vsp vision care

VSP South Carolina 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)

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.

SOUTH CAROLINA MEDICAID CLIENT DETAILS

Eligibility & Authorization

Members are reported by a 10-digit identification number.

BlueChoice HealthPlan coverage is shown on the VSP Patient Record Report as "VSP Elements (Advantage/Medicaid network)"

Medicaid Appointment Availability Requirements

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

- 24-hour access to provide instruction on how and where to obtain services
- 45minute (maximum) wait time from scheduled appointment time
- 4-6 weeks 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 Coverage

Members 20 and under: BlueChoice HealthPlan members are eligible for a routine exam every 12 months.

21 and over: BlueChoice HealthPlan members are eligible for a routine exam every 12 months.

Material Coverage

20 and under: BlueChoice HealthPlan members are eligible for glasses every 12 months.

21 and over: BlueChoice HealthPlan members are eligible for glasses every 24 months (see client exception below for more details).

LENSES

Polycarbonate lenses must be provided to all members 20 years of age and younger, are covered, and must be billed with the appropriate codes. Non-polycarbonate lenses are not covered.

NOTE: Polycarbonate single vision, bifocal, and trifocal lenses in an Otis & Piper frame include UV and scratch coating. You won't receive a separate payment for lenses.

LENS ENHANCEMENTS

If visually necessary, the following lens enhancements are covered for patients 20 years of age and younger only.

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

- Anti-reflective coating
- High index when power is ±10 or greater in any meridian in either eye; or prism is +10 diopters in either lens.
- Mirror coating
- Oversize
- Photochromic
- Polarized
- Scratch-resistant coating
- Tints
- UV lens

If not visually necessary, refer to the Advantage Network Lens Enhancements Chart for pricing and follow the guidelines below under Patient Responsibility: Non-covered Services/Materials.

FRAMES

The only covered frames are those in the Otis & Piper Eyewear Collection. These frames are lab-supplied through VSP**One**™ Columbus.

Deluxe frame: A non-Otis & Piper frame may be selected if visual/medical necessity is established.

Patient supplied frame: Not allowed.

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

FRAME CASE

VSP**One** Columbus will supply a frame case for Otis & Piper frames. If a non-Otis & Piper frame is selected, a frame case must be provided. It is a covered item and included in the frame reimbursement.

Redos

Orders must be returned to VSP**One** Columbus. Contact the lab at **800.251.5150** for additional information.

If you need to return a defective Otis & Piper frame, contact the lab for return instructions. If a patient wants to change a frame, the lab will do a one-time redo at no charge.

REDOS DUE TO LAB ERROR

Within 60 days, redos will be expedited and redone at no cost. Call VSP**One** Columbus at **800.251.5150** with any questions.

REDOS DUE TO DOCTOR OR STAFF ERROR

You'll be charged $10 for redos due to doctor or staff error within 60 days. Do not charge the patient for the redo. Call VSP**One** Columbus for complete details.

REDOS DUE TO PRESCRIPTION CHANGES

Lens redos due to prescription changes within 60 days are a private transaction between your practice, the patient, and the lab. VSP**One** Columbus will complete a redo for $10 or you may use another lab of your choice on a private basis.

Do not send the order back to the lab. The lab will redo lenses and send them to you so you can replace the old lenses.

Client Exceptions

Healthy Blue – BlueChoice HealthPlan of South Carolina expanded coverage for adults (21 and over).

LENSES

Single vision, bifocal, trifocal, or lenticular lenses in plastic or glass are covered. You'll receive your Advantage Plan lens dispensing fee for covered lenses. If a patient chooses to add lens enhancements, charge them according to the Advantage Network Lens Enhancement Chart.

FRAMES

Expanded coverage for adult members includes fully covered frames from the Genesis Collection by Altair®. Frames are lab supplied though VSPOne™ Columbus. You'll receive a $19 frame dispensing fee. Genesis frames are fully covered when a complete pair of prescription glasses (lenses and frame) is ordered. Genesis frame only orders would be a private transaction, and the frame will not be covered by VSP. In-office finishing equipment or stock lenses may not be used.

