VSP® Indiana Medicaid
Network Manual

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

Effective January 1, 2021

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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 VSP's Primary EyeCare Plan 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.

CPT Category II Codes for Eye Exams for Patients with Diabetes

As a health-focused vision care company, VSP highly encourages providers to use CPT Category II codes. The use of Category II codes for Healthcare Effectiveness Data and Information Set (HEDIS®) performance measures helps confirm that you are providing the best quality patient care and further emphasizes the essential role Doctor of Optometry play in overall healthcare. Providing this information also decreases the administrative burden of pulling chart notes for requested patients.

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 comprised of four digits followed by the letter "F".
- CPT Category II codes are for reporting purposes only and are not separately reimbursable.

BILLING CPT CATEGORY II CODES

- CPT Category II codes are billed in the procedure code field, the same as CPT Category I codes.
- 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 eye exams for patients with diabetes use the following optometry-related CPT Category II codes, when applicable:

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
2026	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.

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. You must bill for both the contact lens fitting and materials, to be reimbursed.

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 lens 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
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
H49.00 – 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 VSP's Primary EyeCare Medicaid fee schedule for the state in which you reside. 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.

INDIANA MEDICAID CLIENT DETAILS

Member Identification Number

Members are reported by a 12-digit identification number.

Medicaid Appointment Availability Requirements

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

- 24-hour access to provide instruction on how and where to obtain services
- 30 calendar days for scheduling or rescheduling routine, preventative eye exams
- on-Urgent Symptomatic appointments within 72 hours
- 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

Anthem Hoosier Care Connect, Anthem Hoosier Healthwise and Anthem Healthy Indiana (HIP 2.0, ages 19 - 64): Members are eligible for exam every 12 months.

Copay

Anthem Healthy Indiana (HIP 2.0, ages 19 – 64): $4 copay for Primary EyeCare exams.

Materials Eligibility

Anthem Hoosier Care Connect: Members are eligible for materials every 12 months.

Anthem Hoosier Healthwise:

20 and under: Members are eligible for material every 12 months

21 and over: Members are eligible for materials every 60 months

Anthem Healthy Indiana (HIP 2.0, ages 19 - 64): Members are eligible for materials every 24 months.

INITIAL AND SUBSEQUENT LENSES

In order for a member to be eligible for either initial or subsequent lenses they must meet the following criteria:

Ages 42 and under: A change of at least ± 0.75 diopter in one eye or an axis change of at least 15 degrees in one eye

Ages 43 and over: A change of at least ± 0.50 diopter in one eye or an axis change of at least 15 degrees in one eye

When a member who is not currently eligible requires lenses due to a change in prescription and meets the above diopter criteria, call VSP **800.615.1883** for an authorization. Use modifier SC when billing.

FRAMES

Frames, including, but not limited to, plastic or metal will be reimbursed up to the maximum allowable on the fee schedule. Providers that receive payment from VSP for frames may not bill the member for any additional cost above the VSP reimbursement.

DELUXE FRAMES

A deluxe frame can be reimbursed when visual necessity requires it. Situations where visual necessity for a more expensive frame may be indicated include, but are not limited to:

- Frames to accommodate facial asymmetry or other anomalies of the head, neck, face, or nose
- Allergy to standard frame materials
- Specific lens prescription requirements
- Frames with special modifications such as a ptosis crutch.
- Provision of a frame to an infant where a specialized frame is not available for the regular frame allowance or less

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

Anthem Healthy Indiana (HIP 2.0, ages 19 – 64): Members are not eligible for deluxe frames.

LENS OPTIONS

- Polycarbonate Lenses: For patients 20 and under, 21 and over, SCHIP and HIP 2.0 members who meet at least one of the benefit criteria listed below:
    - Monocular vision requiring corrective lenses in one or both eyes
    - Legal blindness or low vision in one eye
    - Corneal laceration or other severe intractable ocular or adnexal condition.
    - Severe intractable condition in one eye to protect the good eye
    - Eye surgery that requires a corrective lens
- Tints: Tint numbers 1 and 2 are covered. Modifiers U1 and U2 are required. Use modifier U1 when billing for plastic lenses, and use U2 for glass lenses.
- Over-sized Lenses

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

ELECTIVE CONTACT LENSES

Anthem Hoosier Care Connect (20 and under): Members are eligible for $100 elective contact lens allowance for both fitting and evaluation and contact materials. Balance bill the patient for any amount over the allowance.

