vsp vision care

VSP Virginia Medicaid
Network Manual

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Effective January 1, 2023

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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 Essential Medical Eye Care or Integrated Primary EyeCare Program. Any exceptions to this coverage are described in the Client Detail pages and/or the Fee Schedule.

For Telemedicine information refer to: Telemedicine.

Referrals

Follow all referral protocols set forth by your patient's health plan for any services beyond the scope of the patient's VSP plan. Typically, an HMO requires that patient referrals be coordinated by the primary care physician (PCP). However, a PPO usually allows patients to receive care from any medical provider without a PCP referral. Check Client Detail pages for any specific instructions or exceptions.

HEDIS and Eye Exams for Patients with Diabetes

The Healthcare Effectiveness Data and Information Set (HEDIS®) is one of healthcare's most widely used performance improvement tools. The National Committee for Quality Assurance (NCQA) collects HEDIS data from health plans and other healthcare organizations to create annual health outcome surveys. Health plans use HEDIS data to measure performance and identify opportunities for improvement.

HEDIS includes more than 90 measures across multiple domains of care. These measures relate to public health issues, including (and not limited to) asthma medication use, blood pressure control, cancer screening, diabetes care, heart disease, and smoking and tobacco use cessation.

Eye Exam for Patients With Diabetes (EED) – Effectiveness of Care HEDIS Measure

Eye Exam for Patients With Diabetes (EED) is a specific HEDIS measure that requires health plans offering commercial, Medicaid, and Medicare plans to report the percentage of members with diabetes who had a dilated or retinal eye exam.

Measurement Definition:
Patients ages 18–75 with diabetes (Type 1 or Type 2) who received screening or monitoring for diabetic retinal eye disease:

- Retinal or dilated eye exam by an eye care professional in the measurement year or,
- A negative retinal or dilated eye exam by an eye care professional in the year prior to the measurement year.
- Note: Fundus photography with interpretation and report and certain types of retinal imaging (CPT® codes 92227, 92228, 92250, 92260, and 92314) covered by Essential Medical Eye Care may also meet the performance measurement.

WHAT ARE CPT CATEGORY II CODES?

- CPT Category II codes are tracking codes which facilitate data collection related to quality and performance measurement. They allow providers to report services based on nationally recognized, evidence-based performance guidelines for improving quality of patient care.
- CPT Category II codes describe clinical components, usually evaluation, management, or clinical services.
- Category II codes are not to be used as a substitute for Category I codes.
- CPT Category II codes are for reporting purposes only and are not separately reimbursable.

WHAT ARE CPT CATEGORY II CODES?

Current Procedural Terminology (CPT®) Category II codes are informational, supplemental tracking codes that can be used for quality and performance measurement. These codes are intended to facilitate data collection about the quality of care for certain services (e.g., dilated or retinal eye exam) that support performance measures (e.g., Eye Exam for Patients With Diabetes (EED) HEDIS performance measure).

When VSP members with diabetes receive a dilated or retinal eye exam from a network doctor, in addition to billing the exam CPT code, VSP instructs doctors to bill the appropriate supplemental CPT Category II code, which can be used for HEDIS performance measurement.

Including HEDIS supplemental data on VSP claims strengthens the role doctors of optometry have in their patients' healthcare and highlights the impact they have on protecting their patients' vision and overall health. In addition, when VSP network doctors include CPT Category II codes on claims, this data can be securely delivered to VSP health plan clients, reducing the administrative burden of medical record chart reviews for doctors and their staff.

- Category II codes are not to be used as a substitute for Category I codes. CPT Category II codes are for reporting purposes only and are not separately reimbursable. Bill CPT Category II codes with a $0.00 charge amount.
- If you receive a claim denial, your reporting code will still be included in the quality measure.

When billing dilated or retinal eye exams for VSP patients with diabetes, include the appropriate supplemental CPT Category II code, for the Eye Exam for Patients With Diabetes (EED) - HEDIS performance measure:

2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy
2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy
2024F	Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy
2025F	Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy

2026F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy
2033F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy
3072F	Low risk for retinopathy (no evidence of retinopathy in the prior year)

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

MATERIALS COVERAGE

Note: Please refer to the Patient Record Report, authorization, or Client Detail pages to determine if any exceptions are covered by your state Medicaid Plan and/or by the client.

Lenses

Lenses are available to the patient based on state regulations.

Covered basic lenses are established by state regulations.

For more information, please refer to your Client Detail pages and/or Fee Schedule.

Dispensing of Spectacles

If a covered benefit, a dispensing fee may only be billed with a complete set of eyeglasses (frame and lenses). Please refer to your state provider manual for eligibility and state-specific guidelines.

Repair and Refitting Spectacles

If a covered benefit, bill repairs to eyeglasses using CPT code 92370 (repair and refitting of spectacles) or CPT code 92371 (repair of spectacle prosthesis for aphakia).

Do not bill a dispensing code for repairs.

Repair and refitting codes cannot be billed with material HCPCS codes (e.g., V2020) on the same date of service.

