vsp vision care

VSP Illinois Medicaid

Network Manual

Check out the **Manuals** on **VSPOnline**

Effective January 1, 2023

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)

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)
Current Procedural Terminology (CPT) Category II codes developed by the American Medical Association (AMA)

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.

See **Services Subject to Review/Audit** for information regarding material record keeping requirements.

LABORATORY

You may use any lab of your choice on a private invoice basis or fabricate your own materials. Exceptions are noted in the Client Detail pages.

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.

Lab 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.

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:	$30.45 per 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.

Base lenses include:

- 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.

ILLINOIS MEDICAID CLIENT DETAILS

Member Identification Number

Health Care Services Corporation (Blue Cross Community Health Plans) members are reported by a unique numeric ID number.

Medicaid Appointment Availability Requirements

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

- 24-hr access to provide instruction on how and where to obtain services, including instructions for an after-hour emergency
- For scheduled appointments, the wait time in offices should not exceed 60 minutes from appointment time, until the time seen by the provider.
- Three weeks (maximum) for scheduling or rescheduling routine, preventative eye exams.
- 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

Exam

Members are eligible for a routine exam once every 12 months from date of service.

Materials Eligibility

20 and under: Members are eligible for lenses and a frame once every 12 months from date of service.

21 and over: Members are eligible for lenses and a frame once every 24 months from date of service.

LENS OPTIONS

Polycarbonate lenses are covered for all members.

The following lens enhancements are covered when visually necessary:

- High index lenses
- Polarized lenses

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

FRAME

Standard frame – V2020 is covered

Safety frame (deluxe) – V2025 is covered when visually necessary. Bill with modifier KX and visual necessity must be documented in the patient file.

CLIENT EXCEPTION

Health Care Services Corporation (Blue Cross Community Health Plans) 30109035, provides a frame allowance of $40 for all members. You can balance bill the patient for any amount beyond the allowance.

Visually Necessary Contact Lenses

Visually necessary contact lenses are covered if one of the following conditions is present:

- Aniridia
- Aphakia
- Corneal Transplant
- Corneal Dystrophies
- Keratoconus
- Nystagmus
- Anisometropia: 3.00 or more diopter difference in prescription between the two eyes
- High Ametropia: greater than or equal to +/- 10.00 diopters in either eye
- Physical condition of ears or nose which prohibits use of eyeglasses

For additional information on conditions that qualify for visually necessary contact lenses please refer to the Contact Lens Benefit section of VSP Provider Reference Manual.

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

CLIENT EXCEPTIONS

For Health Care Services Corporation (Blue Cross Community Health Plans) 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.

Low Vision

Fitting and aid for low vision is covered if visually necessary. Call VSP at **800.615.1883** to obtain an authorization number for low vision claim(s).

LOW VISION AIDS

Essential low vision devices are covered. Low vision corrective devices must include information explaining in detail the patient's need for the device. Please submit a manufacturer's invoice.

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

Vision Therapy

Vision therapy is covered. Bill exam services (92060) and/or vision therapy sessions (92065) with the appropriate diagnosis code(s). Bill vision therapy services with a separate Vision Therapy authorization.

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

Coordination of Benefits

If the member has vision care coverage through another carrier(s), please bill the other carrier(s) first. Once you have received the Explanation of Benefits (EOB), the Remittance Advice or denial letter from the primary insurance, please submit a copy of the documentation along with the claim to VSP. Medicaid is the payer of last resort.

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.

You must accept payment by VSP as payment in full for services rendered and make no additional charge to any person for covered services, less any applicable copays.

NON-COVERED SERVICES/MATERIALS

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 charge(s) for the service/material(s).
- The patient or guardian must sign an Agreement of Financial Responsibility Form 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 non-covered services or materials. Treat this as a private-pay transaction and follow your private pay-patient policy.

Repair and Replacement

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

Children less than 21 years of age do not have limits on glasses. Eyeglasses may be replaced as needed without prior approval if there is a change in the prescription meeting

Illinois Department of Healthcare and Family Services requirements, or if they are broken beyond repair, lost, or stolen.