A patient has the option of supplying their own frame or purchasing a non-Genesis frame. The non-Genesis retail frame allowance is $50. We'll pay you up to 55% of the patient's retail frame allowance. When the frame exceeds the retail allowance, charge the patient 80% of the retail price exceeding the allowance. Regardless of the frame brand that's purchased, the benefit for lenses will still follow Advantage Plan pricing and orders must be submitted to VSPOne™ Columbus. In-office finishing equipment or stock lenses may not be used.

Questions about the Genesis Collection? Call Altair Sales at **800.505.5557**.

Lab

Orders must be sent to VSP**One** Columbus.

Only in an emergency situation may a private lab be used. See Using Non-Contract Labs for more information. If a non-contract lab is used for an emergency situation, the non-Genesis frame allowance would apply.

Visually Necessary Contact Lenses

Visually necessary contact lenses are covered in lieu of glasses.

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**.

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

Patient Responsibility

COVERED SERVICES

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.

The lens enhancements listed under Material Coverage are covered for patients 20 years of age and younger only.

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 services and/or materials, all of the following requirements must be met:

- 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. Refer to the Advantage Network Lens Enhancement Chart for patient charges.
- You may request that the patient or guardian sign an Agreement of Financial Responsibility that clearly states the patient is aware they are choosing to purchase non-covered services or materials. Keep the form in the patient's records.

Replacement

20 and under: Replacement glasses (frame and lenses, frame only, or lens(es) only) are covered if lost or destroyed, such as destroyed due to house fire, natural disaster, or an automobile accident. Reason for the replacement must be documented in the patient's records.

Call VSP at **800.615.1883** to obtain an authorization number. When billing for replacement of eyeglasses (frame and lenses), frame only, or lens(es) only, visual necessity must be documented in the patient's file.

21 and over: Replacement is not a covered benefit.

Vision Therapy

20 and under: Vision Therapy exams must be billed with 92060 and modifier KX. Visual necessity must be documented in the patient's file. Vision Therapy training (92065) is not a covered benefit.

Call VSP at **800.615.1883** to obtain an authorization number for Vision Therapy claim(s).

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

21 and over: Vision Therapy is not a covered benefit.

Essential Medical Eye Care Coverage

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

Covered benefits are administered according to the VSP policies and procedures in effect upon the date of service. Please click on the 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 SOUTH CAROLINA MEDICAID PLAN

PROFESSIONAL FEE SCHEDULE FOR ROUTINE SERVICES

Effective 09/01/14

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	$50.00
92004	Comprehensive exam, new patient	$63.50
92012	Intermediate exam, established patient	$50.00
92014	Comprehensive exam, established patient	$63.50
92015	Determination of refractive state	$5.00

Dispensing and Material Services

Spectacle Dispensing, complete pair, new or total replacement, in Otis & Piper frame: When billing for replacement, visual necessity must be documented in the patient's file. See VSP South Carolina Medicaid Client Details for requirements.		
V2100-V2199	Fitting of spectacles, except for aphakia, monofocal	$25.00
V2200-V2299	Fitting of spectacles, except for aphakia, bifocal	$25.00
V2300-V2399	Fitting of spectacles, except for aphakia, trifocal	$25.00
V2020	Frame (includes case) You won't receive separate payment for frame. Frames are supplied by VSP**One** Columbus. You'll receive a combined dispensing fee of $25.00 for lenses and frame. When billing for replacement, visual necessity must be documented in the patient's file. See VSP South Carolina Medicaid Client Details for requirements.	See above
Single Vision, Bifocal, Trifocal Lenses in Otis & Piper frame: **Polycarbonate lenses (V2784) must be provided and are covered.** Polycarbonate single vision, bifocal, and trifocal lenses in an Otis & Piper frame include UV and scratch coating. **You won't receive separate payment for lenses.** You'll receive a combined dispensing fee of $25.00 for lenses and frame.		

