vsp vision care

VSP Michigan 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.

MICHIGAN MEDICAID CLIENT DETAILS

Member Identification Number

Aetna Better Health members are reported by a 10-digit identification number.

Molina Healthcare members are reported by a 10 or 12-digit identification number.

Note: Some Molina Healthcare members may be eligible for Medicare and Medicaid coverage (Dual eligible). When checking eligibility online, use the member's 12-digit ID Medicare number displayed on their medical card.

If dual coverage is available, bill Medicare as primary and Medicaid as secondary.

Medicaid Appointment Availability Requirements

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

- 24-hour access to provide instruction on how and where to obtain services
- 30 business days 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

Aetna Better Health members are eligible for an exam every 12 months.

Molina Healthcare (Medicaid) members are eligible for an exam every 24 months.

Molina Duals Options Michigan Health Link (MMP) members are eligible for an exam every 24 months.

Referral

If the patient requires referral to a specialist/MD, refer the patient to the client or the patient's primary physician.

Coordination of Benefits

COMMERCIAL

If a Medicaid beneficiary is enrolled in a commercial health insurance plan, the rules for coverage by the commercial health insurance must be followed. Medicaid is liable for Medicaid covered services that are not part of the commercial health insurance coverage. A response from the other insurance (e.g., Remittance Advice (RA), Explanation of Payments (EOP), Explanation of Medicare Benefits (EOMB) or a denial letter) must be obtained and submitted with the claim.

Aetna Better Health MIChild (SCHIP) members cannot be enrolled in another health plan.

MEDICARE

- Procedure codes 92002-92014 and 92015 must be billed to Medicare prior to billing VSP.

- Submit the Medicare claim to VSP with the RA, EOP, or EOMB or denial letter.
- Do not use S0620 or S0621 to bill eye exams or eye refractions for Medicare patients.

For additional information regarding coordination of benefits, see Submitting Claims/Billing & Reimbursement.

Materials Eligibility

Aetna Better Health members are eligible for materials every 12 months.

Molina Healthcare (Medicaid) members are eligible for materials every 24 months.

Molina Duals Options Michigan Healthlink (MMP) members are eligible for materials every 12 months.

INITIAL LENSES

Initial lenses are defined as the first prescription lenses worn by a person regardless of how they were obtained (i.e., through Medicaid, commercial insurance or a private-pay transaction). The following minimum diopter criteria must be met:

MIChild and Members under 43:

- 0.50D myopia or astigmatism
- 0.75D anisometropia or hyperopia

Members 43 and over:

- 0.50D myopia, astigmatism, hyperopia or presbyopia
- 0.75D anisometropia

SUBSEQUENT LENSES

Members are covered for subsequent lenses -- visually necessary lenses that are provided after the initial lenses are dispensed due to a refractive change in one eye of at least:

- 0.75D in the meridian of greatest change;
- or a change in the cylinder axis of at least 10 degrees for cylinders of 1.00D or more.

These lenses must meet the minimum diopter criteria specified above. Subsequent lenses are not replacement lenses. Please refer to the Replacement section for information on replacement lenses.

TWO PAIR IN LIEU OF BIFOCAL

Members may receive two pairs of single vision lenses, one for distance vision and one for near vision, in lieu of bifocal eyeglasses, if the patient meets either of the following instances:

- The patient has clearly demonstrated the inability to adjust to bifocals.
- The patient's physical condition does not allow for bifocal usage.

Visual necessity must be documented in the patient's medical record. Call VSP at 800.615.1883 for the **second authorization number**.

Providing both multi-focal and single vision eyeglasses for interchangeable usage is not covered.

POLYCARBONATE LENSES

Members are covered for polycarbonate lenses when the diopter criteria for initial or subsequent lenses is met.

To identify polycarbonate lenses, use one of the appropriate base lens HCPCS procedure codes listed below and add modifier U1.

V2100-V2114
V2200-V2214

HIGH INDEX LENSES

Members are covered for high index lenses when the diopter criteria for initial or subsequent lenses is met. To identify high index lenses, use one of the appropriate base lens HCPCS procedure codes listed below and add modifier U2.

V2102, V2111, V2112, V2113, V2114, V2202, V2211, V2212, V2213, V2214

Modifier	Description	Special Instructions
U1	Polycarbonate lenses	Determines payment rate.*
U2	High index lenses	Determines payment rate.*

*V2782 and V2784 will not be reimbursed separately.

