vsp vision care

VSP California Medicaid
Network Manual

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Effective January 1, 2023

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VSP'S MEDICAID PLAN

VSP's Medicaid Plan is based on contracts with health care organizations (clients) to provide the vision care portion of the state's Medicaid program.

Clients are required to provide the minimum benefits specified by your state's Medicaid program, but may also offer enhanced benefits.

Please refer to **Client Detail pages** and/or **Medicaid Fee Schedules** for details about administration of basic state benefits. For state information, refer to the State Medicaid Manual.

ENROLLMENT/DOCTOR PARTICIPATION

Participation is voluntary. Only VSP doctors who have signed a Medicaid Plan Acknowledgment may provide services to Medicaid Plan members. All participating doctors are required to have a state Medicaid identification number.

Eligibility & Authorization

When you contact VSP for an authorization, please provide the following information:

- Last four-digits of the member's Social Security Number and date of birth or the entire client-assigned ID number
- Member's Medicaid number if different from Social Security Number
- Patient's date of birth
- Patient's HMO name

There are several ways to obtain an authorization:

VSP's Electronic Claim Submission System—Enter member's Social Security Number or client-assigned ID number using eyefinity's website and select "Check Patient Eligibility" to access eligible plans. You may wish to print the plan information to discuss plan coverages with your patients.

Customer Service—Call VSP at **800.615.1883**. You may select "1" to contact our automated Interactive Voice Response (IVR) system, or you may speak with a Customer Service Representative who will verify the patient's current eligibility, provide plan information, and issue an authorization.

Note: When the member's eligibility has been verified, VSP will provide an authorization number that is effective through the last day of the current month.

Coordination of Benefits

If the Medicaid patient has vision care coverage through any carrier other than VSP or another VSP plan, you must bill that carrier or the other VSP plan first. The VSP Medicaid Plan should be billed as secondary, where appropriate. For electronic claim submission, be sure to provide the patient's responsibility for exam and refraction separately.

EXAM COVERAGE

Routine eye exam coverage and timeframes are established by State regulations.

In addition to coverage for routine vision care services, Medicaid members are typically covered for services under Essential Medical Eye Care or Integrated Primary EyeCare Program. Any exceptions to this coverage are described in the Client Detail pages and/or the Fee Schedule.

For Telemedicine information refer to: Telemedicine.

Referrals

Follow all referral protocols set forth by your patient's health plan for any services beyond the scope of the patient's VSP plan. Typically, an HMO requires that patient referrals be coordinated by the primary care physician (PCP). However, a PPO usually allows patients to receive care from any medical provider without a PCP referral. Check Client Detail pages for any specific instructions or exceptions.

HEDIS and Eye Exams for Patients with Diabetes

The Healthcare Effectiveness Data and Information Set (HEDIS®) is one of healthcare's most widely used performance improvement tools. The National Committee for Quality Assurance (NCQA) collects HEDIS data from health plans and other healthcare organizations to create annual health outcome surveys. Health plans use HEDIS data to measure performance and identify opportunities for improvement.

HEDIS includes more than 90 measures across multiple domains of care. These measures relate to public health issues, including (and not limited to) asthma medication use, blood pressure control, cancer screening, diabetes care, heart disease, and smoking and tobacco use cessation.

Eye Exam for Patients With Diabetes (EED) – Effectiveness of Care HEDIS Measure

Eye Exam for Patients With Diabetes (EED) is a specific HEDIS measure that requires health plans offering commercial, Medicaid, and Medicare plans to report the percentage of members with diabetes who had a dilated or retinal eye exam.

Measurement Definition:
Patients ages 18–75 with diabetes (Type 1 or Type 2) who received screening or monitoring for diabetic retinal eye disease:

- Retinal or dilated eye exam by an eye care professional in the measurement year or,
- A negative retinal or dilated eye exam by an eye care professional in the year prior to the measurement year.
- Note: Fundus photography with interpretation and report and certain types of retinal imaging (CPT® codes 92227, 92228, 92250, 92260, and 92314) covered by Essential Medical Eye Care may also meet the performance measurement.

WHAT ARE CPT CATEGORY II CODES?

- CPT Category II codes are tracking codes which facilitate data collection related to quality and performance measurement. They allow providers to report services based on nationally recognized, evidence-based performance guidelines for improving quality of patient care.
- CPT Category II codes describe clinical components, usually evaluation, management, or clinical services.
- Category II codes are not to be used as a substitute for Category I codes.
- CPT Category II codes are for reporting purposes only and are not separately reimbursable.

WHAT ARE CPT CATEGORY II CODES?

Current Procedural Terminology (CPT®) Category II codes are informational, supplemental tracking codes that can be used for quality and performance measurement. These codes are intended to facilitate data collection about the quality of care for certain services (e.g., dilated or retinal eye exam) that support performance measures (e.g., Eye Exam for Patients With Diabetes (EED) HEDIS performance measure).

When VSP members with diabetes receive a dilated or retinal eye exam from a network doctor, in addition to billing the exam CPT code, VSP instructs doctors to bill the appropriate supplemental CPT Category II code, which can be used for HEDIS performance measurement.

Including HEDIS supplemental data on VSP claims strengthens the role doctors of optometry have in their patients' healthcare and highlights the impact they have on protecting their patients' vision and overall health. In addition, when VSP network doctors include CPT Category II codes on claims, this data can be securely delivered to VSP health plan clients, reducing the administrative burden of medical record chart reviews for doctors and their staff.

- Category II codes are not to be used as a substitute for Category I codes. CPT Category II codes are for reporting purposes only and are not separately reimbursable. Bill CPT Category II codes with a $0.00 charge amount.
- If you receive a claim denial, your reporting code will still be included in the quality measure.

When billing dilated or retinal eye exams for VSP patients with diabetes, include the appropriate supplemental CPT Category II code, for the Eye Exam for Patients With Diabetes (EED) - HEDIS performance measure:

2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy
2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
2024F	Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy
2025F	Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
2026F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy

2033F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy
3072F	Low risk for retinopathy (no evidence of retinopathy in the prior year)

MATERIALS COVERAGE

Note: Please refer to the Patient Record Report, authorization, or Client Detail pages to determine if any exceptions are covered by your state Medicaid Plan and/or by the client.

Lenses

Lenses are available to the patient based on state regulations.

Covered basic lenses are established by state regulations.

For more information, please refer to your Client Detail pages and/or Fee Schedule.

Dispensing of Spectacles

If a covered benefit, a dispensing fee may only be billed with a complete set of eyeglasses (frame and lenses). Please refer to your state provider manual for eligibility and state-specific guidelines.

Repair and Refitting Spectacles

If a covered benefit, bill repairs to eyeglasses using CPT code 92370 (repair and refitting of spectacles) or CPT code 92371 (repair of spectacle prosthesis for aphakia).

Do not bill a dispensing code for repairs.

Repair and refitting codes cannot be billed with material HCPCS codes (e.g., V2020) on the same date of service.

Please refer to your state provider manual for eligibility and state-specific guidelines.

Replacement

If a covered benefit, bill replacement frame and lenses using the appropriate frame or lens HCPCS code. Do not bill a dispensing code for replacement of just the frame or lenses.

A dispensing fee may only be billed, if you are replacing a complete set of eyeglasses (frame and lenses).

Please refer to your state provider manual for eligibility and state-specific guidelines.

Frames

Frame coverage is based on state regulations. Medicaid plans have an established allowance for the purchase of a new frame. For further information refer to your Client Detail pages and/or Fee Schedule.

Visually Necessary Contact Lenses

If a covered benefit, refer to Client Detail pages as specific criteria applies.

LABORATORY

You may use any lab of your choice on a private invoice basis or fabricate your own materials. Exceptions are noted in the California Medi-Cal Client Details page.

Contract labs that have agreed to provide lenses at a reduced price for VSP are identified in the National Contract Lab List in your VSP Provider Reference Manual. When using a contract lab on this list, please write "VSP Medicaid" and the authorization number on the private invoice to ensure reduced VSP Medicaid materials prices.