- The difference between the old and new prescription is at least 0.75 diopters in either the sphere or cylinder component

Adults who are 21 years of age and older are limited to one pair of eyeglasses in a 24-month service period; however, this does not limit medically necessary eye examinations, or claims for repair/refitting of eyeglasses.

The Illinois Department of Healthcare and Family Services regards the maintenance of adequate records essential for the delivery of quality medical care. Providers must maintain an office record for each patient. The record maintained by the provider is to include the essential details of the patient's condition and of each service or material provided. The signature of the provider is required for the record of the service/visit to be complete. If there is no signature, then the record is incomplete.

Visual necessity must be documented in the patient's file.

Timely Filing

File claims within 180 days of the date of service to ensure compliance with Illinois Medicaid guidelines. Claims that are not filed within this timeframe may be denied. Any corrections to a claim must also be received and/or adjusted within the same time frame. If a correction is received after the deadline, no additional funds will be reimbursed.

Cultural Competency and Language Assistance

AMERICAN SIGN LANGUAGE (ASL) INTERPRETER REQUESTS

Under the Americans with Disabilities Act of 1990, eye doctors and other health care providers are required under this federal law to provide American Sign Language (ASL) interpreter services, at no cost to the patient, to patients who need and request ASL interpreter 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**.

VSP Members Language Assistance Program

VSP provides Cultural Competency training on the Training & Support section of VSPOnline. Several resources addressing topics of interpretation services, better communication, health literacy and census information are available in addition to the training modules.

VSP has implemented a Language Assistance Program (LAP) to provide linguistic services to enrollees who prefer to conduct their affairs in a language other than English including the availability of free interpreter services at the time of an appointment for patients who request them.

DOCUMENT TRANSLATION AND ALTERNATIVE FORMATS

Members who prefer their VSP member materials in a language other than English can receive free translation of VSP member documents, including alternative formats such as

Braille, large format and audio. You may contact VSP Customer Care at **800.615.1883** for more information.

INTERPRETATION

VSP provides telephone interpretation services to any VSP member who prefers to communicate with VSP about their benefits in a language other than English, including TTY/TDD for those who are hearing impaired.

VSP members who want to discuss their benefits in another language can call VSP at **800.877.7195** and indicate their language need. Members can also visit vsp.com to see a list of VSP practices where language(s) other than English are spoken.

You are required to keep your office(s) language capabilities current so members know where they can receive services in languages other than English. We encourage you to review practice information quarterly on VSPOnline at **eyefinity.com**.

Practices must keep in mind that family, friends, and minor children are considered untrained health interpreters. Using family, friends, and minor children poses a problem with patient privacy. In addition, family may impose their view of the patient and their health that can lead to less than the highest quality care desired. To request face-to-face interpretation services at no cost to you or your patient, contact VSP customer Care at **800.615.1883**.

Note: If a patient insists that the provider or staff communicate with bilingual family or friends, document in the member patient record that the VSP member refuses interpreter services and/or uses friend or family to interpret.

DOCUMENTATION

The following items should be documented in the patient's medical record and/or patient history form:

- Patient's preferred written and spoken language
- Refusal of interpreter (if applicable)
- Use of interpreter and who (family member, minor, friend, doctor, office staff, or trained professional interpreter)
- Patient requests to have interpretation services

It is suggested to also document the patient's race and ethnicity with an option for the patient not disclose this information.

CULTURAL COMPETENCY TRAINING

Providers serving Medicaid members are required to complete cultural competence training annually and attest to having completed the training. VSP offers this training on VSPOnline at **eyefinity.com**. If you have completed cultural competency training elsewhere, you may attest to that.

