VSP® New Hampshire Medicaid **Network Manual**

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

Effective January 1, 2020

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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.

Repair and Refitting Spectacles

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

Do not bill a dispensing code for repairs.

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

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

Replacement

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

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

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

Frames

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

Visually Necessary Contact Lenses

If a covered benefit, refer to Client Detail pages as specific criteria applies. You must bill for both the contact lens fitting and materials, to be reimbursed.

LABORATORY

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

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

Lab Price Schedule

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

COST

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

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

Base lens includes:

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

SUBMITTING CLAIMS/BILLING & REIMBURSEMENT

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

Submit Medicaid claims:

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

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

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

Exams:

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

Exams or Materials:

H52.01	Hypermetropia, right eye
H52.02	Hypermetropia, left eye
H52.03	Hypermetropia, bilateral
H52.11	Myopia, right eye
H52.12	Myopia, left eye
H52.13	Myopia, bilateral
H52.201	Unspecified astigmatism, right eye
H52.202	Unspecified astigmatism, left eye
H52.203	Unspecified astigmatism, bilateral
H52.211	Irregular astigmatism, right eye
H52.212	Irregular astigmatism, left eye
H52.213	Irregular astigmatism, bilateral
H52.221	Regular astigmatism, right eye
H52.222	Regular astigmatism, left eye
H52.223	Regular astigmatism, bilateral
H52.31	Anisometropia
H52.32	Aniseikonia
H52.4	Presbyopia
H52.511	Internal ophthalmoplegia (complete) (total), right eye
H52.512	Internal ophthalmoplegia (complete) (total), left eye

H52.513	Internal ophthalmoplegia (complete) (total), bilateral
H52.521	Paresis of accommodation, right eye
H52.522	Paresis of accommodation, left eye
H52.523	Paresis of accommodation, bilateral
H52.531	Spasm of accommodation, right eye
H52.532	Spasm of accommodation, left eye
H52.533	Spasm of accommodation, bilateral
H52.6	Other disorders of refraction
H52.7	Unspecified disorder of refraction
H53.001	Unspecified amblyopia, right eye
H53.002	Unspecified amblyopia, left eye
H53.003	Unspecified amblyopia, bilateral
H53.011	Deprivation amblyopia, right eye
H53.012	Deprivation amblyopia, left eye
H53.013	Deprivation amblyopia, bilateral
H53.021	Refractive amblyopia, right eye
H53.022	Refractive amblyopia, left eye
H53.023	Refractive amblyopia, bilateral
H53.031	Strabismic amblyopia, right eye
H53.032	Strabismic amblyopia, left eye
H53.033	Strabismic amblyopia, bilateral
H53.141	Visual discomfort, right eye
H53.142	Visual discomfort, left eye
H53.143	Visual discomfort, bilateral
H27.01	Aphakia, right eye
H27.02	Aphakia, left eye
H27.03	Aphakia, bilateral
Z96.1	Presence of intraocular lens
H49.00 – H49.9	Paralytic Strabismus
H50.00 – H50.9	Other strabismus
H51.0 – H51.9	Other disorders of binocular movement

Any exceptions are noted in the Client Detail pages.

Medical eyecare services performed in bordering states are reimbursed per VSP's Primary EyeCare Medicaid fee schedule for the state in which you reside. Medicaid fee schedule for the state in which you reside.

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

Coordination of Benefits

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

For Electronic Claims

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

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

For Paper Claims

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

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

NEW HAMPSHIRE MEDICAID CLIENT DETAILS

Member Identification Number

Member ID starts with two alpha characters (NH), followed by seven numbers (e.g., NH1234567)

Exam

20 and under: Members are eligible once every 12 months.

21 and over: Members are eligible once every 12 months.

0-18 SCHIP (Gold/Silver/Buy-in): Members are eligible once every 12 months.

19-65 NHHPP: Members are eligible once every 24 months.

Materials Eligibility

20 and under: Members are eligible once every 12 months.

21 and over: Members are eligible once every 12 months.

0-18 SCHIP (Gold/Silver/Buy-in): Members are eligible once every 12 months.