Price Schedule

Note: The lab price schedule below is valid for Medicaid Plan prescriptions **only**. Please refer to the patient's authorization and the Medicaid Fee Schedule to determine if any exceptions are covered by your state Medicaid Plan and/or by the client.

Bill all allowable items not listed below at your private add-on prices.

COST

Single Vision	$12.15 per pair	
Bifocals	$21.55 per pair	
Trifocals	$30.55 per pair	
Covered Items	**Single Vision**	**Multifocal**
For higher powers add:	$3.65 per lens	$4.15 per lens
For lenticular add:	$11.85 per lens	$13.80 per lens
For slab off add;	$30.45per lens	$30.45 per lens
For prism add:	$1.85 per lens	$1.85 per lens

Laboratories will charge your office on a private invoice basis. All items not listed are billed at the laboratory's private add-on prices. Doctor redos are billed by the laboratory at 50% of the scheduled fees. Exceptions are noted in the California Medi-Cal Client Details page.

Base lenes includes:

- Rxs up to and including 7.00 sphere and 4.00 cylinder
- Plastic or glass lenses (including hardening)
- Zyl, metal, or carbon mounting
- Bifocal or trifocal Segment widths of 25 and 28
- All higher adds
- All base curves
- Press-on prism
- Eye size up to and including 55mm
- Shipping and handling charges to the office

SUBMITTING CLAIMS/BILLING & REIMBURSEMENT

The filing limit for submitting claims in most states is 180 days from the date of service. Exceptions are noted in the Client Detail pages.

Submit Medicaid claims:

- Electronically through eClaim on eyefinity.com.
- Via paper on a typewritten or computer-generated standard CMS-1500 form.
- Enter the authorization number in Box 23 of the CMS-1500 form. Use the appropriate Place of Service and Type of Service codes from your state Medicaid manual, and submit the CMS-1500 form directly to VSP for processing after providing services. It is not necessary to include the lab's invoice for materials.

VSP will only reimburse claims received for patients who are eligible at the time of service.

All Medicaid claims must be billed with the appropriate diagnosis codes:

Exams:

Z01.00	Encounter for examination of eyes and vision without abnormal findings
Z01.01	Encounter for examination of eyes and vision with abnormal findings
Z01.020	Encounter for examination of eyes and vision following failed vision screening without abnormal findings
Z01.021	Encounter for examination of eyes and vision following failed vision screening with abnormal findings
Z13.5	Encounter for screening for eye and ear disorders
Z46.0	Encounter for fitting and adjustment of spectacles and contact lenses

Exams or Materials:

H52.01	Hypermetropia, right eye
H52.02	Hypermetropia, left eye
H52.03	Hypermetropia, bilateral
H52.11	Myopia, right eye
H52.12	Myopia, left eye
H52.13	Myopia, bilateral
H52.201	Unspecified astigmatism, right eye
H52.202	Unspecified astigmatism, left eye
H52.203	Unspecified astigmatism, bilateral
H52.211	Irregular astigmatism, right eye
H52.212	Irregular astigmatism, left eye
H52.213	Irregular astigmatism, bilateral
H52.221	Regular astigmatism, right eye
H52.222	Regular astigmatism, left eye
H52.223	Regular astigmatism, bilateral
H52.31	Anisometropia
H52.32	Aniseikonia

H52.4	Presbyopia
H52.511	Internal ophthalmoplegia (complete) (total), right eye
H52.512	Internal ophthalmoplegia (complete) (total), left eye
H52.513	Internal ophthalmoplegia (complete) (total), bilateral
H52.521	Paresis of accommodation, right eye
H52.522	Paresis of accommodation, left eye
H52.523	Paresis of accommodation, bilateral
H52.531	Spasm of accommodation, right eye
H52.532	Spasm of accommodation, left eye
H52.533	Spasm of accommodation, bilateral
H52.6	Other disorders of refraction
H52.7	Unspecified disorder of refraction
H53.001	Unspecified amblyopia, right eye
H53.002	Unspecified amblyopia, left eye
H53.003	Unspecified amblyopia, bilateral
H53.011	Deprivation amblyopia, right eye
H53.012	Deprivation amblyopia, left eye
H53.013	Deprivation amblyopia, bilateral
H53.021	Refractive amblyopia, right eye
H53.022	Refractive amblyopia, left eye
H53.023	Refractive amblyopia, bilateral
H53.031	Strabismic amblyopia, right eye
H53.032	Strabismic amblyopia, left eye
H53.033	Strabismic amblyopia, bilateral
H53.141	Visual discomfort, right eye
H53.142	Visual discomfort, left eye
H53.143	Visual discomfort, bilateral
H27.01	Aphakia, right eye
H27.02	Aphakia, left eye
H27.03	Aphakia, bilateral
Z96.1	Presence of intraocular lens - COB only, will be accepted without refractive error diagnosis.
H49.01 – H49.9	Paralytic Strabismus
H50.00 – H50.9	Other strabismus
H51.0 – H51.9	Other disorders of binocular movement

Any exceptions are noted in the Client Detail pages.

Medical eyecare services performed in bordering states are reimbursed per Essential Medical Eye Care Medicaid fee schedule for the state in which you reside.

You are responsible for verifying the accuracy of your payment. For Medicaid patients, overpayments must be corrected within 60 days.

Coordination of Benefits

Coordination of benefits is available in most states. Exceptions are noted in the Client Detail pages. If the patient has other vision coverage, coordinate benefits and bill the other carrier. Medicaid is the payor of last resort.

For Electronic Claims

- Exam only claims (with or without a refraction) can be submitted electronically as long as a routine or refractive diagnosis is present,
- When you receive payment from the primary plan, keep a copy of the original CMS-1500 form showing the exam and refraction services submitted to the primary plan, along with the Explanation of Payment or Explanation of Benefits from the health plan/Medicare, in the patient's file.

Note: Enter exam and refraction separately with this exact language in box 19: "secondary COB claim patient resp EXAM $XX.XX REFRACTION $XX.XX." (Indicate the dollar amount of the patient's responsibility in place of the XX.XX).

For Paper Claims

- When you receive payment from the primary plan, send a copy of the original CMS-1500 form showing the exam and refraction services submitted to the health plan, along with the Explanation of Payment or Explanation of Benefits from the health plan, to VSP. Don't send a summary.

Refer to the Coordination of Benefits (COB) section of the **VSP Manual** for complete information.

CALIFORNIA MEDICAID CLIENT DETAILS

CA Medicaid Compliance Training

All providers who serve CA Medicaid patients are required by the California Department of Health Care Services (DHCS), to complete training which is provided by VSP, within 10 days of joining the VSP Medicaid network and annually thereafter. Doctors who own their practice are required to attest annually that they and their staff, including employee doctors, have completed the training.

- Cultural Competency
- Critical Incident
- General Compliance
- Fraud Waste and Abuse
- Better Communication, Better Care: Provider Tools to Care for Diverse Populations
- Seniors and Persons with Disabilities
- Patients' Rights and Responsibilities

Training will be emailed to practices annually. Providers must ensure and attest that their employees have completed the training, and to provide evidence of such completion if requested by VSP. Electronic signatures on training attestations (which will also be in the email) are required to show proof of completion.

Providers must retain records of training for a period of 10 years.

Failure to meet the training requirement may lead to removal from the VSP Medicaid Network.

American Sign Language (ASL) Interpretation Services

If you or a member of your staff are ASL-fluent, you may, of course, communicate with hearing-impaired patients in that manner. If neither you nor a member of your staff have fluency in ASL, make arrangements for an ASL face-to-face interpreter to assist at no cost to the patient or to you. If you need help finding an ASL interpreter, you may contact VSP Customer Care at **800.615.1883**.

Medicaid Appointment Availability Requirements

The following access standards are required for participation in the VSP California Medicaid Doctor Network:

- 24-hour access to provide instruction on how and where to obtain services
- 30 seconds to answer office phone or ability to leave a message within 45 seconds
- 30 minute (maximum) wait time from scheduled appointment time
- 15 business days (maximum) for scheduling or rescheduling routine, preventative eye exams
- Medical exam should be made within 7 days
- Specialty care appointments should be made within 15 business days
- Urgent care during office hours should be seen within 24 hours based on patient condition
- Emergent care should be directed to the appropriate emergency facility

Eyeglass Lenses

Note: All providers are instructed to use Prison Industry Authority (PIA) optical laboratories to fabricate lenses for dates of service on or after January 1, 2020.