VSP ILLINOIS MEDICAID PLAN

PROFESSIONAL FEE SCHEDULE FOR ROUTINE SERVICES

Effective 4/1/2022

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

92002	Intermediate exam, new patient	$34.76
92004	Comprehensive exam, new patient	$40.00
92012	Intermediate exam, established patient	$30.62
92014	Comprehensive exam, established patient	$40.00
92015	Determination of refractive state	$10.00

Dispensing and Material Services

Frame:		
V2020	Frame (includes case)	$20.00
V2025	Deluxe frame Service must be billed with modifier KX. See VSP Illinois Medicaid Client Details for requirements. Visual necessity must be documented in the patient's file.	$35.00

Dispensing:		
92340	Fitting of spectacles, except for aphakia; monofocal	$20.24
92341	Fitting of spectacles, except for aphakia; bifocal	$28.14

Single Vision Lenses, per lens:		
V2100	Sphere, plano to ± 4.00d	$6.38
V2101	Sphere, ± 4.12 to ± 7.00d	$6.38
V2102	Sphere, ± 7.12 to ± 20.00d	$10.21
V2103	Spherocylinder, plano to ± 4.00d sphere, 0.12 to 2.00d cylinder	$6.38
V2104	Spherocylinder, plano to ± 4.00d sphere, 2.12 to 4.00d cylinder	$6.38
V2105	Spherocylinder, plano to ± 4.00d sphere, 4.25 to 6.00d cylinder	$10.21
V2106	Spherocylinder, plano to ± 4.00d sphere, over 6.00d cylinder	$10.21
V2107	Spherocylinder, ± 4.25 to ± 7.00d sphere, 0.12 to 2.00d cylinder	$6.38
V2108	Spherocylinder, ± 4.25 to ± 7.00d sphere, 2.12 to 4.00d cylinder	$6.38
V2109	Spherocylinder, ± 4.25 to ± 7.00d sphere, 4.25 to 6.00d cylinder	$10.21
V2110	Spherocylinder, ± 4.25 to ± 7.00d sphere, over 6.00d cylinder	$10.21
V2111	Spherocylinder, ± 7.25 to ± 12.00d sphere, 0.25 to 2.25d cylinder	$10.21
V2112	Spherocylinder, ± 7.25 to ± 12.00d sphere, 2.25 to 4.00d cylinder	$10.21

Single Vision Lenses, per lens:		
V2113	Spherocylinder, ± 7.25 to ± 12.00d sphere, 4.25 to 6.00d cylinder	$10.21
V2114	Spherocylinder, sphere over ± 12.00d	$10.21
V2115	Lenticular, myodisc	$19.00
V2121	Lenticular lens, single	$19.00
V2199	Specialty single vision Service must be billed with modifier KX. See VSP Illinois Medicaid Client Details for requirements. Visual necessity must be documented in the patient's file.	Submit invoice for pricing*

Bifocal Lenses, per lens:		
V2200	Sphere, plano to ± 4.00d	$12.43
V2201	Sphere, ± 4.12 to ± 7.00d	$12.43
V2202	Sphere, ± 7.12 to ± 20.00d	$17.20
V2203	Spherocylinder, plano to ± 4.00d sphere, 0.12 to 2.00d cylinder	$12.43
V2204	Spherocylinder, plano to ± 4.00d sphere, 2.12 to 4.00d cylinder	$12.43
V2205	Spherocylinder, plano to ± 4.00d sphere, 4.25 to 6.00d cylinder	$17.20
V2206	Spherocylinder, plano to ± 4.00d sphere, over 6.00d cylinder	$17.20
V2207	Spherocylinder, ± 4.25 to ± 7.00d sphere, 0.12 to 2.00d cylinder	$12.43
V2208	Spherocylinder, ± 4.25 to ± 7.00d sphere, 2.12 to 4.00d cylinder	$12.43
V2209	Spherocylinder, ± 4.25 to ± 7.00d sphere, 4.25 to 6.00d cylinder	$17.20
V2210	Spherocylinder, ± 4.25 to ± 7.00d sphere, over 6.00d cylinder	$17.20
V2211	Spherocylinder, ± 7.25 to ± 12.00d sphere, 0.25 to 2.25d cylinder	$17.20
V2212	Spherocylinder, ± 7.25 to ± 12.00d sphere, 2.25 to 4.00d cylinder	$17.20
V2213	Spherocylinder, ± 7.25 to ± 12.00d sphere, 4.25 to 6.00d cylinder	$17.20
V2214	Spherocylinder, sphere over ± 12.00d	$17.20
V2215	Lenticular, myodisc	$28.30
V2221	Lenticular lens, bifocal	$28.30
V2299	Specialty bifocal Service must be billed with modifier KX. See VSP Illinois Medicaid Client Details for requirements. Visual necessity must be documented in the patient's file.	Submit invoice for pricing*