19-65 NHHPP: Members are eligible once every 12 months.

FRAME

Deluxe frames (V2025) are covered if visually necessary for Medicare members only. The claim must be submitted as a COB with Medicare. Bill as follows:

- Bill V2020 on the first claim line for the cost of a standard frame.
- Bill V2025 on the second claim line for the difference between the charges for a standard and deluxe frame.
- Include a copy of the Medicare EOP or EOB when you submit the claim to VSP.

19-65 NHHPP: Deluxe frames (V2025) are covered if the patient has an unusual circumstance or visual need that prevents them from selecting an existing covered frame.

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

LENSES

20 and under: The refractive error in at least one eye must meet or exceed ±0.50 diopter.

21 and over: The refractive error in each eye must meet or exceed ±0.50 diopter.

TWO PAIR IN LIEU OF BIFOCALS

Well Sense members may receive one pair of glasses with bifocal corrective lenses or two pairs of eyeglasses, one for close vision and one for distance vision, instead of one pair with bifocal corrective lenses.

Patient must have a refractive error of at least ±0.50 diopter for both near and distance vision and the must meet one of the following criteria:

- Cannot wear bifocal satisfactorily

- Patient currently has two pairs of eyeglasses
- There is a safety concern.

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

19-65 NHHPP: Not eligible for two pair in lieu of bifocals.

TRIFOCAL LENS

Trifocal lenses are covered based on specific educational or employment performance needs, or if the patient currently wears trifocals.

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

LENS ENHANCEMENTS

Polycarbonate lenses are covered for all ages.

The following lens enhancements are covered if visually necessary:

- Tints
- Photochromic
- Progressive

19-65 NHHPP: additional lens enhancements are covered if visually necessary:

- Anti-reflective coating
- Balance lens
- High index (1.54 – 1.65 plastic, or 1.60 – 1.79 glass, excluding polycarbonate; greater than or equal to 1.66 plastic or 1.80 glass, excluding polycarbonate)
- Occluder lens
- Polarized
- Prism or press-on prism
- UV coating
- Slab-off prism, glass or plastic

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

MISCELLANEOUS VISION SERVICES

Reimbursement for scratch coating is included in the cost of the base lens.

VISUALLY NECESSARY CONTACT LENSES

Visually necessary contact lenses are covered if patients meet any of the following criteria:

- Ocular pathology in cases where the visual acuity is not correctable to 20/70 or better
- When contact lenses are required to correct aphakia or to treat corneal diseases.

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

VISION THERAPY

A vision therapy exam (92060) is covered. Call VSP at 800.615.1883 to obtain an authorization number for Vision Therapy claim(s). Orthoptic and pleoptic training (92065) are non-covered services.

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 does not 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 above.

- The patient or guardian must be informed prior to services being rendered that this is a non-covered service or material. Advise the patient or patient's guardian of their payment responsibilities before providing services.
- Provide the patient with information regarding the necessity, options, and charge(s) for the service/material.
- You may request that the patient or guardian sign an **Agreement of Financial Responsibility** that clearly states that the patient is aware they are choosing to purchase non-covered services or materials. Keep the form in the patient's records.

Do not bill VSP for these non-covered services or materials. Treat this as a private-pay transaction and follow your private-pay patient policy.

MISSED APPOINTMENTS

Medicaid members may not be billed for missed appointments.

Repair

One repair of eyeglasses is covered every 12 months. Call VSP at 800.615.1883 for an authorization number.

Replacement

20 and under: Replacement of lenses, or lenses and frames, is covered due to loss or when the refractive error changes by +/-0.50 diopter or more in both eyes. Call VSP at 800.615.1883 for an authorization number.

21 and over: Replacement of lenses, or lenses and frames, is covered when the refractive error changes by +/-0.50 diopter or more in both eyes. Call VSP at **800.615.1883** for an authorization number. Lost glasses are not covered.

Primary EyeCare Coverage

VSP's Primary EyeCare plans provide supplemental medical eyecare coverage for the detection, treatment, and management of ocular and/or systemic conditions that produce ocular or visual symptoms. Members may see their VSP doctor when such a condition is suspected. VSP Primary EyeCare coverage is secondary to other medical eye insurance coverage that may reimburse you.

