VSP® Ohio Medicaid **Network Manual**

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

Effective January 1, 2019

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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.

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.

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.

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.

OHIO MEDICAID CLIENT DETAILS

Member Identification Number

Members are reported by a 12-digit numeric identification number.

Members having limited English or reading proficiency, or having a visual or hearing impairment will be identified by a specific code in the Group Name field on the Patient Record Report. The information is shared to help you better assist your patients.

LEP = Limited English Proficiency	**LRPHI** = Limited Reading Proficiency and Hearing Impaired
LRP = Limited Reading Proficiency	**VIHI** = Visual and Hearing Impairment
VI = Visual Impairment	**LERPVI** = Limited English and Reading Proficiency and Visual Impairment
HI = Hearing Impairment	**LERPHI** = Limited English & Reading Proficiency and Hearing Impairment
LERP = Limited English and Reading Proficiency	**LRPVIHI** = Limited Reading Proficiency, Visual and Hearing Impairment
LEPVI = Limited English Proficiency and Visual Impairment	**LRLEPVIHI** = Limited Reading & English Proficiency, Visual and Hearing Impairment
LEPHI = Limited English Proficiency and Hearing Impairment	**LEPVIHI =** Limited English Proficiency & VI and HI
LRPVI = Limited Reading Proficiency and Visual Impaired	

Exam

18 to 44: Aetna Better Health members are eligible for an exam every 12 months.

45 to 59: Aetna Better Health members are eligible for an exam every 24 months.

60 and over: Aetna Better Health members are eligible for an exam every 12 months.

- Pregnant women are eligible for an exam every 12 months. Call VSP at 800.615.1883 to verify eligibility and obtain authorization.

Materials Eligibility

18 to 44: Aetna Better Health members are eligible for lenses and frames every 12 months.

45 to 59: Aetna Better Health members are eligible for lenses and frames every 24 months.

60 and over: Aetna Better Health members are eligible for lenses and frames every 12 months.

- Pregnant women are eligible for lenses and frames every 12 months. Call VSP at 800.615.1883 to verify eligibility and obtain authorization.

LENSES

Initial Lenses: Lens prescriptions must meet one of the following minimum prescription criteria:

- + 0.75 diopters for a hyperopic sphere
- - 0.50 diopters for a myopic sphere
- 0.50 diopters cylinder
- 0.50 diopter imbalance
- 0.50 prism diopter vertical
- 3.00 prism diopter lateral

SUBSEQUENT LENSES

Subsequent lenses are visually necessary lenses that are provided after the initial lenses. Subsequent lenses are not replacement lenses. Please refer to the replacement section for information on replacement lenses.

Subsequent lenses must meet the lens prescription minimum requirements above and must also have a change of one of the following:

- ± 0.50 diopter sphere
- ± 0.50 diopter cylinder
- 10 degrees for a 1 cylinder or less
- 5 degrees for a 1.12 cylinder or more

LENS OPTIONS

- Polycarbonate lenses are covered.
- Scratch-resistant coating is covered.
- Glass lenses and other lens options are only available if visually necessary.

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

FRAME

Only standard frames are covered (V2020).

VISUALLY NECESSARY CONTACT LENSES

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

- Anisometropia greater than or equal to 3.00 diopters
- High ametropia greater than or equal to ±10.00 diopters in either eye in any meridian based on the spectacle prescription

Aphakia	H27.01 (RT), H27.02 (LT), H27.03 (BI)
Corneal dystrophies	H18.50 - H18.59
Corneal transplant	Z94.7
Keratoconus	H18.601 (RT), H18.602 (LT) , H18.603 (BI) Q13.3, Q13.4
Nystagmus	H55.00 - H55.09 H81.10 - H81.13

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.

Low Vision

Low vision aids and fitting of low vision aids are covered if visually necessary. Call VSP at 800.615.1883 to obtain an authorization number for Low Vision claim(s). Low Vision exams are not covered.

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

Vision Therapy

Vision Therapy exams (92060) and Vision Therapy training (92065) are covered. Call VSP at 800.615.1883 to obtain an authorization number for Vision Therapy claim(s).

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

Coordination of Benefits

If the patient has other vision coverage, coordinate benefits and bill the other carrier. Medicaid is the payor of last resort.

REFRACTION

92015 is the Medicaid-covered component of a comprehensive eye exam provided to a Medicaid and Medicare-covered consumer in conjunction with other Medicare covered eye exam procedures. It is reimbursed as a separate and distinct service by Medicaid when Medicare payment for an eye exam does not include payment for the refraction services component of the exam.

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

Patient Responsibility

COVERED SERVICES/MATERIALS

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

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

NON-COVERED SERVICES/MATERIALS

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

- The patient or guardian must be informed prior to services being rendered that this is a non-covered service or material. Advise the patient or patient's guardian of 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.

Replacement

Replacement is allowed for loss, theft, or destruction beyond the patient's control. Please retain a signed statement from patient documenting the circumstances in the patient's file.