SINGLE VISION LENSES

Single vision lenses must meet at least one of the following requirements:

- Minimum Rx of ±0.75D in at least one meridian of either eye.
- Astigmatic correction of 0.75D or more of either eye.
- Total differential prismatic correction in the vertical prism of 0.75D or more.
- Total differential prismatic correction in the horizontal prism of 0.75D or more.
- Power in any meridian that differs from the corresponding meridian of the lens for the other eye by 0.75D or more.

MULTIFOCAL LENSES

Multifocal lenses must have an add power of at least 0.75 diopters in the reading segment. Bifocal lenses are covered if the near add power is at least 0.75 diopters greater than the prescription in the distance portion of the lens. The distance part of a bifocal lens has no qualifying criteria.

Trifocal lenses that meet the criteria for single vision, multifocal and replacement lenses are covered only for recipients who currently wear trifocals. Trifocal lenses for first-time wearers are not a Medi-Cal benefit.

Note: In addition to the appropriate HCPCS code, bill modifier KX and RA for trifocal lenses.

TWO PAIRS IN LIEU OF BIFOCALS

Two pairs of single vision eyeglasses, one for near vision and one for distance vision, are covered in lieu of multifocal eyeglasses only when one of the following conditions exists:

- There is evidence that a recipient cannot wear bifocal lenses satisfactorily due to non-adaptation or a safety concern (conditions specified below).
- A recipient currently uses two pairs of such eyeglasses and does not use multifocal eyeglasses.

Lenses must be fabricated at PIA lab. PIA will review the prescription requirements, and if approved fabricate the lenses.

When billing two pairs of single vision eyeglasses frames in lieu of bifocals for recipients 38 years of age and older who meet the conditions specified in the California Department of Health Care Services Vision Care Provider Manual:

Primary diagnosis

Presbyopia	H52.4

Secondary diagnosis

Unspecified subjective visual disturbances	H53.10

Visual discomfort	H53.141 – H53.149
Visual distortions of shape and size	H53.15
Psychophysical visual disturbances	H53.16
Other subjective visual disturbances	H53.19
Other visual disturbances	H53.8
Unspecified visual disturbance	H53.9

LENS OPTIONS

Polycarbonate lenses (V2784) are fabricated at the PIA optical laboratories without a Treatment Authorization Request (TAR) for recipients younger than 18 years of age, and for recipients 18 years of age or older who meet the following criteria of visual impairment in one or both eyes.

Visual impairment is defined as visual acuity with optimal correction equal to or poorer than 0.30 decimal notation or 20/60 Snellen, or equivalent at specified distances, or when either visual field is limited to ten degrees or less from the point of fixation in any direction.

Because polycarbonate lenses are fabricated at the PIA optical laboratories for Medi-Cal recipients who meet the above criteria, dispensing optical providers (optometrists, ophthalmologists and dispensing opticians) should bill only lens dispensing fees (CPT codes 92340, 92341, 92342, 92352 or 92353). HCPCS code V2784 (lens, polycarbonate or equal, any index, per lens) should not be billed in addition to the lens dispensing fees in this case.

Progressive lenses (V2781) requests must be submitted on the 50-3 TAR form with supporting medical justification.

Balance lens (V2700) is covered when the corrected visual acuity in the poorer eye is 0.10 diopters or more.

Slab off prism, glass or plastic, per lens (V2710) is covered with the following diagnosis codes:

Anisometropia	H52.31
Aniseikonia	H52.32

Tints V2744 (tint, photochromatic), V2745 (addition to lens, tint, any color, solid, gradient or equal, excludes photochromatic, any lens material) or V2755 (UV lens) are covered for the following conditions and diagnosis codes:

- Eye pathology aggravated by exposure to light is present.
- The normal eye protective system that guards against light is impaired.
- Chronic pathological conditions intensified by exposure to light energy are present.

Anomalies of pupillary function and ocular pain	H57.00 – H57.9
Anophthalmos, microphthalmos and macrophthalmos	Q11.0 – Q11.3
Aphakia and dislocation of lens	H27.00 – H27.9
Autistic disorder	F84.0
Basal cell carcinoma of skin of unspecified eyelid, including canthus	C44.121 - C44.129
Benign neoplasm	D31.40 - D31.42

Benign neoplasm of unspecified part	D31.90 - D31.92
Blepharitis	H01.001 – H01.029
Blindness and low vision	H54.0X – H54.8
Burn and corrosion confined to eye and adnexa	T26.00XA - T26.92XS
Carcinoma in situ of skin of eyelid, including canthus	D04.10 – D04.12
Cataract	H25.011 – H26.9
Chorioretinal inflammation	H30.001 – H30.93
Congenital malformations of anterior segment of eye	Q13.0 – Q13.9
Congenital malformations of posterior segment of eye	Q14.0 – Q14.9
Corneal scars and opacities	H17.00 – H17.9
Diabetes	E10.10 - E13.9
Disorders of accommodation	H52.511 – H52.539
Disorders of optic [2nd] nerve and visual pathways	H47.011 – H47.9
Disorders of the globe	H44.001 – H44.9
Disorders of vitreous body	H43.00 – H43.9
Dry eye syndrome	H04.121 – H04.129
Entropion	H02.001 – H02.149
Epilepsy and recurrent seizures	G40 – G40.91
Foreign body on external eye	T15.00XA - T15.92XS
Glaucoma	H40.001 – H40.9
Herpesviral ocular disease	B00.50 - B00.59
Histoplasmosis capsulati, unspecified	B39.4
Histoplasmosis duboisii	B39.5
Injury of eye and orbit	S05.00XA - S05.92XS
Iridocyclitis	H20.00 – H20.9
Keratitis	H16.001 – H16.9
Lagophthalmos	H02.201 – H02.239
Long term (current) drug therapy	Z79
Malignant melanoma of unspecified eyelid, including canthus	C43.10 - C43.12
Malignant neoplasm of eye and adnexa	C69.00 – C69.92
Melanocytic nevi	D22.10 - D22.12
Melanoma in situ of unspecified eyelid, including canthus	D03.10 - D03.12
Migraine	G43.0 – G43.91
Multiple sclerosis	G35
Nystagmus and other irregular eye movements	H55.00 – H55.89
Other benign neoplasm of skin, including canthus	D23.10 - D23.12
Other disturbances of aromatic amino-acid metabolism	E70.20 - E70.9
Other specified malignant neoplasm of skin of unspecified eyelid, including canthus	C44.191 - C44.199

Parkinson's disease	G20
Phakomatoses	Q85.00 – Q85.9
Pinguecula	H11.151 – H11.159
Presence of intraocular lens	V43.1
Pterygium of eye	H11.001 – H11.069
Retinal detachments and defects	H33.001 – H33.8
Retinal disorders	H35.011 – H35.9
Sarcoidosis	D86.0 - D86.9
Scleritis	H15.001 – H15.9
Secondary Parkinson's disease	G21.0 – G21.9
Systemic lupus erythematosus	M32.0 – M32.9
Thyrotoxicosis with diffuse goiter with thyrotoxic crisis or storm	E05.01
Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm	E05.00
Unspecified malignant neoplasm of skin of left eyelid, including canthus	C44.111 - C44.119
Visual field defects	H53.40 – H53.489

Occluder lens, per lens (V2770) is covered with the following diagnosis codes:

Blindness and low vision	H54.0 – H54.52A2

Note: For coverage information on additional miscellaneous lens items (V2700 – V2799), please refer to the California Department of Health Care Services Vision Care Provider Manual or contact Prison Industry Authority optical laboratory.

DISPENSING

Submit the claim to VSP using the appropriate dispensing code (92340, 92341, 92342, 92352, or 92353), with applicable modifier, and bill with one unit of service. Do not bill VSP for lens materials.