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.

Americans with Disability Access Guidelines

Offices are required to meet the ADA Accessibility Guidelines (ADAAG), which are available from the Department of Justice at (800) USA-ABLE or from The Access Board's website at **www.access-board.gov.**

Patient Rights and Responsibilities

In addition to the Patient Rights and Responsibilities outlined in the VSP Manual, Well Sense patients have the following rights and responsibilities:

- A right to receive information about the organization (VSP / Well Sense) and member rights and responsibilities.
- A right to voice complaints or appeals about the organization or the care it provides.
- A right to make recommendations regarding the organization's member rights and responsibilities policy.
- A responsibility to supply information (to the extent possible) that the organization (VSP/Well Sense) needs in order to arrange care.
- A responsibility to understand their health problems and participate in developing mutually agreed upon treatment goals, to the degree possible.

VSP NEW HAMPSHIRE MEDICAID PLAN

WELL SENSE HEALTH PLAN
PROFESSIONAL FEE SCHEDULE FOR ROUTINE SERVICES

Effective 9/1/2017

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.

Important! This fee schedule applies only to patients covered by Well Sense Health Plan. See the **New Hampshire Health Protection Program (NHHPP) Fee Schedule** for patients covered by NHHPP.

Exam Services

92002	Intermediate exam, new patient	$41.08
92004	Comprehensive exam, new patient	$75.00
92012	Intermediate exam, established patient	$37.70
92014	Comprehensive exam, established patient	$59.06
92015	Determination of refractive state	$21.18
S0620	Routine ophthalmological examination including refraction; new patient	$96.18
S0621	Routine ophthalmological examination including refraction; established patient	$80.24

Dispensing and Material Services

92340	Fitting of spectacles, except for aphakia; monofocal	$25.00
92341	Fitting of spectacles, except for aphakia; bifocal	$32.50
92342	Fitting of spectacles, except for aphakia; multifocal	$16.00
92370	Repair and refitting spectacles, except aphakia	$15.00

Frames

V2020	Frame	$30.00
V2025	Deluxe frame (Medicare COB Only) See VSP New Hampshire Medicaid Client Details.	Submit Medicare EOB or EOP for pricing*

Spectacle Lenses

Single Vision Lenses, per lens:		
V2100	Sphere, plano to ± 4.00d	$5.80
V2101	Sphere, ± 4.12 to ± 7.00d	$7.03
V2102	Sphere, ± 7.12 to ± 20.00d	$10.57