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

Authorization is required. Call VSP at 800.615.1883 for an authorization number.

VSP OHIO MEDICAID PLAN

PROFESSIONAL FEE SCHEDULE FOR ROUTINE SERVICES

Effective 6/1/14

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	$46.00
92004	Comprehensive exam, new patient	$57.00
92012	Intermediate exam, established patient	$42.00
92014	Comprehensive exam, established patient	$52.00
92015	Determination of refractive state is included in the fee for the exam	$0.00
Procedure code 92015 is covered for Medicare patients only. See VSP Ohio Medicaid Client Detail pages.		
92015	Determination of refractive state (COB only for Medicare patients)	$5.00

Dispensing and Material Services

Dispensing:		
92340	Fitting of spectacles, except for aphakia; monofocal	$21.77
92341	Fitting of spectacles, except for aphakia; bifocal	$26.97
92342	Fitting of spectacles, except for aphakia; multifocal	$30.02
Single Vision Lenses, per lens:		
V2100	Sphere, plano to ± 4.00d	$6.38
V2101	Sphere, ± 4.12 to ± 7.00d	$6.38
V2102	Sphere, ± 7.12 to ± 20.00d	$10.21
V2103	Spherocylinder, plano to ± 4.00d sphere, 0.12 to 2.00d cylinder	$6.38
V2104	Spherocylinder, plano to ± 4.00d sphere, 2.12 to 4.00d cylinder	$6.38
V2105	Spherocylinder, plano to ± 4.00d sphere, 4.25 to 6.00d cylinder	$10.21
V2106	Spherocylinder, plano to ± 4.00d sphere, over 6.00d cylinder	$10.21
V2107	Spherocylinder, ± 4.25 to ± 7.00d sphere, 0.12 to 2.00d cylinder	$6.38
V2108	Spherocylinder, ± 4.25 to ± 7.00d sphere, 2.12 to 4.00d cylinder	$6.38
V2109	Spherocylinder, ± 4.25 to ± 7.00d sphere, 4.25 to 6.00d cylinder	$10.21
V2110	Spherocylinder, ± 4.25 to ± 7.00d sphere, over 6.00d cylinder	$10.21
V2111	Spherocylinder, ± 7.25 to ± 12.00d sphere, 0.25 to 2.25d cylinder	$10.21
V2112	Spherocylinder, ± 7.25 to ± 12.00d sphere, 2.25 to 4.00d cylinder	$10.21
V2113	Spherocylinder, ± 7.25 to ± 12.00d sphere, 4.25 to 6.00d cylinder	$10.21
V2114	Spherocylinder, sphere over ± 12.00d	$10.21
V2115	Lenticular, myodisc	$19.00

Dispensing:		
V2118	Lens, aniseikonic single	$19.00
V2121	Lenticular lens, single	$19.00
V2199	Specialty single vision	$10.21
Bifocal Lenses, per lens:		
V2200	Sphere, plano to ± 4.00d	$12.43
V2201	Sphere, ± 4.12 to ± 7.00d	$12.43
V2202	Sphere, ± 7.12 to ± 20.00d	$17.20
V2203	Spherocylinder, plano to ± 4.00d sphere, 0.12 to 2.00d cylinder	$12.43
V2204	Spherocylinder, plano to ± 4.00d sphere, 2.12 to 4.00d cylinder	$12.43
V2205	Spherocylinder, plano to ± 4.00d sphere, 4.25 to 6.00d cylinder	$17.20
V2206	Spherocylinder, plano to ± 4.00d sphere, over 6.00d cylinder	$17.20
V2207	Spherocylinder, ± 4.25 to ± 7.00d sphere, 0.12 to 2.00d cylinder	$12.43
V2208	Spherocylinder, ± 4.25 to ± 7.00d sphere, 2.12 to 4.00d cylinder	$12.43
V2209	Spherocylinder, ± 4.25 to ± 7.00d sphere, 4.25 to 6.00d cylinder	$17.20
V2210	Spherocylinder, ± 4.25 to ± 7.00d sphere, over 6.00d cylinder	$17.20
V2211	Spherocylinder, ± 7.25 to ± 12.00d sphere, 0.25 to 2.25d cylinder	$17.20
V2212	Spherocylinder, ± 7.25 to ± 12.00d sphere, 2.25 to 4.00d cylinder	$17.20
V2213	Spherocylinder, ± 7.25 to ± 12.00d sphere, 4.25 to 6.00d cylinder	$17.20
V2214	Spherocylinder, sphere over ± 12.00d	$17.20
V2215	Lenticular, myodisc	$28.30
V2218	Lens aniseikonic bifocal	$28.30
V2219	Lens bifocal seg width over	$8.00
V2220	Add over 3.25d	$4.00
V2221	Lenticular lens, bifocal	$28.30
V2299	Specialty bifocal	$17.20
Trifocal Lenses, per lens:		
V2300	Sphere, plano to ± 4.00d	$18.03
V2301	Sphere, ± 4.12 to ± 7.00d	$18.03
V2302	Sphere, ± 7.12 to ± 20.00d	$22.93
V2303	Spherocylinder, plano to ± 4.00d sphere, 0.12 to 2.00d cylinder	$18.03
V2304	Spherocylinder, plano to ± 4.00d sphere, 2.25 to 4.00d cylinder	$18.03
V2305	Spherocylinder, plano to ± 4.00d sphere, 4.25 to 6.00d cylinder	$22.93
V2306	Spherocylinder, plano to ± 4.00d sphere, over 6.00d cylinder	$22.93
V2307	Spherocylinder, ± 4.25 to ± 7.00d sphere, 0.12 to 2.00d cylinder	$18.03
V2308	Spherocylinder, ± 4.25 to ± 7.00d sphere, 2.12 to 4.00d cylinder	$18.03
V2309	Spherocylinder, ± 4.25 to ± 7.00d sphere, 4.25 to 6.00d cylinder	$22.93
V2310	Spherocylinder, ± 4.25 to ± 7.00d sphere, over 6.00d cylinder	$22.93
V2311	Spherocylinder, ± 7.25 to ± 12.00d sphere, 0.25 to 2.25d cylinder	$22.93
V2312	Spherocylinder, ± 7.25 to ± 12.00d sphere, 2.25 to 4.00d cylinder	$22.93
V2313	Spherocylinder, ± 7.25 to ± 12.00d sphere, 4.25 to 6.00d cylinder	$22.93