FRAME

A frame is a covered benefit for members at no cost.

DISPENSING SERVICES

Dispensing services are a Medicaid benefit and do not require PA. Vision providers may bill a dispensing fee for dispensing prescription lenses, prescription lenses with frames, or replacing a complete frame.

Reimbursement for the dispensing service includes the vision provider's services in selecting, ordering, verifying, and aligning/fitting of eyeglasses as described above. Routine follow-up and post-prescription visits (e.g., for minor adjustments) are considered part of the dispensing service and are not separately reimbursable.

SAFETY FRAME

Members are covered for safety frames, in addition to regular eyeglasses. These frames correspond to ANSI Z87.1-2003 standards.

Polycarbonate lenses of a minimum two-millimeter thickness must be inserted in a safety frame marked "Z 87" or "Z 87-2."

To identify polycarbonate lenses, use one of the appropriate base lens HCPCS procedure codes listed below and add modifier U1.

V2100-V2114
V2200-V2214

Note: Do not bill the U1 modifier with HCPCS procedure code S0581.

FRAME CASE

One frame case must be provided to the patient as it is a covered material and included in the frame reimbursement.

VISUALLY NECESSARY CONTACT LENSES AND FITTING/DISPENSING

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

- Aphakia
- Keratoconus (if vision cannot be improved to 20/40 or better with eyeglasses)
- Anisometropia or antimetropia (2D or greater that results in aniskonia)
- Congenital cataracts
- Aniridia
- Irregular cornea
- Keratoconjuctivitis sicca
- Other conditions which have no alternative treatment.

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

Patient Responsibility

COVERED SERVICES/MATERIALS

NOTE: It's the doctor's responsibility to verify the eligibility status of each patient 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 U&C fees for the non-covered services or materials if all of the following requirements are met. For exceptions, please refer to Covered Services section above.

- 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.
- 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 these non-covered services or materials. Treat this as a private-pay transaction and follow your private-pay patient policy.

MISSED APPOINTMENTS

Medicaid patients may not be billed for missed appointments.

Repair

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

The following frame repairs are not a covered benefit and cannot be billed to VSP or the patient:

- Aligning temples
- Insertion of screws
- Adjusting frames

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

Replacement

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

FREQUENCY

Aetna Better Health and Molina Healthcare members (20 and under): No more than two pairs of replacement eyeglasses per year if replacement is due to loss, materials broken beyond repair or theft. Visual necessity must be documented in the patient's medical record.

Aetna Better Health members and Molina Healthcare (21 and over): One pair of replacement eyeglasses per year if replacement is due to loss, materials broken beyond repair or theft. Visual necessity must be documented in the patient's medical record.

CRITERIA FOR REPLACEMENT

- **Complete pair of glasses:** When ordering a complete pair of eyeglasses, due to loss, materials broken beyond repair or theft, the replacement eyeglasses must be identical to the previously issued Medicaid eyeglasses.
- **Lenses Only:** Replacement of corrective lenses without frame, due to damage or breakage, is a benefit only if the replacement lenses are covered by Medicaid and the replacement limits have not been exceeded. Replacement lenses must be an identical copy of the damaged or broken lenses.
- **Frames Only:** Replacement of a complete frame (front and temple) is a benefit only when the original frame is broken beyond repair, the prescription lenses remain usable and the replacement limits have not been exceeded. The replacement frame must be identical to the previously issued frame. If an identical frame is not available, the patient must select a frame that is covered by Medicaid. If a previously used frame (acquired before eligibility for Medicaid) requires lenses that are not a benefit (e.g., oversize lenses), a complete pair of eyeglasses that are covered by Medicaid must be ordered.
- **Contact Lens:** Replacement of contact lenses is a benefit only if the replacement contact lenses are covered by Medicaid and the replacement limits have not been exceeded. Replacement contact lenses must be visually necessary.

Aetna Better Health and Molina Healthcare members (20 and under): Two replacements are allowed for each eye per year from the date of order of the initial or subsequent visually necessary contacts.

Aetna Better Health and Molina Healthcare members (21 and over): One replacement is allowed for each eye per year from the date of order of the initial or subsequent visually necessary contacts.