Single Vision Lenses, per lens:		
V2103	Spherocylinder, plano to ± 4.00d sphere, 0.12 to 2.00d cylinder	$10.59
V2104	Spherocylinder, plano to ± 4.00d sphere, 2.12 to 4.00d cylinder	$9.25
V2105	Spherocylinder, plano to ± 4.00d sphere, 4.25 to 6.00d cylinder	$10.36
V2106	Spherocylinder, plano to ± 4.00d sphere, over 6.00d cylinder	$10.59
V2107	Spherocylinder, ± 4.25 to ± 7.00d sphere, 0.12 to 2.00d cylinder	$7.92
V2108	Spherocylinder, ± 4.25 to ± 7.00d sphere, 2.12 to 4.00d cylinder	$9.69
V2109	Spherocylinder, ± 4.25 to ± 7.00d sphere, 4.25 to 6.00d cylinder	$10.32
V2110	Spherocylinder, ± 4.25 to ± 7.00d sphere, over 6.00d cylinder	$10.55
V2111	Spherocylinder, ± 7.25 to ± 12.00d sphere, 0.25 to 2.25d cylinder	$10.74
V2112	Spherocylinder, ± 7.25 to ± 12.00d sphere, 2.25 to 4.00d cylinder	$10.95
V2113	Spherocylinder, ± 7.25 to ± 12.00d sphere, 4.25 to 6.00d cylinder	$13.32
V2114	Spherocylinder, sphere over ± 12.00d	$20.46
V2115	Lenticular, myodisc	$20.29
V2118	Lens, aniseikonic single	$20.29
V2121	Lenticular lens, single	$21.72
V2199	Specialty single vision	Submit invoice for pricing*
Bifocal Lenses, per lens:		
V2200	Sphere, plano to ± 4.00d	$8.26
V2201	Sphere, ± 4.12 to ± 7.00d	$10.51
V2202	Sphere, ± 7.12 to ± 20.00d	$15.35
V2203	Spherocylinder, plano to ± 4.00d sphere, 0.12 to 2.00d cylinder	$15.32
V2204	Spherocylinder, plano to ± 4.00d sphere, 2.12 to 4.00d cylinder	$10.64
V2205	Spherocylinder, plano to ± 4.00d sphere, 4.25 to 6.00d cylinder	$10.74
V2206	Spherocylinder, plano to ± 4.00d sphere, over 6.00d cylinder	$13.63
V2207	Spherocylinder, ± 4.25 to ± 7.00d sphere, 0.12 to 2.00d cylinder	$10.68
V2208	Spherocylinder, ± 4.25 to ± 7.00d sphere, 2.12 to 4.00d cylinder	$10.80
V2209	Spherocylinder, ± 4.25 to ± 7.00d sphere, 4.25 to 6.00d cylinder	$10.52
V2210	Spherocylinder, ± 4.25 to ± 7.00d sphere, over 6.00d cylinder	$14.45
V2211	Spherocylinder, ± 7.25 to ± 12.00d sphere, 0.25 to 2.25d cylinder	$11.46
V2212	Spherocylinder, ± 7.25 to ± 12.00d sphere, 2.25 to 4.00d cylinder	$11.42
V2213	Spherocylinder, ± 7.25 to ± 12.00d sphere, 4.25 to 6.00d cylinder	$23.94
V2214	Spherocylinder, sphere over ± 12.00d	$39.81
V2215	Lenticular, myodisc	$33.29
V2218	Lens aniseikonic bifocal	$36.29
V2219	Lens bifocal seg width over	$7.00
V2220	Add over 3.25d	$7.00
V2221	Lenticular lens, bifocal	$23.50

Single Vision Lenses, per lens:		
V2299	Specialty bifocal	Submit invoice for pricing*
Trifocal Lenses, per lens: Trifocal lenses are only allowed by the Medicaid Plan when visually necessary. Service must be billed with modifier KX. Visual necessity must be documented in the patient's file. See **VSP New Hampshire Medicaid Client Details**.		
V2300	Sphere, plano to ± 4.00d	$11.51
V2301	Sphere, ± 4.12 to ± 7.00d	$12.09
V2302	Sphere, ± 7.12 to ± 20.00d	$21.29
V2303	Spherocylinder, plano to ± 4.00d sphere, 0.12 to 2.00d cylinder	$11.81
V2304	Spherocylinder, plano to ± 4.00d sphere, 2.25 to 4.00d cylinder	$11.85
V2305	Spherocylinder, plano to ± 4.00d sphere, 4.25 to 6.00d cylinder	$12.41
V2306	Spherocylinder, plano to ± 4.00d sphere, over 6.00d cylinder	$19.87
V2307	Spherocylinder, ± 4.25 to ± 7.00d sphere, 0.12 to 2.00d cylinder	$20.41
V2308	Spherocylinder, ± 4.25 to ± 7.00d sphere, 2.12 to 4.00d cylinder	$19.52
V2309	Spherocylinder, ± 4.25 to ± 7.00d sphere, 4.25 to 6.00d cylinder	$19.62
V2310	Spherocylinder, ± 4.25 to ± 7.00d sphere, over 6.00d cylinder	$19.62
V2311	Spherocylinder, ± 7.25 to ± 12.00d sphere, 0.25 to 2.25d cylinder	$21.69
V2312	Spherocylinder, ± 7.25 to ± 12.00d sphere, 2.25 to 4.00d cylinder	$21.69
V2313	Spherocylinder, ± 7.25 to ± 12.00d sphere, 4.25 to 6.00d cylinder	$21.69
V2314	Spherocylinder, sphere over ± 12.00d	$21.69
V2315	Lenticular, myodisc	$32.79
V2318	Lens aniseikonic trifocal	$32.79
V2319	Lens trifocal seg width > 28	$4.50
V2320	Add over 3.25d	$4.50
V2321	Lenticular lens, trifocal	$8.79
V2399	Specialty trifocal	Submit invoice for pricing*
Variable Asphericity Lenses, per lens:		
V2410	**Variable asphericity lens; s**ingle vision, full field, glass or plastic	$34.29
V2430	**Variable asphericity lens;** bifocal, full field, glass or plastic	$34.29
V2499	**Variable asphericity lens; o**ther type	Submit invoice for pricing*
Miscellaneous Covered Options and Services, per lens:		
V2700	Balance lens	$5.00
V2710	Slab off prism, glass or plastic	$28.47
V2718	Press-on lens, Fresnell prism	$17.58
V2730	Special base curve, glass or plastic	$5.00