Please refer to your state provider manual for eligibility and state-specific guidelines.

Replacement

If a covered benefit, bill replacement frame and lenses using the appropriate frame or lens HCPCS code. Do not bill a dispensing code for replacement of just the frame or lenses.

A dispensing fee may only be billed, if you are replacing a complete set of eyeglasses (frame and lenses).

Please refer to your state provider manual for eligibility and state-specific guidelines.

Frames

Frame coverage is based on state regulations. Medicaid plans have an established allowance for the purchase of a new frame. For further information refer to your Client Detail pages and/or Fee Schedule.

Visually Necessary Contact Lenses

If a covered benefit, refer to Client Detail pages as specific criteria applies.

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

LABORATORY

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

Contract labs that have agreed to provide lenses at a reduced price for VSP are identified in the National Contract Lab List in your VSP Provider Reference Manual. When using a contract lab on this list, please write “VSP Medicaid” and the authorization number on the private invoice to ensure reduced VSP Medicaid materials prices.

Lab Price Schedule

Note: The lab price schedule below is valid for Medicaid Plan prescriptions **only**. Please refer to the patient’s authorization and the Medicaid Fee Schedule to determine if any exceptions are covered by your state Medicaid Plan and/or by the client.

COST

Single Vision	$12.15 per pair	
Bifocals	$21.55 per pair	
Trifocals	$30.55 per pair	
Covered Items	**Single Vision**	**Multifocal**
For higher powers add:	$3.65 per lens	$4.15 per lens
For lenticular add:	$11.85 per lens	$13.80 per lens
For slab off add:	$30.45 per lens	$30.45 per lens
For prism add:	$1.85 per lens	$1.85 per lens

Laboratories will charge your office on a private invoice basis. All items not listed are billed at the laboratory’s private add-on prices. Doctor redos are billed by the laboratory at 50% of the scheduled fees.

Base lenses include:

- Rxs up to and including 7.00 sphere and 4.00 cylinder
- Plastic or glass lenses (including hardening)
- Zyl, metal, or carbon mounting
- Bifocal or trifocal Segment widths of 25 and 28
- All higher adds
- All base curves
- Press-on prism
- Eye size up to and including 55mm
- Shipping and handling charges to the office

SUBMITTING CLAIMS/BILLING & REIMBURSEMENT

The filing limit for submitting claims in most states is 180 days from the date of service. Exceptions are noted in the Client Detail pages.

Submit Medicaid claims:

- Electronically through eClaim on eyefinity.com.
- Via paper on a typewritten or computer-generated standard CMS-1500 form.
- Enter the authorization number in Box 23 of the CMS-1500 form. Use the appropriate Place of Service and Type of Service codes from your state Medicaid manual, and submit the CMS-1500 form directly to VSP for processing after providing services. It is not necessary to include the lab's invoice for materials.

VSP will only reimburse claims received for patients who are eligible at the time of service.

All Medicaid claims must be billed with the appropriate diagnosis codes:

Exams:

Z01.00	Encounter for examination of eyes and vision without abnormal findings
Z01.01	Encounter for examination of eyes and vision with abnormal findings
Z01.020	Encounter for examination of eyes and vision following failed vision screening without abnormal findings
Z01.021	Encounter for examination of eyes and vision following failed vision screening with abnormal findings
Z13.5	Encounter for screening for eye and ear disorders
Z46.0	Encounter for fitting and adjustment of spectacles and contact lenses

Exams or Materials:

H52.01	Hypermetropia, right eye
H52.02	Hypermetropia, left eye
H52.03	Hypermetropia, bilateral
H52.11	Myopia, right eye
H52.12	Myopia, left eye
H52.13	Myopia, bilateral
H52.201	Unspecified astigmatism, right eye
H52.202	Unspecified astigmatism, left eye
H52.203	Unspecified astigmatism, bilateral
H52.211	Irregular astigmatism, right eye
H52.212	Irregular astigmatism, left eye
H52.213	Irregular astigmatism, bilateral
H52.221	Regular astigmatism, right eye
H52.222	Regular astigmatism, left eye
H52.223	Regular astigmatism, bilateral
H52.31	Anisometropia