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

Timely Filing

Providers must file claims within 12 months from the date of service to ensure compliance with Michigan Medicaid guidelines. Claims received outside of this timeframe may be denied for untimely submission.

Client Exceptions

Molina MMP members are eligible for post-cataract services (exam and materials following cataract surgery). See Post Cataract Enhancement Clients for complete information. 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.

Bill visually necessary lens enhancements using the corresponding HCPCS code or miscellaneous HCPCS code with lab invoice based on fee schedule with the appropriate diagnosis codes and modifier KX. Visual necessity must be documented in the patient's file.

Low Vision

A low vision evaluation is covered for members who present with moderate, severe, or profound visual impairment. See the **Michigan 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).

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.

Vision Therapy

Vision Therapy is covered as needed. Bill exam services (92060) and/or vision therapy sessions (92065) with appropriate diagnosis code(s). 92499 used for unlisted ophthalmological service or rocedure, used for vision therapy training aid.

Note: For all vision therapy services, bill with appropriate diagnosis codes and modifier KX. Visual necessity must be documented in the patient's file. Issue an authorization under Vision Therapy.

Essential Medical Eye Care Coverage

Essential Medica 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 MICHIGAN MEDICAID PLAN

PROFESSIONAL FEE SCHEDULE FOR ROUTINE SERVICES

Effective 7/1/2018

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

Exam Services

S0620	Ophthalmological exam including refraction, new patient	$46.75
S0621	Ophthalmological exam including refraction, established patient.	$49.13
Procedure codes 92002, 92004, 92012, 92014, and 92015 are covered for Medicare patients only. See VSP Michigan Medicaid Client Detail pages Coordination of Benefits Medicare.		
92002	Intermediate exam, new patient	$37.40
92004	Comprehensive exam, new patient	$39.78
92012	Intermediate exam, established patient	$37.40
92014	Comprehensive exam, established patient	$39.78
92015	Determination of refractive state	$9.35

Frame

V2020	Frame (includes case)	$31.90
V2756	Eye glass case	$0.00

Dispensing

92340	Fitting of spectacles, except for aphakia; monofocal	$19.81
92341	Fitting of spectacles, except for aphakia; bifocal	$22.58
92342	Fitting of spectacles, except for aphakia; multifocal, other than bifocal	$24.37
92352	Fitting of spectacle prosthesis for aphakia; monofocal	$22.58
92353	Fitting of spectacle prosthesis for aphakia; multifocal	$26.35

Spectacle Services

Single Vision Lenses, per lens: **Use modifier U1 to identify polycarbonate lenses** **Use modifier U2 to identify high-index lenses**		
V2100	Sphere, plano to ± 4.00D	$4.80
V2100 - U1	Sphere, plano to ± 4.00D	$8.64
V2101	Sphere, plano to ± 4.12 to 7.00 D	$5.57
V2101 - U1	Sphere, plano to ± 4.12 to 7.00 D	$9.72
V2102	Sphere, plano to ± 7.12 to 20.00 D	$8.41
V2102 - U1	Sphere, plano to ± 7.12 to 20.00 D	$10.26
V2102 - U2	Sphere, plano to ± 7.12 to 20.00 D	$13.50