If entire elective contact lens 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 below.

VISUALLY NECESSARY CONTACT LENSES

Visually necessary contact lenses are covered. Examples of visually necessary contact lenses include, but are not limited to, patients with severe facial deformity who are physically unable to wear eyeglasses or who have severe allergy to all frame materials.

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**.

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

EYEGLASS CASES

Reimbursement for an eyeglass case is included in the maximum allowable for frame and lenses.

Low Vision

Low vision aids and fitting and evaluation of aids only are covered.

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

Vision Therapy

Vision Therapy is covered for children and adults. Call VSP at **800.615.1883** to obtain an authorization number for Vision Therapy claim(s). Bill exam services (92060) and/or vision therapy sessions (92065) with appropriate diagnosis code(s). Vision therapy sessions are limited to one unit or visit per day.

Bill with the 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 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

Frame: VSP does not cover any portion of a deluxe frame purchase, except when visually necessary. If a member chooses to upgrade to a deluxe frame without visual necessity, VSP considers the entire frame noncovered, and the provider may bill it to the member.

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 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 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.

Repair

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

Replacement

Replacement is only allowed due to extenuating circumstances beyond the recipient's control, for example, fire, theft, or an automobile accident. Documentation of these circumstances should be maintained at the doctor's office. Modifier U8 should be used when billing for replacement.

If the member has a prescription change, please refer to the initial and subsequent lens section in Materials Eligibility above.

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

Replacement of visually necessary contact lenses is a covered benefit; only when meeting the replacement criteria above.

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

Date of Service Definition

All claims must reflect a date of service. The date of service is the date the specific services were actually supplied, dispensed, or rendered to the patient. For example, when providing glasses for a member, the date of service would reflect the date the member received the glasses.

Timely Filing

For dates of service on or before December 31, 2018, providers must file claims within twelve (12) months of the date of service to ensure compliance with Indiana Medicaid guidelines. Claims received outside of this timeframe may be denied for untimely submission.

For dates of service on or after January 1, 2019, providers must file claims within one hundred eighty (180) days of the date of to service ensure to compliance with Indiana Medicaid guidelines. Claims received outside of this timeframe may be denied for untimely submission.

Primary EyeCare Coverage

VSP's Primary EyeCare plans provide 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.

Primary EyeCare

Printable Manual

VSP's printable version of the Provider Reference Manual with Indiana Medicaid Details is available. See the Indiana Medicaid manual.

VSP INDIANA MEDICAID PLAN

PROFESSIONAL FEE SCHEDULE FOR ROUTINE SERVICES

Effective 2/1/15

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	$58.74
92004	Comprehensive exam, new patient	$107.44
92012	Intermediate exam, established patient	$61.55
92014	Comprehensive exam, established patient	$89.35
92015	Determination of refractive state	$14.67

Dispensing

Dispensing of eyeglasses is included in the payment of the spectacle lenses		
92340	**Fitting of spectacles, except for aphakia; monofocal**	**$0.00**
92341	**Fitting of spectacles, except for aphakia; bifocal**	**$0.00**
92342	**Fitting of spectacles, except for aphakia; multifocal, other than bifocal**	**$0.00**