H52.32	Aniseikonia
H52.4	Presbyopia
H52.511	Internal ophthalmoplegia (complete) (total), right eye
H52.512	Internal ophthalmoplegia (complete) (total), left eye
H52.513	Internal ophthalmoplegia (complete) (total), bilateral
H52.521	Paresis of accommodation, right eye
H52.522	Paresis of accommodation, left eye
H52.523	Paresis of accommodation, bilateral
H52.531	Spasm of accommodation, right eye
H52.532	Spasm of accommodation, left eye
H52.533	Spasm of accommodation, bilateral
H52.6	Other disorders of refraction
H52.7	Unspecified disorder of refraction
H53.001	Unspecified amblyopia, right eye
H53.002	Unspecified amblyopia, left eye
H53.003	Unspecified amblyopia, bilateral
H53.011	Deprivation amblyopia, right eye
H53.012	Deprivation amblyopia, left eye
H53.013	Deprivation amblyopia, bilateral
H53.021	Refractive amblyopia, right eye
H53.022	Refractive amblyopia, left eye
H53.023	Refractive amblyopia, bilateral
H53.031	Strabismic amblyopia, right eye
H53.032	Strabismic amblyopia, left eye
H53.033	Strabismic amblyopia, bilateral
H53.141	Visual discomfort, right eye
H53.142	Visual discomfort, left eye
H53.143	Visual discomfort, bilateral
H27.01	Aphakia, right eye
H27.02	Aphakia, left eye
H27.03	Aphakia, bilateral
Z96.1	Presence of intraocular lens - COB only, will be accepted without refractive error diagnosis.
H49.01 – H49.9	Paralytic Strabismus
H50.00 – H50.9	Other strabismus
H51.0 – H51.9	Other disorders of binocular movement

Any exceptions are noted in the Client Detail pages.

Medical eyecare services performed in bordering states are reimbursed per Essential Medical Eye Care Medicaid fee schedule for the state in which you reside.

You are responsible for verifying the accuracy of your payment. For Medicaid patients, overpayments must be corrected within 60 days.

Coordination of Benefits

Coordination of benefits is available in most states. Exceptions are noted in the Client Detail pages. If the patient has other vision coverage, coordinate benefits and bill the other carrier. Medicaid is the payor of last resort.

For Electronic Claims

- Exam only claims (with or without a refraction) can be submitted electronically as long as a routine or refractive diagnosis is present,
- When you receive payment from the primary plan, keep a copy of the original CMS-1500 form showing the exam and refraction services submitted to the primary plan, along with the Explanation of Payment or Explanation of Benefits from the health plan/Medicare, in the patient's file.

Note: Enter exam and refraction separately with this exact language in box 19: "secondary COB claim patient resp EXAM $XX.XX REFRACTION $XX.XX." (Indicate the dollar amount of the patient's responsibility in place of the XX.XX).

For Paper Claims

- When you receive payment from the primary plan, send a copy of the original CMS-1500 form showing the exam and refraction services submitted to the health plan, along with the Explanation of Payment or Explanation of Benefits from the health plan, to VSP. Don't send a summary.

Refer to the Coordination of Benefits (COB) section of the **VSP Manual** for complete information.

VIRGINIA 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 Virginia Medicaid Doctor Network:

- 24-hour access to provide instruction on how and where to obtain services
- 30 seconds to answer office phone or ability to leave a message within 45 seconds
- 30 minute (maximum) wait time from scheduled appointment time
- 10 calendar days (maximum) for scheduling or rescheduling routine, preventative eye exams
- Medical exam should be made within 7 days
- Specialty care appointments should be made within 15 business days
- Urgent care during office hours should be seen within 24 hours based on patient condition
- Emergent care should be directed to the appropriate emergency facility

Exam

Aetna Better Health of Virginia (ABD and LIFC), Aetna Better Health CCC Plus (20 and under), Aetna Better Health of Virginia FAMIS (19 and under), Magellan Complete Care of Virginia): Members are eligible for exam every 24 months.

Virginia Premier: Members are eligible for a routine exam every 12 months.

VIRGINIA MEDICAID MEDALLION 4.0

Aetna Better Health: Adults (21 and over) are eligible for exam every 12 months.

Aetna Better Health: Children (20 and under), FAMIS (19 and under) are eligible for exam every 24 months.

Magellan Complete Care of Virginia: Children (20 and under), Adults (21 and over), FAMIS (19 and under) are eligible for exam every 24 months.

Virginia Premier: are eligible for exam every 12 months.

Exam Copay

Aetna Better Health, Magellan Complete Care of Virginia: FAMIS (19 and under): $0, $2 or $5 copay for routine eye exams.

The following clients have opted to offer enhanced Medicaid services to some of their Medicaid populations. Please refer to the **Client Exceptions** section.

- Aetna Better Health Virginia DSNP

- Aetna Better Health of Virginia CCC Plus (MLTSS)
- Magellan Complete Care of Virginia (Adults 21 and over)
- Virginia Premier DSNP
- Virginia Premier MLTSS

Materials Eligibility

Aetna Better Health of Virginia (ABD and LIFC), Aetna Better Health CCC Plus (20 and under), Aetna Better Health of Virginia FAMIS (19 and under), Magellan Complete Care of Virginia (20 and under): Members are eligible for lens and frame every 24 months.

Aetna Better Health: Adults (21 and over) are eligible for a $250 combined materials allowance every 12 months.

Aetna Better Health: Children (20 and under) and FAMIS (19 and under) are eligible for materials every 24 months.

Magellan Complete Care of Virginia: Children (20 and under), Adults (21 and over) combined materials allowance of $150, FAMIS (19 and under) are eligible for materials every 24 months.

Virginia Premier (Diabetic): are eligible for materials every 12 months.

Virginia Premier DSNP: Members are eligible for materials every 12 months with a combined material allowance of $300.