Dispensing:		
V2314	Spherocylinder, sphere over ± 12.00d	$22.93
V2315	Lenticular, myodisc	$34.31
V2318	Lens aniseikonic trifocal	$34.31
V2319	Lens trifocal seg width > 28	$12.00
V2320	Add over 3.25d	$12.00
V2321	Lenticular lens, trifocal	$34.31
Variable Asphericity Lenses, per lens:		
V2410	Variable asphericity lens, single vision, full field, glass or plastic	$30.00
V2430	Variable asphericity lens, bifocal, full field, glass or plastic	$50.00
Miscellaneous Covered Options and Services, per lens:		
S0580	Polycarbonate	$15.00
S0581	Nonstandard lens; industrial thickness	$7.00
V2700	Balance lens	$6.10
V2710	Slab off, glass or plastic	$35.00
V2715	Prism	$3.00
V2718	Press-on lens, Fresnell prism	$35.00
V2730	Special base curve, glass or plastic	$8.00
V2760	Scratch resistant coating	$5.00
V2770	Occluder lens	$10.00
Miscellaneous Covered Options and Services, per lens: Service must be billed with modifier KX. See VSP Ohio Medicaid Client Details for requirements. Visual necessity must be documented in the patient's file.		
V2744	Tint, photochromatic	$7.00
V2745	Addition to lens, tint, any color, solid, gradient or equal (excludes photochromic, any lens material)	$5.00
V2755	UV lens	$6.00
V2780	Oversize lens	$8.00
V2781	Progressive lens, per lens	$35.00
V2799	Miscellaneous vision service	Submit invoice for pricing*
Frame:		
V2020	Frame (includes case)	$25.00
V2756	Eye glass case	$0.00

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 Ohio Medicaid Client Details for requirements. Visual necessity must be documented in the patient's file.	Maximum allowance per eye

V2500	PMMA, spherical	$31.06
V2501	PMMA, toric or prism ballast	$51.77
V2502	PMMA, bifocal	$51.77
V2503	PMMA, color vision deficiency	$51.77
V2510	Gas permeable, spherical	$50.22
V2511	Gas permeable, toric or prism ballast	$75.32
V2512	Gas permeable, bifocal	$100.42
V2513	Gas permeable, extended wear	$100.42
V2520	Hydrophilic, spherical	$60.26
V2521	Hydrophilic, toric or prism ballast	$70.30
V2522	Hydrophilic, bifocal	$77.65
V2523	Hydrophilic, extended wear	$97.00
V2530	Scleral, gas impermeable	$62.12
V2599	Contact lens, other type	$100.42
Visually Necessary Contact Lens Fitting and Dispensing Service must be billed with modifier KX. See VSP Ohio 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	$77.86
92311	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, for aphakia, one eye	$34.80
92312	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, for aphakia, both eyes	$41.24
92313	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneoscleral lens	$42.80
92314	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and fitting by independent technician; corneoscleral lens, both eyes except for aphakia	$49.33
92315	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and fitting by independent technician; corneal lens for aphakia, one eye	$19.61
92316	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and fitting by independent technician; corneal lens for aphakia, both eyes	$27.86
92317	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and fitting by independent technician; corneoscleral lens	$16.51
92325	Modification of contact lens (separate procedure), with medical supervision of adaptation	$7.37
92326	Replacement of contact lens, single or both	$28.49

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	$54.59
92355	Fitting of spectacle mounted low vision aid; telescopic or other compound lens system	$38.27
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	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	$19.85
92065	Orthoptic and/or pleoptic training, with continuing medical direction and evaluation	$13.65

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

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