Variable Asphericity Lenses, per lens:		
V2410	Variable asphericity lens, single vision, full field, glass or plastic	$14.50
V2430	Variable asphericity lens, bifocal, full field, glass or plastic	$24.50

Miscellaneous Covered Options and Services, per lens:		
V2700	Balance lens	$6.38
V2710	Slab off, glass or plastic	$30.45
V2715	Prism	$2.71

Miscellaneous Covered Options and Services, per lens:		
V2730	Special base curve, glass or plastic	$13.03
V2756	Frame case included in the reimbursement for frame	$0.00
V2784	Lens, polycarbonate or equal, any index	$6.43
Miscellaneous Covered Options and Services, per lens: The below services must be billed with modifier KX. See VSP Illinois Medicaid Client Details for requirements. Visual necessity must be documented in the patient's file.		
V2762	Polarization	$29.97
V2782	Lens, index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbonate	$32.37
V2797	Vision supply, accessory and/or service component of another HCPCS vision code	Submit invoice for pricing*
V2799	Miscellaneous vision service	Submit invoice for pricing*

Repair Services

Repair and refitting codes cannot be billed with dispensing and/or material HCPCS codes (e.g., V2020) on the same date of service.		
92370	Repair and refitting spectacles; except for aphakia	$4.63

Visually Necessary Contact Lenses

Visually Necessary Contact Lens Fitting and Dispensing Service must be billed with modifier KX. See VSP Illinois Medicaid Client Details for requirements. Visual necessity must be documented in the patient's file.		
92072	Fitting of contact lens for management of keratoconus, initial fitting	$125.12
92310	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia	$100.32
92311	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, for aphakia, one eye	$103.11
92312	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, for aphakia, both eyes	$118.62
92313	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneoscleral lens	$96.80
92314	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and fitting by independent technician; corneoscleral lens, both eyes except for aphakia	$84.69
92315	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and fitting by independent technician; corneal lens for aphakia, one eye	$78.17

92316	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and fitting by independent technician; corneal lens for aphakia, both eyes	$97.01
92317	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and fitting by independent technician; corneoscleral lens	$81.99

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. See VSP Illinois Medicaid Client Details for requirements. Visual necessity must be documented in the patient's file.		Maximum allowance per eye
V2500	PMMA, spherical	$92.01
V2501	PMMA, toric or prism ballast	$122.68
V2520	Hydrophilic, spherical	$122.25
V2531	Scleral, gas permeable	$544.58
V2599	Contact lens, other type	Submit invoice for pricing*

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. See VSP Illinois Medicaid Client Details for requirements. Visual necessity must be documented in the patient's file.		
92354	Fitting of spectacle mounted low vision aid; single element system	$12.50
92355	Fitting of spectacle mounted low vision aid; telescopic or other compound lens system	$19.60
V2600	Hand held low vision and other nonspectacle mounted aids	Submit invoice for pricing*

Vision Therapy

Vision Therapy services must be billed with modifier KX. See VSP Illinois Medicaid Client Details for requirements. Visual necessity must be documented in the patient's file.		
92060	Sensorimotor examination with multiple measurements of ocular deviation with interpretation and report	$60.86
92065	Orthoptic training; performed by a physician or other qualified health care professional	$50.97

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

vsp vision care

PO Box 997100
Sacramento, CA 95899-7100
800.615.1883

vsp.com