Virginia Premier MLTSS (Diabetic and Non-Diabetic): Members are eligible for a $100 combined material allowance every 12 months.

LENS ENHANCEMENTS

Solid tints/dyes are limited to patients with certain documented medical conditions, such as albinism and/or photophobia.

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

All plastic lenses provided to patients must have an anti-scratch coating.

Virginia Premier (20 and under) and Virginia Premier FAMIS (19 and under): Polycarbonate single vision, bifocal, and trifocal lenses in an Otis & Piper frame are covered and include UV and scratch coating. You won't receive a separate payment for lenses. Refer to the Advantage Network Lens Enhancements Chart for pricing on non-covered lens enhancements and follow the guidelines below under Patient Responsibility: Non-covered Services/Materials.

Aetna Better Health of Virginia, and Aetna Better Health of Virginia FAMIS (19 and under), Magellan Complete Care of Virginia (20 and under) and Virginia Premier (diabetic members): Patients are eligible for polycarbonate lenses if they meet at least one of the benefit criteria listed below:

- High power lenses (+/- 4.00 diopters in either meridian for either eye)
- Monocular visual acuity (20/200 or worse in either eye)

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

FRAME

Virginia Premier (20 and under): Members must select a frame from the Otis & Piper Eyewear Collection. These frames are lab-supplied through VSPOne™ Columbus.

Deluxe frame: If the patient has an unusual circumstance or visual need that prevents them from selecting any of the existing covered frames; use V2025 to bill for the deluxe frame.

Patient supplied frame: Not allowed.

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

Aetna Better Health of Virginia, Aetna Better Health of Virginia FAMIS (19 and under), Magellan Complete Care of Virginia (20 and under) and Virginia Premier (diabetic members): Frames are covered according to the VSP Virginia Medicaid Plan Professional Fee Schedule.

FRAME CASE

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

Virginia Premier (20 and under): VSPOne 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.

LAB

Elements orders must be sent to VSPOne Columbus.

REDOS

Otis & Piper orders must be returned to VSPOne 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 VSPOne 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 VSPOne 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. VSPOne 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. Lab will redo lenses and send them to you so you can replace old lenses.

ELECTIVE CONTACT LENSES

Members are not covered for elective contact lenses; exceptions are noted below. Verify ECL eligibility and allowance on patient record report.

Aetna Better Health CCC Plus 30077004 (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.

Aetna Better Health 30083950 (Medallion 4.0 - 20 and under) - Members are eligible for $250 elective contact lens allowance for both fitting and evaluation and contact materials. Balance bill the patient for any amount over the allowance.

Magellan Complete Care of Virginia 30083948 (FAMIS 19 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

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

When submitting a claim for piggyback lenses, you must bill with all appropriate codes and provide the following information in Box 19: Piggyback lenses.

GLASSES TO WEAR OVER CONTACT BENEFITS

Spectacle lenses with frame to wear over visually necessary contacts are covered with one of the following conditions:

- Aphakia
  - H27.01 - H27.03 or Q12.3
  - High ametropia - 10.00 diopters or greater
- Presbyopia
- Accommodative disorder
- Binocular function disorder
- Different prism requirements for distance and near vision

A prescription is required for the lenses. When glasses are visually necessary to wear over contact lenses, call VSP at **800.615.1883** to request the spectacle lenses and frame authorization number at the same time or within 30 days of the contact lens claim submission date. For patients with keratoconus, request an authorization number for spectacle lenses and frame to be worn over contact lenses within 12 months of the contact lens claim submission date. Please have the relevant criteria information available when calling. Visual necessity must be documented in the patient's file.

Vision Therapy

Vision Therapy Exam (92060): The first vision therapy eye exam is covered for visual necessity. If more than one exam is required, the service requires written documentation supporting the additional need. Call VSP at **800.615.1883** to obtain an authorization number for Vision Therapy claim(s). Bill 92060 with appropriate diagnosis codes.

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

Vision Therapy Sessions (92065): The first six vision therapy sessions are covered for visual necessity. If more than six sessions are required, the seventh and subsequent sessions billed require written documentation supporting the continuing need. Call VSP at **800.615.1883** to obtain an authorization number for Vision Therapy claim(s). Bill 92065 with appropriate diagnosis codes.

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

Virginia Premier FAMIS (19 and under) and Virginia Premier (21 and over, non-diabetic members): Vision Therapy is not covered.

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.

Aetna Better Health of Virginia, Aetna Better Health CCC Plus (20 and under), Aetna Better Health of Virginia FAMIS (19 and under), Virginia Premier (Diabetic members), Magellan Complete Care of Virginia (20 and under) and Virginia Premier (20 and under): Members may not be balance billed for any covered service.

Frames exceeding $35 are considered non-covered frames. If a non-covered frame is chosen, the patient pays the full cost of the frame. Do not balance bill the patient for any difference in cost.

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.

Repair

Virginia Premier (20 and under): For defective Otis & Piper frames, refer to the Lab Redo section for details.