Spectacle Dispensing, complete pair, new or total replacement, in Deluxe frame: **New or replacement frames must be billed with** modifier KX. Visual necessity must be documented in the patient's file. See VSP South Carolina Medicaid Client Details for requirements.		
V2100-V2199	Fitting of spectacles, except for aphakia, monofocal	$16.00
V2200-V2299	Fitting of spectacles, except for aphakia, bifocal	$21.00
V2300-V2399	Fitting of spectacles, except for aphakia, trifocal	$35.00
V2025	Deluxe frame (includes case) Must be billed with modifier KX. Visual necessity must be documented in the patient's file. See VSP South Carolina Medicaid Client Details for requirements.	$65.00
V2756	Eye glass case	$0.00
Single Vision, Bifocal, Trifocal Lenses in Deluxe frame, complete pair: **Polycarbonate lenses (V2784) must be provided.** Must be billed with modifier KX. Visual necessity must be documented in the patient's file. See VSP South Carolina Medicaid Client Details for requirements.		

LENS REPLACEMENT

Lens Replacement, Otis & Piper frame: **You won't receive separate payment for lenses.** You'll receive a combined dispensing fee of $25.00 for lenses and frame.
Lens Replacement, Deluxe frame: **To indicate replacement lenses, bill with** modifier KX. Visual necessity must be documented in the patient's file. See VSP South Carolina Medicaid Client Details for requirements.

Miscellaneous Covered Lens Enhancements and Services, per lens Reimbursement for balance lens, prism/slab-off prism, special base curve, and specialty occupational multifocal lenses are included in the cost of the base lens. **Bill the following lens enhancements with** modifier KX. Visual necessity must be documented in the patient's file. See VSP South Carolina Medicaid Client Details for requirements. See Advantage Network Lens Enhancement Chart for reimbursement.		
V2744	Tint, photochromic	See Advantage Network Lens Enhancement Chart for reimbursement.
V2745	Addition to lens, tint, any color, solid, gradient or equal excluding photochromic, any lens material	
V2750	Anti-reflective coating	
V2755	UV lens	
V2760	Scratch-resistant coating	
V2761	Mirror coating, any type, solid, gradient, or equal, any lens material	

Miscellaneous Covered Lens Enhancements and Services, per lens Reimbursement for balance lens, prism/slab-off prism, special base curve, and specialty occupational multifocal lenses are included in the cost of the base lens. **Bill the following lens enhancements with** modifier KX. Visual necessity must be documented in the patient's file. See VSP South Carolina Medicaid Client Details for requirements. See Advantage Network Lens Enhancement Chart for reimbursement.		
V2762	Polarization, any lens material	
V2780	Oversize lens	
V2782	Lens, index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbonate	
V2783	Lens, index greater than or equal to 1.66 plastic or greater than or equal to 1.80 glass, excludes polycarbonate	
V2784	Lens, polycarbonate or equal, any index	

Miscellaneous Non-covered Lens Enhancements and Services, per lens See Advantage Network Lens Enhancement Chart for doctor service fees.

VISUALLY NECESSARY CONTACT LENSES

Visually Necessary Contact Lenses: Contacts are only allowed by the Medicaid Plan when visually necessary according to Medicaid's guidelines. Service must be billed with modifier KX. See VSP South Carolina Medicaid Client Details for requirements. Visual necessity must be documented in the patient's file.		Maximum allowance per eye
V2500	Contact lens, PMA, spherical	$13.00
V2501	PMMA, toric or prism ballast	$22.00
V2510	Contact lens, gas permeable, spherical	$30.00
V2511	Contact lens, gas permeable, toric or prism ballast	$42.00
V2520	Contact lens, hydrophilic, spherical	$17.00
V2521	Contact lens, hydrophilic, toric or prism ballast	$50.00
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 South Carolina Medicaid Client Details for requirements. Visual necessity must be documented in the patient's file.		
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	$69.27

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 South Carolina Medicaid Client Details for requirements. Visual necessity must be documented in the patient's file.		
92311	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, one eye	$65.03
92312	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, both eyes	$73.99
92313	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneoscleral lens	$62.34

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 (e.g., restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure)	$43.46

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

vsp vision care

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