VISUALLY NECESSARY CONTACT LENSES

For specialty contact lenses that don't meet a HCPCS definition, use V2799 and modifier NU or RA as appropriate. Attach an invoice detailing the wholesale cost of the contact lenses.

Piggyback lenses are a covered benefit for patients who aren't able to tolerate rigid gas permeable contact lenses. This requires the use of soft contact lenses and rigid gas permeable contact lenses, in the manner of a piggyback fitting. When submitting a claim for piggyback lenses you must bill for both soft and rigid contact lenses in conjunction with modifier KX. In Box 19 indicate Piggyback Lenses.

Visually necessary contact lenses are covered for eligible Medi-Cal members if one of the following conditions is present:

Aniridia (due to ocular condition)

- Aphakia
- Keratoconus
- Nystagmus
- Aniseikonia
- Chronic pathology or deformity of nose, skin or ears
- Anisometropia 3 or greater, or
- When glasses are contraindicated due to chronic corneal or conjunctival pathology or deformity (other than corneal astigmatism);
- High ametropia ±10.00D in at least one eye
- Congenital Cone Dystrophy – allow red contacts

Bill with the appropriate diagnosis codes and modifier KX. Visual necessity must be documented in the patient's file.

GLASSES TO WEAR OVER CONTACTS BENEFIT

Spectacle lenses with frame to wear over visually necessary contacts is a covered benefit for eligible Medi-Cal members with one of the following conditions:

- Aphakia (H27.01 - H27.03 or Q12.3)
- High ametropia —10.00 diopters or greater
- Presbyopia (H52.4)
- Accommodative disorder
- Binocular function disorder
- Different prism requirements for distance and near vision
- A prescription is required for the lenses

When glasses to be worn over contact lenses are visually necessary, call VSP at **800.615.1883** to request the spectacle lenses and frame authorization number at the same time or within 30 days of the contact lens claim submission date. For patients with keratoconus, request an authorization number for spectacle lenses and frame to be worn over contact lenses within 12 months of the contact lens claim submission date. Please have the relevant criteria information available when calling. Visual necessity must be documented in the patient's file.

FRAME

Two frames are covered for members who cannot wear bifocal lenses. See Bifocal Lenses or Two Pair in Lieu of Bifocals for criteria.

Deluxe frames (V2025) and safety frames (S0516) are covered. Use modifier NU to identify a new frame. Use modifier RA for a replacement frame.

Bill with the appropriate diagnosis codes and modifier KX. Visual necessity must be documented in the patient's file.

MEDI-CAL BENEFICIARIES RECEIVING LONG-TERM CARE IN A SKILLED NURSING FACILITY

You are encouraged to verify that the facility belongs in one of the skilled nursing facility (SNF) categories (ICF/DD, NF-A or NF-B) and is licensed by the California Department of Public Health (CDPH). For more information, visit the CDPH Health Facilities page.

If the nursing facility is not a Medi-Cal Provider, use modifier KX to indicate that the recipient's residency exemption was verified. When submitting claims, you must include the SNF's name in the Name of Referring Provider or Other Source field (Box 17) on the CMS-1500 form. For electronic claims, the nursing facility's NPI must be entered.

The Prison Industry Authority (PIA) fabricates lenses for members who reside in SNFs. Enter the facility's NPI number on the e-order form when placing the order. You may contact the facility directly or review the National Plan and Provider Enumeration System (NPPES) Registry to obtain its NPI.

Patient Responsibility

COVERED SERVICES/MATERIALS

NOTE: It's the doctor's responsibility to verify the eligibility status of each member at the time of service and obtain the appropriate authorization. Failure to obtain authorization doesn't create a payment liability for the patient.

Providers must accept Medi-Cal's maximum allowable as payment in full. Charges exceeding Medi-Cal allowances may not be billed to recipients.

NON-COVERED SERVICES/MATERIALS

Frame: If a non-covered frame is chosen, the patient pays the full cost of the frame.

Lenses: The following lens options are not covered: V2730 and V2786. You may charge the patient your U&C fees for the non-covered options.

- Trifocal lenses: If member is not currently wearing trifocal lenses, bill the patient your U&C for only the trifocal lenses. Bill VSP for the frame and the dispensing procedure codes.

If the patient or guardian requests any non-covered service and/or material, you may bill the patient your usual and customary fees for the non-covered services or materials if all of the following requirements are met. For exceptions, please refer to Covered Services section.

- The patient or guardian must be informed prior to services being rendered that this is a non-covered service or material. Advise the patient or patient's guardian of their payment responsibilities before providing services.
- Provide the patient with information regarding the necessity, options and charges(s) for the service/material(s).
- The patient or guardian must sign an Agreement of Financial Responsibility form or equivalent that clearly states the patient is aware they are choosing to purchase non-covered services or materials as a private-pay customer. Keep the form in the patient's records.

Do not bill VSP for these non-covered services or materials. Treat this as a private-pay transaction and follow your private pay patient policy.

MISSED APPOINTMENTS

Medicaid members may not be billed for missed appointments.

INTERIM EXAMINATIONS

Additional eye examination with refraction within 24 months is covered only when a sign or symptom indicates a need for this service. Please call VSP at **800.615.1883** for an authorization number.

Repair

Repair is covered. Authorization is required; please call VSP at **800.615.1883** for an authorization number.

CPT codes 92370 and 92371 cannot be billed with HCPCS Code V2020 on the same date of service. Frame parts include nose pad arm with adjustable pad, nose pads, nose pad covers, temples and temple covers, and frame front.

Replacement of lost, stolen, broken or damaged eyeglasses

Replacement of lost, stolen, broken or significantly damaged eyeglasses is covered more frequently than once every 24 months when justified. Limitation to eyewear orders or replacements are subject to utilization controls set by the Department of Health Care Services. The Medi-Cal labs ordering website detects excessive replacement requests and will ask for justification. Department of Health Care Services will deny abusive, fraudulent, and/or requests that are not justified.

Patient or patient's representative/guardian is required to supply the provider with a signed statement.

The statement must certify the circumstances of the loss or destruction and the steps taken to recover the lost item. The signed statement must be retained in the provider's record for at least three years.

Authorization is required; please call VSP at **800.615.1883** for an authorization number.

LENSES

Replacement lenses must meet the Materials Eligibility criteria above and one or more of the following:

- ±0.50D change in any corresponding meridian.
- 20 degrees or greater for cylinder power of .50-/62D.
- 15 degrees or greater for cylinder power of .75-.87D.
- 10 degrees or greater for cylinder power of 1.00-1.87D.
- 5 degrees or greater for cylinder power of 2.00D.
- Change in axis of cylinder power of .12-.37D as sole reason for change is not covered.
- Previous lens is lost, stolen, broken or marred to a degree significantly interfering with vision or eye safety.
- Lens replacement is necessary because of frame replacement due to patient growth, metal allergy or other justifiable visual reasons.
- Visual necessity must be documented in the patient's medical record.

FRAMES

Replacement is allowed for loss, theft or destruction beyond the patient's control; requires signed statement from patient with copy in file.

Frame replacement within two years of initial coverage is limited to the same model whenever possible.

A replacement frame won't be covered if the existing frame can be made suitable for continued use by adjustment, repair or replacement of a broken front or temples. Replacement frames that are deliberately destroyed, abused or discarded by the patient aren't covered.

A replacement frame may be covered for reasons other than those listed above if the patient signs a statement explaining the circumstances and the reason the existing frame cannot be used. Keep the signed statement in the patient's file for a minimum of three years.

Client Exceptions

MEMBER IDENTIFICATION NUMBER

These clients report members by an alpha/numeric identification number comprised of 8 digits and 1 alpha character:

Anthem Blue Cross
CalOptima
CalOptima OneCare
Central Coast Alliance for Health
Gold Coast Health Plan
LA Care Health Plan (traditional Medicaid)
Positive Healthcare
Santa Clara Family Health Plan

These clients report members by an alpha/numeric identification number comprised of 8 digits and 1 alpha character or their SSN:

Community Health Group
Kern Health Systems

These clients report members as follows:

Health Plan of San Joaquin: Members are reported by a 9-digit identification number starting with 200.