Aetna Better Health of Virginia (20 and under, ABD and LIFC), Aetna Better Health CCC Plus (20 and under), Aetna Better Health of Virginia FAMIS (19 and under), Virginia Premier D-SNP (20 and under), Virginia Premier MLTSS (20 and under), Virginia Premier (Medallion 4.0, diabetic adults 21 and over, diabetic 20 and under, non-diabetic 20 and under) and Magellan Complete Care of Virginia (20 and under): Members are eligible once every 12 months. Authorization is required; please call VSP at 800.615.1883 for an authorization number. Frame repair is billed using HCPCS code V2020 and modifier RP. The combination of V2020 and modifier RP shall pay the maximum allowable for repair and parts replacement.

Virginia Premier (Medallion 4.0, non-diabetic members, adults 21 and over): Lens and frame repairs are not covered.

Non-covered services/materials are not eligible for repair.

Replacement

Virginia Premier (20 and under), Virginia Premier FAMIS (19 and under): Members are eligible for a lens redo within 60 days. For lens redos within 60 days or a defective frame, refer to the Lab Redo section for details.

Replacement coverage is based on visual necessity and is typically limited to once every 12 months. Significant functional visual disability must exist and standards of medical practice must be met before replacement glasses are prescribed. Authorization is required; please call VSP at **800.615.1883** for an authorization number.

Aetna Better Health of Virginia (20 and under, ABD and LIFC), Aetna Better Health CCC Plus (20 and under), Aetna Better Health of Virginia FAMIS (19 and under), Virginia Premier D-SNP (20 and under), Virginia Premier MLTSS (20 and under), Virginia Premier (Medallion 4.0, diabetic adults 21 and over, diabetic 20 and under, non-diabetic 20 and under) and Magellan Complete Care of Virginia (20 and under):

Replacement coverage is based on visual necessity and is typically limited to once every 12 months. Significant functional visual disability must exist and standards of medical practice must be met before replacement glasses are prescribed. Authorization is required; please call VSP at **800.615.1883** for an authorization number.

Virginia Premier (Medallion 4.0, non-diabetic adults 21 and over): Lens and frame replacement is not covered.

Non-covered services/materials are not eligible for replacement.

Client Exceptions

AETNA BETTER HEALTH VIRGINIA DSNP 30079796

Aetna Better Health Disabled and Special Needs Population (DSNP) offers an exam every 12 months and materials every 12 months with a $300 allowance.

If entire material 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.

Dual Coverage: Some members may have two Aetna Better Health plans (D-SNP and MLTSS) under separate ID numbers. Be sure to check with your patient if they are covered under both plans and if so, get both ID numbers to verify eligibility. Bill exam and glasses, if eligible, under MLTSS and bill contacts under DSNP. Members can coordinate between the two plans to pay for overages. If coordinating benefits, D-SNP would be primary, MLTSS would be secondary.

AETNA BETTER HEALTH VIRGINIA CCC PLUS (MLTSS) 30077004

Aetna Better Health CCC Plus is a Managed Long-Term Services and Support (MLTSS) plan. Aetna Better Health CCC Plus offers member **21 and over** a routine exam every 12 months and materials every 12 months with a $250 allowance. Allowance is covered only once per eligibility period.

If entire material 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.

Dual Coverage: Some members may have two Aetna Better Health plans (D-SNP and MLTSS) under separate ID numbers. Be sure to check with your patient if they are covered under both plans and if so, get both ID numbers to verify eligibility. Bill exam and glasses, if eligible, under MLTSS and bill contacts under DSNP. Members can coordinate between the two plans to pay for overages. If coordinating benefits, D-SNP would be primary, MLTSS would be secondary.

MAGELLAN COMPLETE CARE OF VIRGINIA 30076612 – ADULTS 21 AND OVER

Magellan Complete Care of Virginia offers member 21 and over a routine exam every 24 months and materials every 24 months with a $150 allowance. Allowance is covered only once per eligibility period.

If entire material 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.

VIRGINIA PREMIER DSNP 300083229

Virginia Premier Disabled and Special Needs Population (DSNP) offers a routine exam every 12 months and materials every 12 months with a $300 allowance.

Dual Coverage: Some members may have two VA Premier plans (D-SNP and MLTSS) under separate ID numbers. Be sure to check with your patient if they are covered under both plans and if so, get both ID numbers to verify eligibility. Members can coordinate between the two plans to pay for overages. If coordinating benefits, D-SNP would be primary, MLTSS would be secondary.

VIRGINIA PREMIER MLTSS 30076353

Virginia Premier Managed Long Term Services and Support (MLTSS) offers a routine exam every 12 months.

Members (diabetic and non-diabetic) are eligible for materials every 12 months with a $100 allowance. Allowance is covered only once per eligibility period.

If entire material 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.

Dual Coverage: Some members may have two VA Premier plans (D-SNP and MLTSS) under separate ID numbers. Be sure to check with your patient if they are covered under both plans and if so, get both ID numbers to verify eligibility. Members can coordinate between the two plans to pay for overages. If coordinating benefits, D-SNP would be primary, MLTSS would be secondary.