Material Services

Single Vision Lenses, per lens:		
V2100	Sphere, plano to ± 4.00d	$24.42
V2101	Sphere, ± 4.12 to ± 7.00d	$31.56
V2102	Sphere, ± 7.12 to ± 20.00d	$48.91
V2103	Spherocylinder, plano to ± 4.00d sphere, 0.12 to 2.00d cylinder	$26.04
V2104	Spherocylinder, plano to ± 4.00d sphere, 2.12 to 4.00d cylinder	$27.99
V2105	Spherocylinder, plano to ± 4.00d sphere, 4.25 to 6.00d cylinder	$35.13
V2106	Spherocylinder, plano to ± 4.00d sphere, over 6.00d cylinder	$37.68
V2107	Spherocylinder, ± 4.25 to ± 7.00d sphere, 0.12 to 2.00d cylinder	$33.47
V2108	Spherocylinder, ± 4.25 to ± 7.00d sphere, 2.12 to 4.00d cylinder	$34.62
V2109	Spherocylinder, ± 4.25 to ± 7.00d sphere, 4.25 to 6.00d cylinder	$42.35
V2110	Spherocylinder, ± 4.25 to ± 7.00d sphere, over 6.00d cylinder	$38.16
V2111	Spherocylinder, ± 7.25 to ± 12.00d sphere, 0.25 to 2.25d cylinder	$43.96
V2112	Spherocylinder, ± 7.25 to ± 12.00d sphere, 2.25 to 4.00d cylinder	$48.01
V2113	Spherocylinder, ± 7.25 to ± 12.00d sphere, 4.25 to 6.00d cylinder	$48.08
V2114	Spherocylinder, sphere over ± 12.00d	$58.98
V2115	Lenticular, myodisc	$58.68
V2118	Lens, aniseikonic single	$63.54
V2121	Lenticular lens, single	$69.45
V2199	Specialty single vision	Submit invoice for pricing*

Bifocal Lenses, per lens:		
V2200	Sphere, plano to ± 4.00d	$32.49
V2201	Sphere, ± 4.12 to ± 7.00d	$35.27
V2202	Sphere, ± 7.12 to ± 20.00d	$41.82
V2203	Spherocylinder, plano to ± 4.00d sphere, 0.12 to 2.00d cylinder	$32.72
V2204	Spherocylinder, plano to ± 4.00d sphere, 2.12 to 4.00d cylinder	$34.35
V2205	Spherocylinder, plano to ± 4.00d sphere, 4.25 to 6.00d cylinder	$37.36
V2206	Spherocylinder, plano to ± 4.00d sphere, over 6.00d cylinder	$42.54
V2207	Spherocylinder, ± 4.25 to ± 7.00d sphere, 0.12 to 2.00d cylinder	$36.16
V2208	Spherocylinder, ± 4.25 to ± 7.00d sphere, 2.12 to 4.00d cylinder	$38.35

V2209	Spherocylinder, ± 4.25 to ± 7.00d sphere, 4.25 to 6.00d cylinder	$50.13
V2210	Spherocylinder, ± 4.25 to ± 7.00d sphere, over 6.00d cylinder	$53.42
V2211	Spherocylinder, ± 7.25 to ± 12.00d sphere, 0.25 to 2.25d cylinder	$47.01
V2212	Spherocylinder, ± 7.25 to ± 12.00d sphere, 2.25 to 4.00d cylinder	$49.02
V2213	Spherocylinder, ± 7.25 to ± 12.00d sphere, 4.25 to 6.00d cylinder	$49.99
V2214	Spherocylinder, sphere over ± 12.00d	$55.00
V2215	Lenticular, myodisc	$71.85
V2218	Lens aniseikonic bifocal	$76.38
V2219	Lens bifocal seg width over 28 mm	$33.43
V2220	Add over 3.25d	$26.23
V2221	Lenticular lens, bifocal	$70.84
V2299	Specialty bifocal	Submit invoice for pricing*