Partnership HealthPlan of CA: Members are reported by an identification number comprised of 8 digits, 1 alpha character, plus 1 digit.

San Francisco Health Plan: Members are reported by an 11-digit identification number.

You may obtain a recipient's Medi-Cal Benefits Identification Card number (BIC's I.D.) on the Automated Eligibility Verification System (AEVS) using a valid **Social Security Number and date of birth**. This information is available on AEVs, Point of Service devices, and Transaction Services on the Medi-Cal website. PIA account holders can also get the current issue date from the 14 digit BIC # retrieved by running the eligibility check using PIA Optical Online website.

Note: Transaction Services on the Medi-Cal website will ask for an issue date. You can use the current date to submit the eligibility requests to retrieve the current Medi-Cal I.D.

ANTHEM

Anthem Medi-Connect (Client IDs 30049369 and 30050240) offers a routine exam every 12 months and materials every 24 months with allowance to go towards materials. Allowance is covered only once per eligibility period and varies by county (Los Angeles $175 allowance, Santa Clara $100 allowance).

If entire material allowance isn't used at the initial visit, the remaining allowance cannot be used at a later date. You can balance bill the patient for any amount beyond the allowance. For details, see the Patient Responsibility section.

Coordination of Care for Medicare-Medicaid Plan (MMP) Members

You and/or your patient may be asked to participate in care planning and management by a member of Anthem's case management/service coordination team. The goal is to ensure that patients experience seamless transitions across health care settings, providers and services.

To have a copy of your patient's care plan faxed or mailed to you or to reach their care team, call the number provided on their identification card.

CALOPTIMA ONECARE

CalOptima OneCare (Client ID 12264659) offers a routine eye exam every 12 months. Materials are offered every 24 months with a $300 allowance. Allowance is covered only once per eligibility period.

If entire material allowance isn't used at the initial visit, the remaining allowance cannot be used at a later date. You can balance bill the patient for any amount beyond the allowance. For details, see the Patient Responsibility section.

CalOptima OneCare members are eligible for post-cataract services (exam and $100 material allowance following cataract surgery). Call VSP at **800.615.1883** to obtain an authorization number for Post Cataract services. Post Cataract services are covered with one of the following diagnosis codes: Z96.1, H27.00-H27.03, or Q12.3.

Please verify eligibility to determine which laboratory should be used.

CALOPTIMA ONECARE CONNECT

CalOptima OneCare Connect (Client ID 30058212) offers a routine exam every 12 months and materials every 24 months with a $300 allowance. Allowance is covered only once per eligibility period.

If entire material allowance isn't used at the initial visit, the remaining allowance cannot be used at a later date. You can balance bill the patient for any amount beyond the allowance. For details, see the Patient Responsibility section.

Please verify eligibility to determine which laboratory should be used.

For all non-vision related questions, refer member to OneCare Connect toll free at **855.705.8823** or TTY/TDD at **800.735.2929.**

CALOPTIMA PACE

CalOptima PACE (Client ID 30058212, Division 0208) offers a routine exam every 12 months and materials every 12 months with a $200 allowance. Allowance is covered only once per eligibility period.

If entire material allowance isn't used at the initial visit, the remaining allowance cannot be used at a later date. You can balance bill the patient for any amount beyond the allowance. For details, see the Patient Responsibility section.

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN MEDI-CONNECT

Blue Shield of California Promise Health Plan Medi-Connect (Client ID 30084320) offers a routine exam every 12 months and materials every 24 months with a $500 allowance. Allowance is covered only once per eligibility period.

If entire material allowance isn't used at the initial visit, the remaining allowance cannot be used at a later date. You can balance bill the patient for any amount beyond the allowance. For details, see the Patient Responsibility section.

COMMUNITY HEALTH GROUP

Community Health Group (Client ID 12017488) offers a routine eye exam every 12 months, to diabetic patients. All other eligible adults (21 and older) are offered a routine eye exam every 24 months.

Community Health Group Medi-Connect (Client ID 30041019) offers a routine exam and materials every 12 months with a $300 allowance. Allowance is covered only once per eligibility period.

If entire material allowance isn't used at the initial visit, the remaining allowance cannot be used at a later date. You can balance bill the patient for any amount beyond the allowance. For details, see the Patient Responsibility section.

GOLD COAST HEALTH PLAN

Gold Coast Health Plan (Client ID 30029924) members are only able to receive services from VSP Medicaid doctors within Ventura County. All members with diabetes receive a routine eye exam every 12 months.

File claims within 180 days of the date of service. Claims that are not filed within this timeframe may be denied or subject to reduction in payment in compliance with California Medicaid guidelines.

KERN HEALTH SYSTEMS

Kern Health Systems (Client ID 12049397) offers a routine eye exam every 12 months, to diabetic patients. All other eligible adults (21 and older) are offered a routine eye exam every 24 months.

LA CARE HEALTH PLAN

For LA Care Health Plan (Client ID 12290367) members when visual necessity is identified but does not meet the criteria listed, you may contact VSP to request specific benefit review for your patient prior to rendering services. Specific benefits available for review include necessary contact lenses and low vision.

For practices seeing members of this health plan, an Industry Collaboration Effort (ICE) Language Self-Assessment must be completed annually and kept on file for each staff member who offers linguistic services. Download and print the Self-Assessment.

You are required to download and print a flier and post it in your practice to let your patients know that you can assist them in languages other than English.

LA CARE HEALTH PLAN CAL MEDI-CONNECT (CMC)

Effective 1/1/2020, plan changed to an Advantage Plan. Refer to the Patient Record Report for coverage details.

LA Care Cal Medi-Connect (Client ID 30047415) offers a routine exam every 12 months and materials every 24 months base lens covered in full with a $300 frame or $300 ECL allowance. Allowance is covered only once per eligibility period.

If entire material allowance isn't used at the initial visit, the remaining allowance cannot be used at a later date. You can balance bill the patient for any amount beyond the allowance. For details, see the Patient Responsibility section.

Language Documentation

Indicate the patient's language in the patient's medical record.

If a patient refuses to accept interpretation services, document patient refusal of interpreter service and the request to use a friend or family member in the medical record.

Interpretation Services

You are required to download and print a flier and post it in your practice to let your LA Care members know that you can assist them in languages other than English.

Critical Incident Reporting

Reporting to the Appropriate Agency/Authority
VSP Contracted Providers who identify a Critical Incident, related to a VSP member who participates in a Cal MediConnect plan, is required to report the incident immediately upon awareness to the appropriate Agency/Authority.

Below is guidance for Providers to enable appropriate reporting.

State of CA information: Link to Hotline phone numbers and hours of operation for each county for:

Child Protective Services (CPS

Adult Protective Services (APS)

Reporting to Patient's Medical Health Plan
Providers and Employees are required to complete, within two (2) business days of the identification of a Critical Incident; the Critical Incident Report form and submit the report to the appropriate Cal MediConnect Health Care Plan that provides coverage for the Member.

Each Cal MediConnect Health Plan is responsible for investigation and tracking of incidents reported by VSP Providers and/or Employees.

Cal MediConnect Health Plans Contact Information:

LA Care: QI Department, **CI@lacare.org**"

SANTA CLARA FAMILY HEALTH PLAN

(Client ID 30021469)

IMPORTANT: Annual Regulatory Training Requirement

Regulatory compliance rules are in place mandating all VSP Medi-Cal Providers and their staff to complete the following training modules 10 days after enrolling in the Medicaid Network and annually thereafter to remain in compliance:

- Cultural Competency
- Critical Incident
- General Compliance
- Fraud Waste and Abuse
- Better Communication, Better Care: Provider Tools to Care for Diverse Populations
- Seniors and Persons with Disabilities
- Patients' Rights and Responsibilities

Annual training will be emailed to practices in Q2. Providers must ensure and attest that their employees have completed the training, and to provide evidence of such completion if requested by VSP. Electronic signatures on training attestations (which will also be in the email) are required to show proof of completion.