Timely Filing

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

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 appropriate link below to view covered procedure codes for your state. Please note codes are only covered when appropriate based on your scope of licensure as well as the current laws, rules and regulations as determined by the State and Federal Government.

Essential Medical Eye Care

VSP VIRGINIA MEDICAID PLAN

VIRGINIA PREMIER 20 AND UNDER, FAMIS

Professional Fee Schedule for Routine Services

Effective 7/1/2022

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

Exam Services

92002	Intermediate exam, new patient	$0.00
92004	Comprehensive exam, new patient	$0.00
92012	Intermediate exam, established patient	$0.00
92014	Comprehensive exam, established patient	$0.00
92015	Determination of refractive state is included in the fee for the exam	$0.00
92015	Determination of refractive state for COB only	$0.00

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 Virginia 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
Variable Asphericity Lenses, per pair in Otis & Piper frame:		
V2410	Single vision, full field, glass or plastic	$25.00
V2430	Bifocal, full field, glass or plastic	$25.00
V2499	Variable Sphericity Lens, other type	$25.00

<table>
<tr><td>V2020</td><td>Frame
You won’t receive separate payment for frame. Frames are supplied by VSPOne 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 Virginia Medicaid Client Details for requirements.</td><td>See above</td></tr>
<tr><td colspan="3">Single Vision, Bifocal, Trifocal Lenses in Otis & Piper frame:
Polycarbonate lenses (V2784) are covered as a standard option for Otis & Piper frame. 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.</td></tr>
</table>

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 Virginia Medicaid Client Details for requirements.		
Spectacle Dispensing, complete pair, new or total replacement, in Deluxe frame: When billing for replacement, visual necessity must be documented in the patient's file. See VSP Virginia Medicaid Client Details for requirements.		
Repair and Replacement Dispensing. Service must be billed with modifier RP.		
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 Must be billed with modifier KX. Visual necessity must be documented in the patient's file. See VSP Virginia Medicaid Client Details for requirements.	$50.00
Miscellaneous Covered Lens Enhancements and Services, per lens: See Advantage Network Lens Enhancement Chart for reimbursement.		
V2760	Scratch resistant coating, per lens	See Advantage Network Lens Enhancement Chart for reimbursement.
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 Virginia Medicaid Client Details for requirements. See Advantage Network Lens Enhancement Chart for reimbursement.		
V2745	Addition to lens, tint, any color, solid, gradient or equal (excludes photochromatic) any lens material	See Advantage Network Lens Enhancement Chart for reimbursement
V2755	UV lens	
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	Maximum allowance per eye
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 Virginia Medicaid Client Details for requirements. Visual necessity must be documented in the patient's file.	

V2500	PMMA, spherical	$100.00
V2501	PMMA, toric or prism ballast	$120.00
V2502	PMMA, bifocal	$140.00
V2503	PMMA, color vision deficiency	$120.00
V2510	Gas permeable, spherical	$100.00
V2511	Gas permeable, toric or prism ballast	$120.00
V2512	Gas permeable, bifocal	$140.00
V2513	Gas permeable, extended wear	$120.00
V2520	Hydrophilic, spherical	$100.00
V2521	Hydrophilic, toric or prism ballast	$120.00
V2522	Hydrophilic, bifocal	$140.00
V2523	Hydrophilic, extended wear	$120.00
V2530	Scleral	$225.00
V2531	Contact lens, scleral, gas permeable	Submit invoice for pricing*
V2599	Not otherwise classified	$150.00
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 Virginia Medicaid Client Details for requirements. Visual necessity must be documented in the patient's file.		
92070	Fitting of contact lens for management of keratoconus, initial fitting	$120.60
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	$63.19
92311	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, one eye	$63.02
92312	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, both eyes	$71.48
92313	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneoscleral lens	$71.48
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	$61.46
92415	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and fitting; corneal lens for aphakia, one eye	$64.57

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	$85.31
92326	Replacement of contact lens	$23.38

FAMIS: Refer to the Client Detail pages for instructions when billing for elective contact lenses instead of glasses. Reimbursement shall be up to $100.

Vision Therapy

Vision Therapy Services must be billed with modifier KX. See VSP Virginia Medicaid Client Details for requirements. Visual necessity must be documented in the patient's file. Vision Therapy is not covered for Virginia Premier FAMIS.		
92060	Sensorimotor examination with multiple measurements of ocular deviation.	$37.12
92065	Orthoptic training; performed by a physician or other qualified health care professional.	$22.27

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

VSP VIRGINIA MEDICAID PLAN

PROFESSIONAL FEE SCHEDULE FOR ROUTINE SERVICES

Effective 5/1/19

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	$44.00
92004	Comprehensive exam, new patient	$50.00
92012	Intermediate exam, established patient	$41.00
92014	Comprehensive exam, established patient	$46.00
92015	Determination of refractive state is included in the fee for the exam	$0.00
92015	Determination of refractive state for COB only	$10.00