Single Vision Lenses, per lens:		
V2784	Lens, polycarbonate or equal, any index	$2.00
Miscellaneous Covered Options and Services, per lens: Service must be billed with modifier KX. See **VSP New Hampshire Medicaid Client Details** for requirements. Visual necessity must be documented in the patient's file.		
V2744	Tint, photochromic	$26.45
V2745	Addition to lens, tint, any color, solid, gradient or equal (excludes photochromic, any lens material)	$5.00
V2781	Progressive lens	Submit invoice for pricing*
V2799	Miscellaneous vision service	Submit invoice for pricing*

Repair and Refitting

92370	Repair and refitting spectacles, except aphakia	$15.00

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 New Hampshire 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	$150.00
V2502	PMMA, bifocal	$150.00
V2503	PMMA, color vision deficiency	$100.00
V2510	Gas permeable, spherical	$100.00
V2511	Gas permeable, toric or prism ballast	$150.00
V2512	Gas permeable, bifocal	$150.00
V2513	Gas permeable, extended wear	$150.00
V2520	Hydrophilic, spherical	$100.00
V2521	Hydrophilic, toric or prism ballast	$150.00
V2522	Hydrophilic, bifocal	$150.00
V2523	Hydrophilic, extended wear	$150.00
V2530	Scleral	$164.63
V2531	Scleral, gas permeable	$309.14
V2599	Contact lens, other type	Submit invoice for pricing*
Visually Necessary Contact Lens Fitting and Dispensing		

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	$25.00
92311	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, for aphakia, one eye	$42.00
92312	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, for aphakia, both eyes	$48.00
92313	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneoscleral lens	$36.00
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	$38.97
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	$27.00
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	$33.00
92317	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and fitting by independent technician; corneoscleral lens	$18.00
92325	Modification of contact lens (separate procedure), with medical supervision of adaptation	$9.20
92326	Replacement of contact lens, single or both; maximum two units	$29.28

Vision Therapy

92060	Sensorimotor examination with multiple measurements of ocular deviation with interpretation and report	$21.00

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

VSP NEW HAMPSHIRE MEDICAID PLAN

NEW HAMPSHIRE HEALTH PROTECTION PROGRAM (NHHPP) PROFESSIONAL FEE SCHEDULE FOR ROUTINE SERVICES – TERMED 12/31/2018

Effective 9/1/17

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.

Important! In compliance with federal regulation, 42 CFR 438.4(b) (1) the NH Department of Health and Human Services (DHHS) has migrated the current NHHPP fee schedule to the State Medicaid Fee Schedule. Effective September 1, 2017 claims submitted to VSP for services provided to a NHHPP member will be reimbursed at the Medicaid Fee Schedule.