V2103	Spherocylinder, plano to ± 4.00D, sphere, .12 to 2.00D cylinder	$4.91
V2103 - U1	Spherocylinder, plano to ± 4.00D, sphere, .12 to 2.00D cylinder	$8.85
V2104	Spherocylinder, plano to ± 4.00D, sphere, 2.12 to 4.00D cylinder	$7.07
V2104 - U1	Spherocylinder, plano to ± 4.00D, sphere, 2.12 to 4.00D cylinder	$10.12
V2105	Spherocylinder, plano to ± 4.00D, sphere, 4.25 to 6.00D cylinder	$7.95
V2105 - U1	Spherocylinder, plano to ± 4.00D, sphere, 4.25 to 6.00D cylinder	$10.26
V2106	Spherocylinder, plano to ± 4.00D, sphere, over 6.00D cylinder	$8.11
V2106 - U1	Spherocylinder, plano to ± 4.00D, sphere, over 6.00D cylinder	$10.81
V2107	Spherocylinder, plano to ± 4.25 to 7.00D sphere, .12 to 2.00D cylinder	$5.60
V2107 - U1	Spherocylinder, plano to ± 4.25 to 7.00D sphere, .12 to 2.00D cylinder	$9.75
V2108	Spherocylinder, plano to ± 4.25 to 7.00D sphere, 2.12 to 4.00D cylinder	$7.50
V2108 - U1	Spherocylinder, plano to ± 4.25 to 7.00D sphere, 2.12 to 4.00D cylinder	$10.61
V2109	Spherocylinder, plano to ± 4.25 to 7.00D sphere, 4.25 to 6.00D cylinder	$8.14
V2109 - U1	Spherocylinder, plano to ± 4.25 to 7.00D sphere, 4.25 to 6.00D cylinder	$9.47
V2110	Spherocylinder, plano to ± 4.25 to 7.00D sphere, over 6.00D cylinder	$8.12
V2110 - U1	Spherocylinder, plano to ± 4.25 to 7.00D sphere, over 6.00D cylinder	$11.22
V2111	Spherocylinder, plano to ± 7.25 to 12.00D sphere, .25 to 2.25d cylinder	$8.09
V2111 - U1	Spherocylinder, plano to ± 7.25 to 12.00D sphere, .25 to 2.25d cylinder	$10.67
V2111 - U2	Spherocylinder, plano to ± 7.25 to 12.00D sphere, .25 to 2.25d cylinder	$13.81
V2112	Spherocylinder, plano to ± 7.25 to 12.00D sphere, 2.25 to 4.00D cylinder	$8.36
V2112 - U1	Spherocylinder, plano to ± 7.25 to 12.00D sphere, 2.25 to 4.00D cylinder	$10.19
V2112 - U2	Spherocylinder, plano to ± 7.25 to 12.00D sphere, 2.25 to 4.00D cylinder	$13.81
V2113	Spherocylinder, plano to ± 7.25 to 12.00D sphere, 4.25 to 6.00D cylinder	$8.75
V2113 - U1	Spherocylinder, plano to ± 7.25 to 12.00D sphere, 4.25 to 6.00D cylinder	$10.26
V2113 - U2	Spherocylinder, plano to ± 7.25 to 12.00D sphere, 4.25 to 6.00D cylinder	$15.80
V2114	Spherocylinder, sphere over ± 12.00D	$7.01
V2114 - U1	Spherocylinder, sphere over ± 12.00D	$10.97