Trifocal Lenses, per lens:		
V2300	Sphere, plano to ± 4.00d	$41.83
V2301	Sphere, ± 4.12 to ± 7.00d	$62.10
V2302	Sphere, ± 7.12 to ± 20.00d	$60.98
V2303	Spherocylinder, plano to ± 4.00d sphere, 0.12 to 2.00d cylinder	$41.93
V2304	Spherocylinder, plano to ± 4.00d sphere, 2.25 to 4.00d cylinder	$43.21
V2305	Spherocylinder, plano to ± 4.00d sphere, 4.25 to 6.00d cylinder	$50.34
V2306	Spherocylinder, plano to ± 4.00d sphere, over 6.00d cylinder	$57.91
V2307	Spherocylinder, ± 4.25 to ± 7.00d sphere, 0.12 to 2.00d cylinder	$48.36
V2308	Spherocylinder, ± 4.25 to ± 7.00d sphere, 2.12 to 4.00d cylinder	$59.66
V2309	Spherocylinder, ± 4.25 to ± 7.00d sphere, 4.25 to 6.00d cylinder	$61.13
V2310	Spherocylinder, ± 4.25 to ± 7.00d sphere, over 6.00d cylinder	$64.25
V2311	Spherocylinder, ± 7.25 to ± 12.00d sphere, 0.25 to 2.25d cylinder	$72.56
V2312	Spherocylinder, ± 7.25 to ± 12.00d sphere, 2.25 to 4.00d cylinder	$66.13
V2313	Spherocylinder, ± 7.25 to ± 12.00d sphere, 4.25 to 6.00d cylinder	$69.79
V2314	Spherocylinder, sphere over ± 12.00d	$73.00
V2315	Lenticular, myodisc	$80.97
V2318	Lens aniseikonic trifocal	$95.32
V2319	Lens trifocal seg width over 28 mm	$35.99
V2320	Add over 3.25d	$43.67
V2321	Lenticular lens, trifocal	$94.32
V2399	Specialty trifocal	$51.75

Variable Asphericity Lenses, per lens:		
V2410	**Variable asphericity lens; s**ingle vision, full field, glass or plastic	$61.55
V2430	**Variable asphericity lens; b**ifocal, full field, glass or plastic	$70.96

V2499	**Variable asphericity lens; o**ther type	Submit invoice for pricing*

Miscellaneous Covered Options and Services, per lens:		
V2700	Balanced lens	$31.64
V2710	Add on: Slab off, glass or plastic	$43.28
V2715	Add on: Prism	$9.15
V2718	Add on: Press-on lens, Fresnel prism	$21.33
V2730	Special base curve	$17.29
V2745	Addition to lens; tint, any color, solid, gradient or equal, excludes photochromatic For plastic material bill with modifier U1. For glass material, bill with modifier U2. See VSP Indiana Medicaid Client Details for more information.	$7.18
V2755	Ultraviolet lens	$11.13
V2770	Occluder lens(es)	$12.93
Miscellaneous Covered Options and Services, per lens: Service must be billed with modifier KX. See VSP Indiana Medicaid Client Details for requirements. Visual necessity must be documented in the patient's file.		
V2780	Oversize lens(es)	$8.23
V2784	Polycarbonate or equal lens(es)	$38.07
V2799	Miscellaneous vision service	Submit invoice for pricing*

Frames:		
V2020	Frame (includes case)	$20.00
V2756	Eye glass case	$0.00
Deluxe frame is only allowed by the Medicaid Plan when visually necessary according to Medicaid's guidelines. Service must be billed with modifier KX. See VSP Indiana Medicaid Client Details. Visual necessity must be documented in the patient's file.		
V2025	Deluxe frame	Submit invoice for pricing*

Repair and Refitting:		
92370	Repair and refitting spectacles; except for aphakia	$21.97
92371	Repair and refitting of spectacle prosthesis for aphakia	$21.97

Visually Necessary Contact Lens Services

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 Indiana Medicaid Client Details. Visual necessity must be documented in the patient's file.		Maximum allowance per eye
V2500	PMMA, spherical	$63.28
V2501	PMMA, toric or prism ballast	$92.05
V2502	PMMA, bifocal	$119.80
V2503	PMMA, color vision deficiency	$115.83
V2510	Gas permeable, spherical	$85.99
V2511	Gas permeable, toric or prism ballast	$126.38
V2512	Gas permeable, bifocal	$147.40
V2513	Gas permeable, extended wear	$135.15
V2520	Hydrophilic, spherical	$70.60
V2521	Hydrophilic, toric or prism ballast	$156.74
V2522	Hydrophilic, bifocal	$126.90
V2523	Hydrophilic, extended wear	$105.28
V2530	Scleral	$172.50
V2531	Scleral, gas permeable	$506.52
V2599	Contact lens, other type	Submit invoice for pricing*