Exam Services

92002	Intermediate exam, new patient	$41.08
92004	Comprehensive exam, new patient	$75.00
92012	Intermediate exam, established patient	$37.70
92014	Comprehensive exam, established patient	$59.06
92015	Determination of refractive state	$21.18
S0620	Routine ophthalmological examination including refraction; new patient	$96.18
S0621	Routine ophthalmological examination including refraction; established patient	$80.24

Dispensing and Material Services

92340	Fitting of spectacles, except for aphakia; monofocal	$25.00
92341	Fitting of spectacles, except for aphakia; bifocal	$32.50
92342	Fitting of spectacles, except for aphakia; multifocal	$16.00
92370	Repair and refitting spectacles, except aphakia	$15.00

Frames

V2020	Frame	$30.00
V2025	Deluxe frame Service must be billed with modifier KX. Visual necessity must be documented in the patient's file. See **VSP New Hampshire Medicaid Client Details** for requirements.	Submit invoice for pricing*

Spectacle Lenses

Single Vision Lenses, per lens; fees include scratch resistant coating:		
V2100	Sphere, plano to ± 4.00d	$5.80

Single Vision Lenses, per lens; fees include scratch resistant coating:		
V2101	Sphere, ± 4.12 to ± 7.00d	$7.03
V2102	Sphere, ± 7.12 to ± 20.00d	$10.57
V2103	Spherocylinder, plano to ± 4.00d sphere, 0.12 to 2.00d cylinder	$10.59
V2104	Spherocylinder, plano to ± 4.00d sphere, 2.12 to 4.00d cylinder	$9.25
V2105	Spherocylinder, plano to ± 4.00d sphere, 4.25 to 6.00d cylinder	$10.36
V2106	Spherocylinder, plano to ± 4.00d sphere, over 6.00d cylinder	$10.59
V2107	Spherocylinder, ± 4.25 to ± 7.00d sphere, 0.12 to 2.00d cylinder	$7.92
V2108	Spherocylinder, ± 4.25 to ± 7.00d sphere, 2.12 to 4.00d cylinder	$9.69
V2109	Spherocylinder, ± 4.25 to ± 7.00d sphere, 4.25 to 6.00d cylinder	$10.32
V2110	Spherocylinder, ± 4.25 to ± 7.00d sphere, over 6.00d cylinder	$10.55
V2111	Spherocylinder, ± 7.25 to ± 12.00d sphere, 0.25 to 2.25d cylinder	$10.74
V2112	Spherocylinder, ± 7.25 to ± 12.00d sphere, 2.25 to 4.00d cylinder	$10.95
V2113	Spherocylinder, ± 7.25 to ± 12.00d sphere, 4.25 to 6.00d cylinder	$13.32
V2114	Spherocylinder, sphere over ± 12.00d	$20.46
V2115	Lenticular, myodisc	$20.29
V2118	Lens, aniseikonic single	$20.29
V2121	Lenticular lens, single	$21.72
V2199	Specialty single vision	$6.54
Bifocal Lenses, per lens; fees include scratch resistant coating:		
V2200	Sphere, plano to ± 4.00d	$8.26
V2201	Sphere, ± 4.12 to ± 7.00d	$10.51
V2202	Sphere, ± 7.12 to ± 20.00d	$15.35
V2203	Spherocylinder, plano to ± 4.00d sphere, 0.12 to 2.00d cylinder	$15.32
V2204	Spherocylinder, plano to ± 4.00d sphere, 2.12 to 4.00d cylinder	$10.64
V2205	Spherocylinder, plano to ± 4.00d sphere, 4.25 to 6.00d cylinder	$10.74
V2206	Spherocylinder, plano to ± 4.00d sphere, over 6.00d cylinder	$13.63
V2207	Spherocylinder, ± 4.25 to ± 7.00d sphere, 0.12 to 2.00d cylinder	$10.68
V2208	Spherocylinder, ± 4.25 to ± 7.00d sphere, 2.12 to 4.00d cylinder	$10.80
V2209	Spherocylinder, ± 4.25 to ± 7.00d sphere, 4.25 to 6.00d cylinder	$10.52
V2210	Spherocylinder, ± 4.25 to ± 7.00d sphere, over 6.00d cylinder	$14.45
V2211	Spherocylinder, ± 7.25 to ± 12.00d sphere, 0.25 to 2.25d cylinder	$11.46
V2212	Spherocylinder, ± 7.25 to ± 12.00d sphere, 2.25 to 4.00d cylinder	$11.42
V2213	Spherocylinder, ± 7.25 to ± 12.00d sphere, 4.25 to 6.00d cylinder	$23.94
V2214	Spherocylinder, sphere over ± 12.00d	$39.81
V2215	Lenticular, myodisc	$33.29
V2218	Lens aniseikonic bifocal	$36.29
V2219	Lens bifocal seg width over 28mm	$7.00
V2220	Bifocal add over 3.25d	$7.00
V2221	Lenticular lens, bifocal	$23.50
V2299	Specialty bifocal	$9.19