V2114 - U2	Spherocylinder, sphere over ± 12.00D	$17.05
V2115	Lenticular, myodisc	$14.69
V2121	Lenticular, single vision	$19.94
V2199	Not otherwise classified single vision lens Service must be billed with modifier KX. Visual necessity must be documented in the patient's file.	Submit invoice for pricing*
Bifocal Lenses, per lens: **Use modifier U1 to identify polycarbonate lenses** **Use modifier U2 to identify high-index lenses**		
V2200	Sphere, plano to ± 4.00D	$6.73
V2200 - U1	Sphere, plano to ± 4.00D	$11.77
V2201	Sphere, ± 4.12 to 7.00D	$7.80
V2201 - U1	Sphere, ± 4.12 to 7.00D	$11.73
V2202	Sphere, ± 7.12 to 20.00D	$9.18
V2202 - U1	Sphere, ± 7.12 to 20.00D	$14.53
V2202 - U2	Sphere, ± 7.12 to 20.00D	$19.56
V2203	Spherocylinder, plano to ± 4.00D sphere, .12 to 2.00D cylinder	$7.73
V2203 - U1	Spherocylinder, plano to ± 4.00D sphere, .12 to 2.00D cylinder	$11.50
V2204	Spherocylinder, plano to ± 4.00D sphere, 2.12 to 4.00D cylinder	$7.82
V2204 - U1	Spherocylinder, plano to ± 4.00D sphere, 2.12 to 4.00D cylinder	$11.09
V2205	Spherocylinder, plano to ± 4.00D sphere, 4.25 to 6.00D cylinder	$7.98
V2205 - U1	Spherocylinder, plano to ± 4.00D sphere, 4.25 to 6.00D cylinder	$11.64
V2206	Spherocylinder, plano to ± 4.00D sphere, over 6.00D cylinder	$7.97
V2206 - U1	Spherocylinder, plano to ± 4.00D sphere, over 6.00D cylinder	$11.79
V2207	Spherocylinder, ± 4.25 to 7.00D sphere, .12 to 2.00D cylinder	$7.80
V2207 - U1	Spherocylinder, ± 4.25 to 7.00D sphere, .12 to 2.00D cylinder	$11.79
V2208	Spherocylinder, ± 4.25 to 7.00D sphere, 2.12 to 4.00D cylinder	$7.89
V2208 - U1	Spherocylinder, ± 4.25 to 7.00D sphere, 2.12 to 4.00D cylinder	$10.89
V2209	Spherocylinder, ± 4.25 to 7.00D sphere, 4.25 to 6.00D cylinder	$7.83
V2209 - U1	Spherocylinder, ± 4.25 to 7.00D sphere, 4.25 to 6.00D cylinder	$8.63
V2210	Spherocylinder, ± 4.25 to 7.00D sphere, over 6.00D cylinder	$7.70
V2210 - U1	Spherocylinder, ± 4.25 to 7.00D sphere, over 6.00D cylinder	$8.67
V2211	Spherocylinder, ± 7.25 to 12.00D sphere, .25 to 2.25Dcylinder	$7.87
V2211 - U1	Spherocylinder, ± 7.25 to 12.00D sphere, .25 to 2.25Dcylinder	$16.08
V2211 - U2	Spherocylinder, ± 7.25 to 12.00D sphere, .25 to 2.25Dcylinder	$20.30
V2212	Spherocylinder, ± 7.25 to 12.00D sphere, 2.25 to 4.00D cylinder	$8.03
V2212 - U1	Spherocylinder, ± 7.25 to 12.00D sphere, 2.25 to 4.00D cylinder	$11.64
V2212 - U2	Spherocylinder, ± 7.25 to 12.00D sphere, 2.25 to 4.00D cylinder	$25.13
V2213	Spherocylinder, ± 7.25 to 12.00D sphere, 4.25 to 6.00D cylinder	$7.73
V2213 - U1	Spherocylinder, ± 7.25 to 12.00D sphere, 4.25 to 6.00D cylinder	$13.14

V2213 - U2	Spherocylinder, ± 7.25 to 12.00D sphere, 4.25 to 6.00D cylinder	$32.52
V2214	Spherocylinder, over ± 12.00D	$8.00
V2214 - U1	Spherocylinder, over ± 12.00D	$12.00
V2214 - U2	Spherocylinder, over ± 12.00D	$33.55
V2219	Bifocal seg width over 28mm	$2.88
V2220	Bifocal add over 3.25D	$2.88
V2221	Lenticular, bifocal	$15.00
V2299	Specialty bifocal Service must be billed with modifier KX. Visual necessity must be documented in the patient's file.	Submit invoice for pricing*
Trifocal Lenses, per lens:		
V2300	Sphere, plano to ± 4.00D	$9.32
V2301	Sphere, ± 4.12 to 7.00D	$8.97
V2302	Sphere, ± 4.12 to 7.00D	$6.60
V2303	Spherocylinder, plano to ± 4.00D sphere, .12 to 2.00D cylinder	$9.16
V2304	Spherocylinder, plano to ± 4.00D sphere, 2.12 to 4.00D cylinder	$9.16
V2305	Spherocylinder, plano to ± 4.00D sphere, 4.25 to 6.00D	$8.90
V2306	Spherocylinder, plano to ± 4.00D sphere, over 6.00D cylinder	$9.24
V2307	Spherocylinder, ± 4.25 to 7.00D sphere, .12 to 2.00D cylinder	$9.24
V2308	Spherocylinder, ± 4.25 to 7.00D sphere, 2.12 to 4.00D cylinder	$9.54
V2309	Spherocylinder, ± 4.25 to 7.00D sphere, 4.25 to 6.00D cylinder	$6.60
V2310	Spherocylinder, ± 4.25 to 7.00D sphere, over 6.00D cylinder	Submit invoice for pricing*
V2311	Spherocylinder, ± 7.25 to 12.00D sphere, .25 to 2.25D cylinder	$10.77
V2312	Spherocylinder, ± 7.25 to 12.00D sphere, 2.25 to 4.00D cylinder	$11.01
V2313	Spherocylinder, ± 7.25 to 12.00D sphere, 4.25 to 6.00D cylinder	$6.60
V2314	Spherocylinder, over ± 12.00D	$6.60
V2320	Trifocal add over 3.25D	$2.88
V2399	Specialty trifocal Service must be billed with modifier KX. 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	$16.41
V2430	Variable asphericity lens, bifocal, full field, glass or plastic	$18.30
V2499	Variable asphericity lens, other type Service must be billed with modifier KX. Visual necessity must be documented in the patient's file.	Submit invoice for pricing*