Visually Necessary Contact Lens Fitting and Dispensing		
92072	Fitting of contact lens for management of keratoconus, initial fitting	$99.83
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	$68.67
92311	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, for aphakia, one eye	$73.19
92312	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, for aphakia, both eyes	$82.98
92313	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneoscleral lens	$70.13
92314	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens, both eyes, except for aphakia	$56.36
92315	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens for aphakia, one eye	$51.89

92316	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens for aphakia, both eyes	$65.01
92317	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneoscleral lens	$53.62
92325	Modification of contact lens, with medical supervision of adaptation	$28.65
92326	Replacement of contact lens	$24.69

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.		
92354	Fitting of spectacle mounted low vision aid; single element system	$222.34
92355	Fitting of spectacle mounted low vision aid; telescopic or other compound lens system	$108.38
V2600	Hand held low vision and other nonspectacle 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, near vision	Submit invoice for pricing*

Vision Therapy

Vision Therapy services must be billed with modifier KX. Visual necessity must be documented in the patient's file.		
92060	Sensorimotor examination with multiple measurements of ocular deviation with interpretation and report	$46.94
92065	Orthoptic and/or pleoptic training, with continuing medical direction and evaluation	$37.77

* Please refer to the Contacting VSP by Mail section.

VSP INDIANA MEDICAID PLAN

HEALTHY INDIANA PLAN (HIP 2.0)
PROFESSIONAL FEE SCHEDULE FOR ROUTINE SERVICES

Effective 6/01/2019

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	$80.48
92004	Comprehensive exam, new patient	$145.04
92012	Intermediate exam, established patient	$84.38
92014	Comprehensive exam, established patient	$121.22
92015	Determination of refractive state	$19.07

Dispensing

Dispensing of eyeglasses is included in the payment of the spectacle lenses		
92340	Fitting of spectacles, except for aphakia; monofocal	$0.00
92341	Fitting of spectacles, except for aphakia; bifocal	$0.00
92342	Fitting of spectacles, except for aphakia; multifocal, other than bifocal	$0.00

Material Services

Single Vision Lenses, per lens:		
V2100	Sphere, plano to ± 4.00d	$45.99
V2101	Sphere, ± 4.12 to ± 7.00d	$44.18
V2102	Sphere, ± 7.12 to ± 20.00d	$76.4
V2103	Spherocylinder, plano to ± 4.00d sphere, 0.12 to 2.00d cylinder	$38.7
V2104	Spherocylinder, plano to ± 4.00d sphere, 2.12 to 4.00d cylinder	$39.9
V2105	Spherocylinder, plano to ± 4.00d sphere, 4.25 to 6.00d cylinder	$47.45
V2106	Spherocylinder, plano to ± 4.00d sphere, over 6.00d cylinder	$52.57
V2107	Spherocylinder, ± 4.25 to ± 7.00d sphere, 0.12 to 2.00d cylinder	$46.82
V2108	Spherocylinder, ± 4.25 to ± 7.00d sphere, 2.12 to 4.00d cylinder	$46.95
V2109	Spherocylinder, ± 4.25 to ± 7.00d sphere, 4.25 to 6.00d cylinder	$65.38
V2110	Spherocylinder, ± 4.25 to ± 7.00d sphere, over 6.00d cylinder	$52.8
V2111	Spherocylinder, ± 7.25 to ± 12.00d sphere, 0.25 to 2.25d cylinder	$63.99
V2112	Spherocylinder, ± 7.25 to ± 12.00d sphere, 2.25 to 4.00d cylinder	$72.29
V2113	Spherocylinder, ± 7.25 to ± 12.00d sphere, 4.25 to 6.00d cylinder	$73.1
V2114	Spherocylinder, sphere over ± 12.00d	$86.62
V2115	Lenticular, myodisc	$87.3

