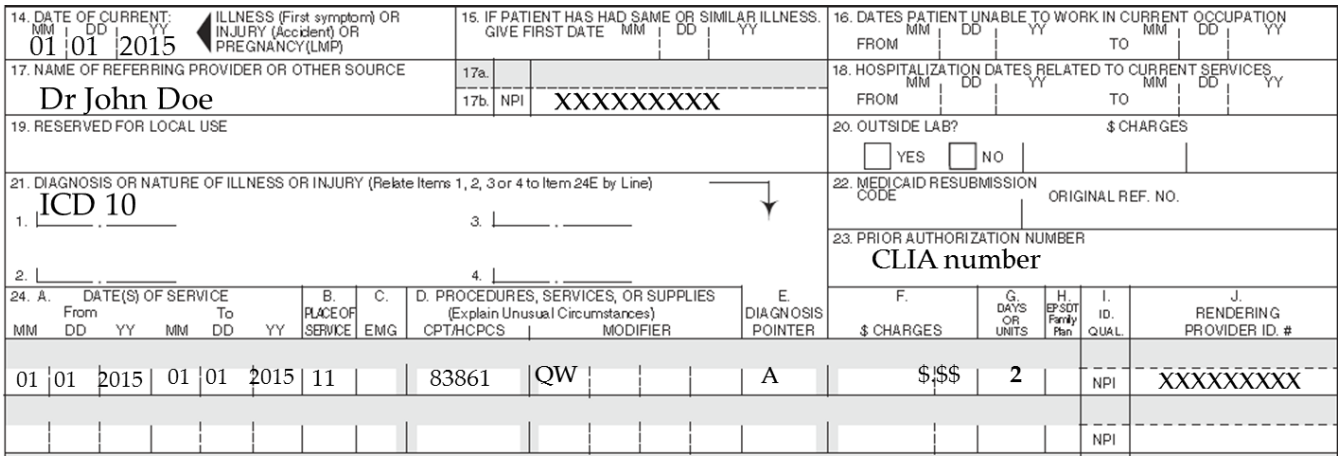
14. DATE OF CURRENT: MM DD YY / ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
01 01 2015		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Dr John Doe	17a. / 17b. NPI XXXXXXXXX	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. ICD 10 2. 3. 4.		22. MEDICAID 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. #
01 01 2015 01 01 2015	11		83861		A	$ $$	2		NPI	XXXXXXXXX
									NPI	

Medical Card Services (MCS) Advantage Plan

Triple-S (SSS) Advantage Plan

- When billing two units on one line, double your fee in box 24F, so that the amount reflects the two units that are being billed.



14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — MM DD YY TO
01 01 2015		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Dr John Doe	17a. 17b. NPI: XXXXXXXXX	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — MM DD YY TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☐ NO — $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line): 1. ICD 10 2. 3. 4.		22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER: CLIA 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. #
01	01	2015	01	01	2015	11		83861	QW	A	$,$$	2		NPI	XXXXXXXXX
														NPI	