Providers must retain records of training for a period of 10 years.

Failure to meet the training requirement may lead to removal from the VSP Medicaid Network.

Critical Incident Reporting

Reporting to the Appropriate Agency/Authority

VSP Contracted Providers who identify a Critical Incident, related to a VSP member who participates in a Cal MediConnect plan, is required to report the incident immediately upon awareness to the appropriate Agency/Authority.

Below is guidance for Providers to enable appropriate reporting.

State of California Information: **http://www.dss.cahwnet.gov/cdssweb/PG20.htm**. This link provides Hotline phone numbers and hours of operation for each county.

For Children: Child Protective Services (CPS) Hotline for the county you reside in.

For Adults: Adult Protective Services (APS) Hotline for the county you reside in.

Reporting to Patient's Medical Health Plan

Providers and Employees are required to complete, within two (2) business days of the identification of a Critical Incident; the Critical Incident Report form and submit the report to the appropriate Cal MediConnect Health Care Plan that provides coverage for the Member.

Each Cal MediConnect Health Plan is responsible for investigation and tracking of incidents reported by VSP Providers and/or Employees.

PRISON INDUSTRY AUTHORITY LAB

All providers are instructed to use Prison Industry Authority (PIA) optical laboratories to fabricate lenses for dates of service on or after January 1, 2020. If a specialized lens or material is prescribed that PIA is unable to fabricate, the ophthalmic lens orders must be fabricated at a non-PIA optical laboratory. See Non-PIA (Private) Lab.

Processing Period

Allow five working days to process prescriptions with combined sphere-cylinder power of less than 7.12 diopters.

Ten working days is required to process prescriptions with combined sphere-cylinder power of more than 4 diopters, or other special orders.

Delivery time to and from the optical laboratory is not included in the specified turnaround times.

Working with the PIA labs

VSP, the PIA labs, and the Department of Health Services encourage you to follow these steps to address any concerns.

Contact the PIA lab directly, especially if there is a problem with a prescription order.

If you don't get the desired results by contacting the lab, contact the Lab Manager of the facility.

If the problem still isn't resolved, contact the PIA Headquarters office. This person can address problems not resolved in steps 1 or 2.

If the first three steps don't produce satisfactory results, your final recourse is to contact the Department of Health Services.

PIA Optical Labs Contact List

Name	County Code (s)	
California State Prison Solano Prison Industry Authority Optical Lab 2100 Peabody Road Vacaville, CA 95687-6615 Customer Service 800.700.9861 707.454.3447 Superintendent II 707.451.0182, ext. 6625 Fax 707.454.3214	Alameda: 01 Alpine: 02 Amador: 03 Butte: 04 Colus: 06 Contra Costa: 07 Del Norte: 08 El Dorado: 09 Glenn: 11 Humboldt: 12 Lake: 17 Lassen: 18 Marin: 21 Mendocino: 23 Modoc: 25 Napa: 28 Nevada: 29	Placer: 31 Plumas: 32 Riverside: 33 Sacramento: 34 San Bernardino: 36 San Francisco: 38 Santa Clara: 43 Santa Cruz: 44 Shasta: 45 Sierra: 46 Siskiyou: 47 Solano: 48 Sonoma: 49 Sutter: 51 Tehama: 52 Trinity: 53 Yolo: 57 Yuba: 58
	Note: All counties should submit glass orders to CSP-SOL	
Valley State Prison for Women/ CCWF Prison Authority Optical Lab CCWF/VSPW 23370 Road 22 Chowchilla, CA 93610-4329 Customer Service 800.377.8953 x7427 Superintendent II **559.665.6100 x6253** Fax 559.665.5147	Calaveras: 05 Fresno: 10 Imperial: 13 Inyo: 14 Kern: 15 Kings: 16 Los Angeles: 19 Madera: 20 Mariposa: 22 Merced: 24 Mono: 26 Monterey: 27 **Orange: 30***	San Benito: 35 San Diego: 37 **San Joaquin: 39*** **Stanislaus: 50*** Tulare: 54 Tuolumne: 55 Ventura: 56
Department of Health Services, Vision Care Program Consultant:		

Donny Shiu, OD
Medi-Cal Vision Care Program Consultant
California Department of Health Care Services
P.O. Box 997413, MS 4604
Sacramento, CA 95899-7413
Phone: **916.445.4884**
Fax: **916.440.5640**
E-mail: donny.shiu@dhcs.ca.gov

Note: When using a PIA lab, submit the claim to VSP using the appropriate dispensing code (92340, 92341, 92342, 92352, or 92353), with applicable modifier, and bill with one unit of service. Do not bill VSP for lens materials.

***Note:** Effective 2/01/2020, the counties of Orange, San Joaquin, and Stanislaus submit materials to CSP-Solano Optical Lab.

NON-PIA (PRIVATE) LAB

If authorized, ophthalmic lens orders that cannot be fabricated by PIA must be made at a non-PIA (private) optical laboratory. When using a non-PIA lab, submit the claim to VSP using the appropriate code for ophthalmic lenses (HCPCS codes V2100 – V2499), miscellaneous lens items (V2700 – V2799), and dispensing services (CPT codes 92340 – 92342 and 92352 – 92353).

Bill with the appropriate diagnosis codes and modifier KX. Note "PIA Denied" in Box 19 of the *CMS-1500* claim form.

Note: All procedure codes for materials must be billed with the appropriate modifier:
NU – new equipment
RA – replacement
KX – specific required documentation on file; you may also use modifier KX to indicate that the recipient's residency exemption at skilled nursing facilities has been verified or that the member has previously worn trifocals.

Claims billing with an allowance plan:

- Not required to use a PIA lab for fabrication of materials, lens and frame.
- Not required to use modifiers when billing for ECL materials.
- Dispensing (92340, 92341, 92342) applies towards the plans allowance.

Language Requirements

For Medicaid practices across California, an Industry Collaboration Effort (ICE) Language Self-Assessment should be completed annually and kept on file for each staff member who offers linguistic services. Download and print the Self-Assessment.

Timely Claim Filing

File claims within 180 days of the date of service. Submissions received over 180 days from the month of service, or if the received date of the adjustment is greater than 6 months from the month of the original EOP date, are subject to reduced reimbursement in accordance with state guidelines (MMCD Policy Letter 08-002.)

Coordination of Benefits

Private health insurance belonging to a Medi-Cal beneficiary must be billed first before billing Medi-Cal. Medi-Cal may be billed for the balance, including other health coverage (OHC) co-payments, OHC co-insurance and OHC deductibles.

Verify members' eligibility through Medi-Cal. If the patient has additional vision or health insurance coverage and you aren't a participating doctor with that carrier, refer the member to the primary insurance carrier. If you participate with the OHC contact the other patient's OHC for eyewear ordering and billing information. Submit the claim to the OHC and then submit the claim to VSP along with a copy of the other insurance's Explanation of Benefits (EOB), Remittance Advice (RA) or denial letter. Patients with OHC aren't eligible for Prison Industry Authority (PIA) contracted services.

Coordinated claims are subject to timeliness filing guidelines (see Timely Claim Filing).

Note: If the patient has an OHC indicator, or if the PIA lab rejects the prescription because the patient has other health insurance indicator, ask the patient if they have other insurance. If the patient denies carrying other insurance, contact the Medi-Cal Other Health Care unit at **800.541.5555**, or **916.636.1980** if you are located outside of California. You may also access the OHC forms at http://www.dhcs.ca.gov/services to remove or modify the invalid OHC indicator.

Denied Claim Appeals

Please see **Claim Appeals** in the VSP Provider Reference Manual for more information.

Services Provided Out of the Office

Service(s) typically provided in the office can be provided out of the office at the request of the patient, in addition to basic service (**bill with modifiers 22 and KX).**

99056 – This code must be billed with modifiers 22 and KX and one of the following CPT codes on the same date of service: 92002, 92004, 92012, 92014, 92310-92312.