V2118	Lens, aniseikonic single	$95.00
V2121	Lenticular lens, single	$85.67
V2199	Specialty single vision	Submit invoice for pricing*
Bifocal Lenses, per lens:		
V2200	Sphere, plano to ± 4.00d	$51.78
V2201	Sphere, ± 4.12 to ± 7.00d	$55.48
V2202	Sphere, ± 7.12 to ± 20.00d	$68.77
V2203	Spherocylinder, plano to ± 4.00d sphere, 0.12 to 2.00d cylinder	$53.33
V2204	Spherocylinder, plano to ± 4.00d sphere, 2.12 to 4.00d cylinder	$54.88
V2205	Spherocylinder, plano to ± 4.00d sphere, 4.25 to 6.00d cylinder	$60.84
V2206	Spherocylinder, plano to ± 4.00d sphere, over 6.00d cylinder	$71.43
V2207	Spherocylinder, ± 4.25 to ± 7.00d sphere, 0.12 to 2.00d cylinder	$60.37
V2208	Spherocylinder, ± 4.25 to ± 7.00d sphere, 2.12 to 4.00d cylinder	$59.31
V2209	Spherocylinder, ± 4.25 to ± 7.00d sphere, 4.25 to 6.00d cylinder	$69.63
V2210	Spherocylinder, ± 4.25 to ± 7.00d sphere, over 6.00d cylinder	$75.03
V2211	Spherocylinder, ± 7.25 to ± 12.00d sphere, 0.25 to 2.25d cylinder	$73.04
V2212	Spherocylinder, ± 7.25 to ± 12.00d sphere, 2.25 to 4.00d cylinder	$76.46
V2213	Spherocylinder, ± 7.25 to ± 12.00d sphere, 4.25 to 6.00d cylinder	$80.40
V2214	Spherocylinder, sphere over ± 12.00d	$84.02
V2215	Lenticular, myodisc	$104.91
V2218	Lens aniseikonic bifocal	$106.91
V2219	Lens bifocal seg width over 28 mm	$49.32
V2220	Add over 3.25d	$43.80
V2221	Lenticular lens, bifocal	$87.37
V2299	Specialty bifocal	Submit invoice for pricing*
Trifocal Lenses, per lens:		
V2300	Sphere, plano to ± 4.00d	$70.79
V2301	Sphere, ± 4.12 to ± 7.00d	$86.81
V2302	Sphere, ± 7.12 to ± 20.00d	$81.11
V2303	Spherocylinder, plano to ± 4.00d sphere, 0.12 to 2.00d cylinder	$68.14
V2304	Spherocylinder, plano to ± 4.00d sphere, 2.25 to 4.00d cylinder	$68.94
V2305	Spherocylinder, plano to ± 4.00d sphere, 4.25 to 6.00d cylinder	$77.01
V2306	Spherocylinder, plano to ± 4.00d sphere, over 6.00d cylinder	$79.29
V2307	Spherocylinder, ± 4.25 to ± 7.00d sphere, 0.12 to 2.00d cylinder	$75.50
V2308	Spherocylinder, ± 4.25 to ± 7.00d sphere, 2.12 to 4.00d cylinder	$82.35
V2309	Spherocylinder, ± 4.25 to ± 7.00d sphere, 4.25 to 6.00d cylinder	$86.18
V2310	Spherocylinder, ± 4.25 to ± 7.00d sphere, over 6.00d cylinder	$90.02
V2311	Spherocylinder, ± 7.25 to ± 12.00d sphere, 0.25 to 2.25d cylinder	$103.93