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**
92352	Fitting of spectacle prosthesis for aphakia; monofocal	**$0.00**
92353	Fitting of spectacle prosthesis for aphakia; multifocal	**$0.00**

Spectacle Services

Frames (Includes case): Refer to VSP Virginia Medicaid Client Details for FAMIS fee schedule.		
V2020	Frame purchase, includes dispensing	$35.00
V2025	Deluxe frame Must be billed with modifier KX. See VSP Virginia Medicaid Client Details for requirements. Visual necessity must be documented in the patient's file.	$50.00
V2756	Eye glass case	$0.00

Repair and Replacement Services:		
V2020	Replacement due to irreparable damage	$35.00
V2020-RP	Repair and parts replacement	$12.50

Single Vision Lenses, per lens; Refer to VSP Virginia Medicaid Client Details for FAMIS fee schedule.		
V2100	Sphere, plano to ± 4.00D	$25.00
V2101	Sphere, ± 4.12 to ± 7.00D	$25.00
V2102	Sphere, ± 7.12 to ± 20.00D	$25.00
V2103	Spherocylinder, plano to ± 4.00D sphere, 0.12 to 2.00D cylinder	$25.00
V2104	Spherocylinder, plano to ± 4.00D sphere, 2.12 to 4.00D cylinder	$25.00
V2105	Spherocylinder, plano to ± 4.00D sphere, 4.25 to 6.00D cylinder	$25.00
V2106	Spherocylinder, plano to ± 4.00D sphere, over 6.00D cylinder	$25.00
V2107	Spherocylinder, ± 4.25 to ± 7.00D sphere, 0.12 to 2.00D cylinder	$25.00
V2108	Spherocylinder, ± 4.25 to ± 7.00D sphere, 2.12 to 4.00D cylinder	$25.00
V2109	Spherocylinder, ± 4.25 to ± 7.00D sphere, 4.25 to 6.00D cylinder	$25.00
V2110	Spherocylinder, ± 4.25 to ± 7.00D sphere, over 6.00D cylinder	$25.00
V2111	Spherocylinder, ± 7.25 to ± 12.00D sphere, 0.25 to 2.25D cylinder	$25.00
V2112	Spherocylinder, ± 7.25 to ± 12.00D sphere, 2.25 to 4.00D cylinder	$25.00
V2113	Spherocylinder, ± 7.25 to ± 12.00D sphere, 4.25 to 6.00D cylinder	$25.00
V2114	Spherocylinder, sphere over ± 12.00D	$25.00
V2115	Lenticular, (myodisc)	$25.00
V2118	Aniseikonic lens	$25.00
V2121	Lenticular lens, single	$25.00
V2199	Specialty single vision	$25.00

Bifocal Lenses, per lens; Refer to **Virginia Medicaid Client Details** for FAMIS fee schedule.		
V2200	Sphere, plano to ± 4.00D	$25.00
V2201	Sphere, ± 4.12 to ± 7.00D	$25.00
V2202	Sphere, ± 7.12 to ± 20.00D	$25.00
V2203	Spherocylinder, plano to ± 4.00D sphere, 0.12 to 2.00D cylinder	$25.00
V2204	Spherocylinder, plano to ± 4.00D sphere, 2.12 to 4.00D cylinder	$25.00
V2205	Spherocylinder, plano to ± 4.00D sphere, 4.25 to 6.00D cylinder	$25.00
V2206	Spherocylinder, plano to ± 4.00D sphere, over 6.00D cylinder	$25.00
V2207	Spherocylinder, ± 4.25 to ± 7.00D sphere, 0.12 to 2.00D cylinder	$25.00
V2208	Spherocylinder, ± 4.25 to ± 7.00D sphere, 2.12 to 4.00D cylinder	$25.00

Bifocal Lenses, per lens; Refer to **Virginia Medicaid Client Details** for FAMIS fee schedule.		
V2209	Spherocylinder, ± 4.25 to ± 7.00D sphere, 4.25 to 6.00D cylinder	$25.00
V2210	Spherocylinder, ± 4.25 to ± 7.00D sphere, over 6.00D cylinder	$25.00
V2211	Spherocylinder, ± 7.25 to ± 12.00D sphere, 0.25 to 2.25D cylinder	$25.00
V2212	Spherocylinder, ± 7.25 to ± 12.00D sphere, 2.25 to 4.00D cylinder	$25.00
V2213	Spherocylinder, ± 7.25 to ± 12.00D sphere, 4.25 to 6.00D cylinder	$25.00
V2214	Spherocylinder, sphere over ± 12.00D	$25.00
V2215	Lenticular (myodisc)	$25.00
V2218	Aniseikonic lens	$25.00
V2219	Seg width over 28mm	$25.00
V2220	Add over 3.25D	$25.00
V2221	Lenticular lens, bifocal	$25.00
V2299	Specialty bifocal	$25.00