Low Vision

A low vision evaluation is covered for members who present with moderate, severe, or profound visual impairment. See the California Medicaid Fee Schedule for the appropriate CPT Evaluation and Management procedure code which best describes the service. Call VSP at 800.615.1883 to obtain an authorization number for Low Vision claim(s).

A low vision evaluation includes, but is not limited to, a detailed case history, effectiveness of any low vision aids in use, visual acuity in each eye with best spectacle correction, steadiness of fixation, assessment of aids required for distance vision and near vision, evaluation of any supplemental aids, evaluation of therapeutic filters, development of treatment, counseling of patient and advice to patient's family (if appropriate).

HCPCS codes V2600 – V2615 must be billed with an appropriate modifier on the claim for payment: Modifiers required for billing low vision aids include:

NU New equipment

RA Replacement of a Durable Medical Equipment item

Low Vision Aids: Only basic and essential low vision aids are a benefit. Please submit a manufacturer's invoice when submitting the claim.

Low vision rehabilitative services procedure codes (97112 and 97530) are not covered by VSP. Please refer to the patient's health plan for coverage.

Note: For all low vision services, bill with appropriate diagnosis codes and modifier KX. Visual necessity must be documented in the patient's file.

Effective 1/1/2020 the State of CA no longer covers Vision Therapy, coverage for Low Vision only.

Essential Medica Eye Care Coverage

Essential Medical Eye Care provides supplemental medical eyecare coverage for the detection, treatment and management of ocular and/or systemic conditions that produce ocular or visual symptoms. Members may see their VSP doctor when such a condition is suspected.

Covered benefits are administered according to the VSP policies and procedures in effect upon the date of service. Please click on the appropriate link below to view covered procedure codes for your state. Please note codes are only covered when appropriate based on your scope of licensure as well as the current laws, rules and regulations as determined by the State and Federal Government.

Essential Medical Eye Care

VSP CALIFORNIA MEDICAID PLAN

PROFESSIONAL FEE SCHEDULE FOR ROUTINE SERVICES

Effective 6/1/16

Reimbursement for routine vision care services is based on the lesser of the billed amount or the maximum allowable reimbursement as reflected on this fee schedule. Fees are subject to change with notification from VSP.

Exam Services

Evaluation and Management services are covered through the Primary EyeCare plan.

92002	Intermediate exam, new patient	$29.52
92004	Comprehensive exam, new patient	$35.50
92012	Intermediate exam, established patient	$20.33
92014	Comprehensive exam, established patient	$35.50
92015	Determination of refractive state	$7.21

Using Prison Industry Authority (PIA) Labs

For services provided to Medi-Cal members, please verify with PIA that they can supply the lens/materials. Please verify if a Medi-Cal Treatment Authorization Request (TAR) is required.

If PIA is not able to provide the lens/materials, bill VSP for the non-supplied PIA lens or materials. Bill with the appropriate diagnosis codes and modifier KX. Put “PIA Denied” in Box 19.

Dispensing and Material Services

Submit claims for lens materials and frames, including replacement parts, to PIA. Use modifier NU to identify new lens(es). Use modifier RA when replacing lens(es). Use KX and RA to identify current trifocal wearers. See VSP California Medicaid Client Details page.

Single Vision Dispensing Services:		
92340	Fitting of spectacles, except for aphakia, monofocal, other than bifocal per pair	$19.39
92352	Fitting of spectacles, prosthesis for aphakia, monofocal, per pair	$19.39
Bifocal Dispensing Services:		
92341	Fitting of spectacles, except for aphakia, bifocal, per pair	$28.62
92353	Fitting of spectacles, prosthesis for aphakia, multifocal, per pair	$28.62
Trifocal Dispensing Services: Only patients currently wearing trifocal lenses are covered. Medical necessity must be documented in the patient’s medical record. Use modifier KX and RA. KX is used to indicate that documentation is on file stating that the recipient is a current trifocal wearer and not a first time wearer.		
92342	Fitting of spectacles, except for aphakia, multifocal other than bifocal, per pair	$39.38
Frames: Use modifier NU to identify new frame. Use modifier RA to identify replacement of frame. See client detail pages.		

V2020	Frame (includes case)	$19.18
V2756	Eye glass case	$0.00
Deluxe and safety frames must be billed with modifier KX. Visual necessity must be documented in the patient's file. Use modifier NU to identify new frame. Use modifier RA to identify replacement of frame.		
V2025	Deluxe frame (includes case)	$25.98
S0516	Safety eyeglass frame	$25.98
Repair and Refitting. See VSP California Medicaid Client Details **page.**		
92370	Repair and refitting spectacles; except for aphakia	$5.67
92371	Repair and refitting spectacles prosthesis for aphakia	$5.67

Using Private Labs

Frames

Frames: Use modifier NU to identify new frame. Use modifier RA to identify replacement of frame. See client detail pages.		
V2020	Frame (includes case)	$19.18
V2756	Eye glass case	$0.00
Deluxe and safety frames must be billed with modifier KX. Visual necessity must be documented in the patient's file. Use modifier NU to identify new frame. Use modifier RA to identify replacement of frame.		
V2025	Deluxe frame (includes case)	$25.98
S0516	Safety eyeglass frame	$25.98

Lenses

Use modifier NU to identify new lens(es). Use modifier RA when dispensing and replacing lens. See VSP California Medicaid Client Details page.

Single Vision Lenses, per lens:		
V2100	Sphere, plano to ± 4.00d	$16.47
V2101	Sphere, ± 4.12 to ± 7.00d	$19.52
V2102	Sphere, ± 7.12 to ± 20.00d	$23.18
V2103	Spherocylinder, plano to ± 4.00d sphere, 0.12 to 2.00d cylinder	$16.63
V2104	Spherocylinder, plano to ± 4.00d sphere, 2.12 to 4.00d cylinder	$16.76
V2105	Spherocylinder, plano to ± 4.00d sphere, 4.25 to 6.00d cylinder	$26.45
V2106	Spherocylinder, plano to ± 4.00d sphere, over 6.00d cylinder	$28.03
V2107	Spherocylinder, ± 4.25 to ± 7.00d sphere, 0.12 to 2.00d cylinder	$19.70
V2108	Spherocylinder, ± 4.25 to ± 7.00d sphere, 2.12 to 4.00d cylinder	$19.96
V2109	Spherocylinder, ± 4.25 to ± 7.00d sphere, 4.25 to 6.00d cylinder	$29.71
V2110	Spherocylinder, ± 4.25 to ± 7.00d sphere, over 6.00d cylinder	$33.61
V2111	Spherocylinder, ± 7.25 to ± 12.00d sphere, 0.25 to 2.25d cylinder	$23.17
V2112	Spherocylinder, ± 7.25 to ± 12.00d sphere, 2.25 to 4.00d cylinder	$23.17
V2113	Spherocylinder, ± 7.25 to ± 12.00d sphere, 4.25 to 6.00d cylinder	$33.66

