Share of Cost (SOC): CMS-1500 Vision Care

Page updated: August 2020

This section explains how to complete claims for services rendered to recipients who paid a Share of Cost (SOC). The procedure codes used in the following examples are for illustration purposes only and may not be reimbursable to all provider types. Refer to the *Share of Cost* (SOC) section in the Part 1 manual for an explanation of SOC and how to determine the following:

- If a recipient must pay an SOC
- The SOC amount a recipient must pay
- If the recipient's SOC is certified for the month

SOC Fields on Claim

SOC amounts are entered in the *Claim Codes* (Box 10D) and *Amount Paid* (Box 29) fields of the *CMS-1500* claim form. Do not enter decimal points or dollar signs. Enter full dollar and cents amounts, even if the amount is even. In the example below, $10.00 is entered as 1000. Use only one claim line for each service billed.

d. INSURANCE PLAN NAME OR PROGRAM NAME | 10d. CLAIM CODES (Designated by NUCC): **1000** | 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 _____

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 **09 23 14**			**92004**						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 $ **1000** | 30. Rsvd for NUCC Use

PHYSICIAN OR SUPPLIER INFORMATION

Figure 1: Share of Cost Amount in *Claim Codes* Field (Box 10D) and *Amount Paid* Field (Box 29).

Billing Multiple Services Rendered on Different Dates of Service

When multiple services are rendered to a recipient on different dates during the certification period, bill Medi-Cal for the overlap service(s).

When the Medi-Cal eligibility verification system returns an eligibility verification message indicating that the recipient has met the SOC obligation and is eligible for Medi-Cal benefits, submit a claim to the California MMIS Fiscal Intermediary.

Example

The following billing example applies to fee-for-service Medi-Cal only. Assume three services are rendered to a recipient on three different dates. The recipient's Share of Cost is $60.

Date	Code	Amount ‹‹(in dollars)››
09/23/14	92004	50.00
09/24/14	V2200	70.00
09/25/14	V2020	25.00
‹‹none››	‹‹none››	‹‹Total›› 145.00

Submit a Share of Cost clearance transaction for each of the three services. The first service provided on a date prior to the overlap should not be billed to Medi-Cal because this service was applied toward the patient's $60 Share of Cost. Bill Medi-Cal only for the overlap services (HCPCS codes V2200 and V2020). Enter the entire combined amount of $95 for the two services in the *Total Charge* area (Box 28). Enter the amount of the patient's Share of Cost applied to the overlap service in the *Claim Codes* field (Box 10D).

To bill, enter the $95 service fee in the *Total Charge* field (Box 28). Enter the amount of the patient's SOC already applied toward the service fee ($60) in the *Claim Codes* (Box 10D) and *Amount Paid* (Box 29) fields.

Box 19: Record Keeping

For record keeping purposes only and to help reconcile payment on the *Remittance Advice Details* (RAD), providers may show in the *Additional Claim Information* field (Box 19) the SOC amount that the recipient paid or obligated.

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC): **6000**

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 _____

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 MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY 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. 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	09	24	14				11		V2200			7000	1		NPI	
2	09	25	14				11		V2020			2500			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 $ 9500

29. AMOUNT PAID $ 6000

30. Rsvd for NUCC Use

PHYSICIAN OR SUPPLIER INFORMATION

Figure 2: Multiple Services Rendered on Different Dates of Service.

Billing Multiple Services Rendered on the Same Date of Service

When multiple services are provided to a recipient on the same date of service during the certification period, bill Medi-Cal for the service provided on the date of the overlap service.

When the Medi-Cal eligibility verification system returns an eligibility verification message indicating that the recipient has met the SOC obligation and is eligible for Medi-Cal benefits, submit a claim to the FI.

Example

The following billing example applies to fee-for-service Medi-Cal only. Assume three services are rendered to a recipient on the same day. The total charges overlap the recipient's $35 SOC.

Date	Code	Amount ‹‹(in dollars)››
09/23/14	V2020	25.00
09/23/14	V2203	70.00
09/23/14	92004	60.00
‹‹none››	‹‹none››	‹‹Total›› 155.00

Submit a SOC clearance transaction for each of the three services. Since all services are rendered on the same day, it is necessary to bill Medi-Cal for each service. Use three claim lines to bill the three services. Enter the total charge in the *Total Charge* area (Box 28). Enter the amount of the patient's SOC applied to this claim in the *Claim Codes* field (Box 10D).

To bill, enter the $155 service fee in the *Total Charge* field (Box 28). Enter the amount of the patient's Share of Cost already applied toward the service charge ($35) in the *Claim Codes* (Box 10D) and *Amount Paid* (Box 29) fields.

d. INSURANCE PLAN NAME OR PROGRAM NAME | 10d. CLAIM CODES (Designated by NUCC): 3500 | 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 _____

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 MM DD YY TO

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

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
LINE 1: FRAMES, PURCHASES. LINE 2: EYEGLASS LENSES, BIFOCALS.
LINE 3: COMPREHENSIVE EYE EXAM.

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	09 23 14		11		V2020			2500	1		NPI	
2	09 23 14		11		V2203			7000	1		NPI	
3	09 23 14		11		92004			6000	1		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 $ 15500 | 29. AMOUNT PAID $ 3500 | 30. Rsvd for NUCC Use

PHYSICIAN OR SUPPLIER INFORMATION

Figure 3: Multiple Services Rendered on the Same Date of Service.

RAD Payment Summary

Share of Cost claims will be reviewed prior to payment. Because the recipient's SOC is applied by the state to pay for the $25 service, this service appears as "Denied" on the *Remittance Advice Details* (RAD code 022) or with a payment amount of $0.00. The other services appear in the "Approved" group as paid or partially paid. The Medi-Cal allowed amount for the $70 service is reduced by the remaining $10 SOC amount. RAD code 408 indicates payment was reduced because of patient liability.

‹‹Legend››

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

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.