V2312	Spherocylinder, ± 7.25 to ± 12.00d sphere, 2.25 to 4.00d cylinder	$95.27
V2313	Spherocylinder, ± 7.25 to ± 12.00d sphere, 4.25 to 6.00d cylinder	$104.00
V2314	Spherocylinder, sphere over ± 12.00d	$106.31
V2315	Lenticular, myodisc	$118.02
V2318	Lens aniseikonic trifocal	$145.09
V2319	Lens trifocal seg width over 28 mm	$65.49
V2320	Add over 3.25d	$69.09
V2321	Lenticular lens, trifocal	$116.33
V2399	Specialty trifocal	Submit invoice for pricing*
Variable Asphericity Lenses, per lens:		
V2410	**Variable asphericity lens; s**ingle vision, full field, glass or plastic	$101.70
V2430	**Variable asphericity lens; b**ifocal, full field, glass or plastic	$107.65
V2499	**Variable asphericity lens; o**ther type	Submit invoice for pricing*
Miscellaneous Covered Options and Services, per lens:		
V2700	Balanced lens	$44.35
V2710	Slab off, glass or plastic	$72.71
V2715	Prism	$14.25
V2718	Press-on lens, Fresnel prism	$30.78
V2730	Special base curve	$25.78
V2745	Addition to lens; tint, any color, solid, gradient or equal, excludes photochromatic For plastic material bill with modifier U1. For glass material, bill with modifier U2. See VSP Indiana Medicaid Client Details for more information.	$10.16
V2755	Ultraviolet lens	$16.58
V2770	Occluder lens(es)	$19.30
Miscellaneous Covered Options and Services, per lens: Service must be billed with modifier KX. See VSP Indiana Medicaid Client Details for requirements. Visual necessity must be documented in the patient's file.		
V2780	Oversize lens(es)	$12.40
V2784	Polycarbonate or equal lens(es)	$46.97
V2799	Miscellaneous vision service	Submit invoice for pricing*

Frame:		
V2020	Frame (included case)	$74.40
V2756	Eye glass case	$0.00

Repair and Refitting:		
92370	Repair and refitting spectacles; except for aphakia	$28.56
92371	Repair and refitting of spectacle prosthesis for aphakia	$20.58

Visually Necessary Contact Lens Services

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 Indiana Medicaid Client Details. Visual necessity must be documented in the patient's file.		Maximum allowance per eye
V2500	PMMA, spherical	$91.01
V2501	PMMA, toric or prism ballast	$129.14
V2502	PMMA, bifocal	$174.99
V2503	PMMA, color vision deficiency	$169.01
V2510	Gas permeable, spherical	$121.35
V2511	Gas permeable, toric or prism ballast	$179.86
V2512	Gas permeable, bifocal	$207.03
V2513	Gas permeable, extended wear	$208.57
V2520	Hydrophilic, spherical	$120.92
V2521	Hydrophilic, toric or prism ballast	$239.45
V2522	Hydrophilic, bifocal	$175.23
V2523	Hydrophilic, extended wear	$183.97
V2530	Scleral	$294.13
V2531	Scleral, gas permeable	$538.64
V2599	Contact lens, other type	Submit invoice for pricing*
Visually Necessary Contact Lens Fitting and Dispensing		
92072	Fitting of contact lens for management of keratoconus, initial fitting	$127.59
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	$89.27
92311	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, for aphakia, one eye	$99.75
92312	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, for aphakia, both eyes	$115.51
92313	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneoscleral lens	$94.18
92314	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens, both eyes, except for aphakia	$73.27

92315	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens for aphakia, one eye	$73.46
92316	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens for aphakia, both eyes	$91.68
92317	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneoscleral lens	$76.77
92325	Modification of contact lens, with medical supervision of adaptation	$40.87
92326	Replacement of contact lens	$34.58

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.		
92354	Fitting of spectacle mounted low vision aid; single element system	$289.04
92355	Fitting of spectacle mounted low vision aid; telescopic or other compound lens system	$140.89
V2600	Hand held low vision 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, near vision	Submit invoice for pricing*

Vision Therapy

Vision Therapy services must be billed with modifier KX. Visual necessity must be documented in the patient's file.		
92060	Sensorimotor examination with multiple measurements of ocular deviation with interpretation and report	$61.90
92065	Orthoptic and/or pleoptic training, with continuing medical direction and evaluation	$50.70

* Please refer to the Contacting VSP by Mail section

PO Box 997100
Sacramento, CA 95899-7100
800.615.1883
vsp.com