V2114	Spherocylinder, sphere over ± 12.00d	$26.91
V2115	Lenticular, myodisc	$69.35
V2121	Lenticular	$58.29
V2199	Not otherwise classified; single vision lens	Submit invoice for pricing*
Single Vision Dispensing Services:		
92340	Fitting of spectacles, except for aphakia, monofocal other than bifocal, per pair	$19.39
92352	Fitting of spectacles, prosthesis for aphakia, monofocal, per pair	$19.39
Bifocal Lenses, per lens:		
V2200	Sphere, plano to ± 4.00d	$26.45
V2201	Sphere, ± 4.12 to ± 7.00d	$32.74
V2202	Sphere, ± 7.12 to ± 20.00d	$38.34
V2203	Spherocylinder, plano to ± 4.00d sphere, 0.12 to 2.00d cylinder	$26.78
V2204	Spherocylinder, plano to ± 4.00d sphere, 2.12 to 4.00d cylinder	$26.79
V2205	Spherocylinder, plano to ± 4.00d sphere, 4.25 to 6.00d cylinder	$39.52
V2206	Spherocylinder, plano to ± 4.00d sphere, over 6.00d cylinder	$39.75
V2207	Spherocylinder, ± 4.25 to ± 7.00d sphere, 0.12 to 2.00d cylinder	$32.77
V2208	Spherocylinder, ± 4.25 to ± 7.00d sphere, 2.12 to 4.00d cylinder	$34.63
V2209	Spherocylinder, ± 4.25 to ± 7.00d sphere, 4.25 to 6.00d cylinder	$44.83
V2210	Spherocylinder, ± 4.25 to ± 7.00d sphere, over 6.00d cylinder	$46.48
V2211	Spherocylinder, ± 7.25 to ± 12.00d sphere, 0.25 to 2.25d cylinder	$38.08
V2212	Spherocylinder, ± 7.25 to ± 12.00d sphere, 2.25 to 4.00d cylinder	$38.34
V2213	Spherocylinder, ± 7.25 to ± 12.00d sphere, 4.25 to 6.00d cylinder	$47.13
V2214	Spherocylinder, sphere over ± 12.00d	$40.38
V2215	Lenticular, myodisc	$86.30
V2220	Add over 3.25d	$12.88
V2221	Lenticular	$68.00
V2299	Specialty bifocal	Submit invoice for pricing*
Bifocal Dispensing Services:		
92341	Fitting of spectacles, except for aphakia, bifocal, per pair	$28.62
92353	Fitting of spectacles, prosthesis for aphakia, multifocal, per pair	$28.62
Trifocal Lenses, per lens: Only patients currently wearing trifocal lenses are covered. Document in the patient's medical record that the patient is currently wearing trifocals. Modifiers KX and RA must be used when replacing trifocal lens(es). See VSP California Medicaid Client Details page.		
V2300	Sphere, plano to ± 4.00d	$38.12
V2301	Sphere, ± 4.12 to ± 7.00d	$41.78
V2302	Sphere, ± 7.12 to ± 20.00d	$48.90

V2303	Spherocylinder, plano to ± 4.00d sphere, 0.12 to 2.00d cylinder	$38.33
V2304	Spherocylinder, plano to ± 4.00d sphere, 2.25 to 4.00d cylinder	$45.19
V2305	Spherocylinder, plano to ± 4.00d sphere, 4.25 to 6.00d cylinder	$49.59
V2306	Spherocylinder, plano to ± 4.00d sphere, over 6.00d cylinder	$49.82
V2307	Spherocylinder, ± 4.25 to ± 7.00d sphere, 0.12 to 2.00d cylinder	$42.84
V2308	Spherocylinder, ± 4.25 to ± 7.00d sphere, 2.12 to 4.00d cylinder	$42.84
V2309	Spherocylinder, ± 4.25 to ± 7.00d sphere, 4.25 to 6.00d cylinder	$55.65
V2310	Spherocylinder, ± 4.25 to ± 7.00d sphere, over 6.00d cylinder	$55.88
V2311	Spherocylinder, ± 7.25 to ± 12.00d sphere, 0.25 to 2.25d cylinder	$48.90
V2312	Spherocylinder, ± 7.25 to ± 12.00d sphere, 2.25 to 4.00d cylinder	$49.13
V2313	Spherocylinder, ± 7.25 to ± 12.00d sphere, 4.25 to 6.00d cylinder	$55.88
V2314	Spherocylinder, sphere over ± 12.00d	$48.90
V2320	Add over 3.25d	$12.88
V2321	Lenticular	$84.19
V2399	Specialty trifocal	Submit invoice for pricing*
Trifocal Dispensing Services:		
92342	Fitting of spectacles, except for aphakia, multifocal other than bifocal, per pair	$39.38
Variable Lenses, per lens: Use modifier NU to identify new lens(es). Use modifier RA when replacing a lens(es). All alpha modifiers must be billed in upper case. See VSP California Medicaid Client Details page.		
V2410	Variable asphericity lens, single vision, full field, glass or plastic	$51.35
V2430	Variable asphericity lens, bifocal, full field, glass or plastic	$87.94
V2499	Variable asphericity lens, other type	Submit invoice for pricing*
Service must be billed with modifier KX. Visual necessity must be documented in the patient's file. Use modifier NU to identify new lens(es). Use RA when replacing lens(es). See VSP California Medicaid Client Details page.		
V2700	**Balance lens is included in the fee for spectacle lens**	**$0.00**
V2702	Deluxe lens feature	Submit invoice for pricing*
V2710	Slab off prism, glass or plastic, per lens	$36.00
V2715	Prism, per lens	$7.35
V2718	Press-on lens , Fresnel prism, per lens	$14.20
V2744	Tint, photochromic, per lens	$8.98
V2745	Addition to lens, tint: any color, solid, gradient, or equal (excludes photochromic)	$5.00
V2750	Antireflective coating	$13.80

V2755	U-V lens	$8.43
V2760	Scratch resistant coating	$12.33
V2761	Mirror coating, any type, solid, gradient or equal, any lens material	$18.00
V2762	Polarization, any lens material	$33.79
V2770	Occluder lens, per lens (cup or clip patch style)	$6.91
V2780	Oversize lens **is included in the fee for spectacle lens**	$0.00
V2781	Progressive lens	$30.00
V2782	Lens, index, 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbonate	$25.00
V2783	Lens, index greater than or equal to 1.66 plastic or greater than or equal to 1.0 glass, excludes polycarbonate	$30.00
V2784	Lens, polycarbonate or equal, any index.	$7.00
V2799	Vision item or service, miscellaneous	Submit invoice for pricing*

Visually Necessary Contact Lenses

Visually Necessary Contact Lenses: Contacts are only allowed by the Medicaid Plan when visually necessary according to Medicaid's guidelines. Service must be billed with modifier KX. Visual necessity must be documented in the patient's file. Use modifier NU to identify new contact lens(es), unless otherwise indicated. Use modifier RA when replacing contact lens(es), unless otherwise indicated. See VSP California Medicaid Client Details page.		Maximum allowance per eye
V2500	PMMA, spherical	$59.35
V2501	PMMA, toric or prism ballast	$93.32
V2510	Gas permeable, spherical	$79.78
V2511	Gas permeable, toric, prism ballast	$128.94
V2513	Gas permeable, extended wear	$137.33
V2520	Hydrophilic, spherical	$70.39
V2521	Hydrophilic, toric, or prism ballast	$122.54
V2523	Hydrophilic, extended wear	$101.63
V2599	Other contact lens types Use this code to bill only for bandage contact lenses. See client detail pages for billing instructions. Bill with RT or LT modifier in addition to NU or RA and KX as instructed as above.	$54.14
V2799	Vision service, miscellaneous For specialty contact lenses that don't meet a HCPCS definition, use V2799 and modifier NU or RA as appropriate.	Submit invoice for pricing*
S0500	Disposable contact lens	$70.39
S0512	Daily wear specialty contact lens	$122.54
S0514	Color contact lens	$59.35
Visually Necessary Contact Lens Fitting and Dispensing		

In addition to the basic eye examination, a contact lens examination is reimbursable with CPT codes 92310 – 92312 for recipients with visually necessary conditions. Bill with modifier 22 or SC and modifier KX. Visual necessity must be documented in the patient's file.		
92072	Fitting of contact lens for management of keratoconus, initial fitting	$101.93
92310	Prescription of optical and physical characteristics of and fitting of contact lenses, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia	$32.76
92311	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, for aphakia, one eye.	$32.76
92312	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, for aphakia, both eyes.	$32.76

Low Vision Services

Low Vision services are only allowed by the Medicaid Plan when visually necessary according to Medicaid's guidelines. Service must be billed with modifier KX. Visual necessity must be documented in the patient's file. Use modifier NU to identify new materials. Use modifier RA when replacing materials.		
V2600	Hand held, nonspectacle mounted	Submit invoice for pricing*
V2610	Single lens spectacle mounted	Submit invoice for pricing*
V2615	Telescopic and other compound lens systems, including distance vision,	Submit invoice for pricing*
92499	Unlisted ophthalmological service or procedure Use this code to bill for low vision exams. See client detail pages for billing instructions.	$74.36

* Please refer to the Contacting VSP by Mail section of the VSP Manual.

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