Miscellaneous Covered Options and Services, per lens:

V2700	Balance lens	Submit invoice for pricing*
V2710	Slab off	$44.79
V2715	Prism	$2.55
V2718	Press-on lens, Fresnel prism	$2.55
V2782	Index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbonate is included in the fee for spectacle lens	$0.00
V2784	polycarbonate or equal, any index is included in the fee for spectacle lens	$0.00
S0581	Non-standard lens (use this code plus the appropriate lens code to initiate industrial thickness lenses)	$1.92
Miscellaneous Covered Options and Services, per lens: Service must be billed with modifier KX. Visual necessity must be documented in the patient's file.		
V2744	Photochromic	$6.67
V2745	Addition to lens, tint	$1.50
V2755	UV lens	$4.00
V2799	Vision item or service, miscellaneous	Submit invoice for pricing*

Repair and Refitting

92370	Repair and refitting spectacles; except for aphakia	$17.23
92371	Repair and refitting spectacles; spectacle prosthesis for aphakia	$6.54

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 Michigan Medicaid Client Details for requirements. Visual necessity must be documented in the patient's file.		Maximum allowance per eye
V2500	Contact lens, PMMA, spherical	Submit invoice for pricing*
V2501	Contact lens, PMMA, toric or prism ballast	Submit invoice for pricing*
V2510	Contact lens, gas permeable, spherical	Submit invoice

		for pricing*
V2511	Contact lens, gas permeable, toric or prism ballast	Submit invoice for pricing*
V2520	Contact lens, hydrophilic, spherical	Submit invoice for pricing*
V2521	Contact lens, hydrophilic, toric or prism ballast	Submit invoice for pricing*
V2531	Contact lens, scleral, gas permeable	Submit invoice for pricing*
V2599	Contact lens, other type	Submit invoice for pricing*

Visually Necessary Contact Lens Fitting and Dispensing

Contact lens fitting and dispensing is only allowed by the Medicaid Plan when visually necessary according to Medicaid's guidelines. Service must be billed with modifier KX. See VSP Michigan 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	$74.88
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	$53.49
92311	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, one eye	$56.26
92312	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, both eyes	$65.57
92313	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneoscleral lens	$54.28
92326	Replacement of contact lens	$30.00

Comprehensive Contact Lens Evaluation

Comprehensive contact lens evaluation is only allowed by the Medicaid Plan when visually necessary according to Medicaid's guidelines. Service must be billed with modifier KX. See VSP Michigan Medicaid Client Details for requirements. Visual necessity must be documented in the patient's file.

S0592	Comprehensive contact lens evaluation Note: Code S0592 may not be billed with any other procedure code. Use this code when this is the only service performed.	$28.72

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.		
92081	Visual field exam, with interpretation and report; limited	$18.82
92082	Visual field exam, with interpretation and report; intermediate	$26.74
92083	Visual field exam, with interpretation and report; extended	$35.86
99205	Office visit, new, level 5,	$115.10
99215	Office visit, established, level 5	$80.82
V2600	Hand held low vision aids and other non-spectacle mounted aids	Submit invoice for pricing*
V2610	Single lens spectacle mounted low vision aids	Submit invoice for pricing*
V2615	Telescopic and other compound lens systems, including distance vision, telescopic	Submit invoice for pricing*

Vision Therapy

Vision Therapy services must be billed with modifier KX. See VSP Michigan Medicaid Client Details for requirements. Visual necessity must be documented in the patient's file.		
92060	Sensorimotor exam with multiple measurements of ocular deviation. See VSP Michigan Medicaid Client Detail pages for covered conditions.	$36.25
92065	Orthoptic training; performed by a physician or other qualified health care professional See VSP Michigan Medicaid Client Detail pages for qualifying training sessions.	$29.72
92499	Unlisted ophthalmological service or procedure; use for vision therapy training aid.	Submit invoice for pricing*

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

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