Trifocal Lenses, per lens; Refer to VSP Virginia Medicaid Client Details for FAMIS fee schedule.		
V2300	Sphere, plano to ± 4.00D	$64.50
V2301	Sphere, ± 4.12 to ± 7.00D	$64.50
V2302	Sphere, ± 7.12 to ± 20.00D	$70.50
V2303	Spherocylinder, plano to ± 4.00D sphere, 0.12 to 2.00D cylinder	$64.50
V2304	Spherocylinder, plano to ± 4.00D sphere, 2.25 to 4.00D cylinder	$64.50
V2305	Spherocylinder, plano to ± 4.00D sphere, 4.25 to 6.00D cylinder	$70.50
V2306	Spherocylinder, plano to ± 4.00D sphere, over 6.00D cylinder	$70.50
V2307	Spherocylinder, ± 4.25 to ± 7.00D sphere, 0.12 to 2.00D cylinder	$64.50
V2308	Spherocylinder, ± 4.25 to ± 7.00D sphere, 2.12 to 4.00D cylinder	$64.50
V2309	Spherocylinder, ± 4.25 to ± 7.00D sphere, 4.25 to 6.00D cylinder	$70.50
V2310	Spherocylinder, ± 4.25 to ± 7.00D sphere, over 6.00D cylinder	$70.50
V2311	Spherocylinder, ± 7.25 to ± 12.00D sphere, 0.25 to 2.25D cylinder	$70.50
V2312	Spherocylinder, ± 7.25 to ± 12.00D sphere, 2.25 to 4.00D cylinder	$70.50
V2313	Spherocylinder, ± 7.25 to ± 12.00D sphere, 4.25 to 6.00D cylinder	$70.50
V2314	Spherocylinder, sphere over ± 12.00D	$70.50

Trifocal Lenses, per lens; Refer to VSP Virginia Medicaid Client Details for FAMIS fee schedule.		
V2315	Lenticular (myodisc)	$69.00
V2318	Aniseikonic lens	$64.50
V2319	Seg width over 28mm	$10.00
V2320	Add over 3.25D	$9.00
V2321	Lenticular lens, trifocal	$69.00
V2399	Specialty trifocal	$70.50

Variable Asphericity Lenses, per lens:		
V2410	Single vision, full field, glass or plastic	$39.35
V2430	Bifocal, full field, glass or plastic	$110.00
V2499	Variable Sphericity Lens, other type	$110.00

Miscellaneous Covered Options and Services, per lens: Ophthalmic lenses may be made of either: (1) plastic with scratch-resistant coating or (2) glass.		
V2760	Scratch resistant coating	$4.50
Miscellaneous Covered Options and Services, per lens: Services must be billed with modifier KX. Visual necessity must be documented in the patient's file.		
V2745	Addition to lens, tint, any color, solid, gradient or equal (excludes photochromatic) any lens material	$3.50
V2755	UV lens	$4.50
V2784	Lens, polycarbonate or equal, any index	$7.00

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 Virginia Medicaid Client Details for requirements. Visual necessity must be documented in the patient's file.		Maximum allowance per eye
V2500	PMMA, spherical	$100.00
V2501	PMMA, toric or prism ballast	$120.00
V2502	PMMA, bifocal	$140.00
V2503	PMMA, color vision deficiency	$120.00
V2510	Gas permeable, spherical	$100.00
V2511	Gas permeable, toric or prism ballast	$120.00
V2512	Gas permeable, bifocal	$140.00
V2513	Gas permeable, extended wear	$120.00

V2520	Hydrophilic, spherical	$100.00
V2521	Hydrophilic, toric or prism ballast	$120.00
V2522	Hydrophilic, bifocal	$140.00
V2523	Hydrophilic, extended wear	$120.00
V2530	Scleral	$225.00
V2531	Contact lens, scleral, gas permeable	Submit invoice for pricing*
V2599	Not otherwise classified	$150.00

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 Virginia Medicaid Client Details for requirements. Visual necessity must be documented in the patient's file.

92072	Fitting of contact lens for management of keratoconus, initial fitting	$120.60
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	$63.19
92311	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, one eye	$63.02
92312	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, both eyes	$71.48
92313	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneoscleral lens	$71.48
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	$61.46
92315	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and fitting; corneal lens for aphakia, one eye	$64.57
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	$85.31
92326	Replacement of contact lens	$23.38

Please note: Refer to the Client Detail Pages for instructions when billing for elective contact lenses instead of glasses. Reimbursement shall be up to $100.

Vision Therapy

Vision Therapy Services must be billed with modifier KX. See VSP Virginia Medicaid Client Details for requirements. Visual necessity must be documented in the patient's file. Vision Therapy is not covered for Virginia Premier FAMIS.		
92060	Sensorimotor examination with multiple measurements of ocular deviation.	$37.12
92065	Orthoptic training; performed by a physician or other qualified health care professional.	$22.27

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.		
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*

* Please refer to the Contacting VSP by Mail section.

PO Box 997100
Sacramento, CA 95899-7100
800.615.1883

vsp.com

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