Single Vision Lenses, per lens; fees include scratch resistant coating:		
Trifocal Lenses, per lens; fees include scratch resistant coating: Trifocal lenses are only allowed by the Medicaid Plan when visually necessary. Service must be billed with modifier KX. Visual necessity must be documented in the patient's file. See **VSP New Hampshire Medicaid Client Details** for requirements.		
V2300	Sphere, plano to ± 4.00d	$11.51
V2301	Sphere, ± 4.12 to ± 7.00d	$12.09
V2302	Sphere, ± 7.12 to ± 20.00d	$21.29
V2303	Spherocylinder, plano to ± 4.00d sphere, 0.12 to 2.00d cylinder	$11.81
V2304	Spherocylinder, plano to ± 4.00d sphere, 2.25 to 4.00d cylinder	$11.85
V2305	Spherocylinder, plano to ± 4.00d sphere, 4.25 to 6.00d cylinder	$12.41
V2306	Spherocylinder, plano to ± 4.00d sphere, over 6.00d cylinder	$19.87
V2307	Spherocylinder, ± 4.25 to ± 7.00d sphere, 0.12 to 2.00d cylinder	$20.41
V2308	Spherocylinder, ± 4.25 to ± 7.00d sphere, 2.12 to 4.00d cylinder	$19.52
V2309	Spherocylinder, ± 4.25 to ± 7.00d sphere, 4.25 to 6.00d cylinder	$19.62
V2310	Spherocylinder, ± 4.25 to ± 7.00d sphere, over 6.00d cylinder	$19.62
V2311	Spherocylinder, ± 7.25 to ± 12.00d sphere, 0.25 to 2.25d cylinder	$21.69
V2312	Spherocylinder, ± 7.25 to ± 12.00d sphere, 2.25 to 4.00d cylinder	$21.69
V2313	Spherocylinder, ± 7.25 to ± 12.00d sphere, 4.25 to 6.00d cylinder	$21.69
V2314	Spherocylinder, sphere over ± 12.00d	$21.69
V2315	Lenticular, myodisc	$32.79
V2318	Lens aniseikonic trifocal	$32.79
V2319	Lens trifocal seg width > 28	$4.50
V2320	Add over 3.25d	$4.50
V2321	Lenticular lens, trifocal	$8.79
V2399	Specialty trifocal	$50.00
Variable Asphericity Lenses, per lens; fees include scratch resistant coating:		
V2410	**Variable asphericity lens; s**ingle vision, full field, glass or plastic	$34.29
V2430	**Variable asphericity lens;** bifocal, full field, glass or plastic	$34.29
V2499	**Variable asphericity lens; o**ther type	$50.00
Miscellaneous Covered Services, per lens: Service must be billed with modifier KX. Visual necessity must be documented in the patient's file. See **VSP New Hampshire Medicaid Client Details** for requirements.		
V2784	Lens, polycarbonate or equal, any index	$2.00
V2700	Balance lens	$5.00
V2710	Slab off prism, glass or plastic	$28.47
V2715	Prism	$2.50
V2718	Press-on lens, Fresnell prism	$17.58
V2730	Special base curve, glass or plastic	$5.00
V2744	Tint, photochromatic	$26.45
V2745	Addition to lens, tint, any color, solid, gradient or equal (excludes photochromic, any lens material)	$5.00

Single Vision Lenses, per lens; fees include scratch resistant coating:		
V2750	Anti-reflective coating	$10.90
V2755	UV lens	$5.30
V2762	Polarization, any lens material	$17.49
V2770	Occluder lens	$5.00
V2781	Progressive lens	Submit invoice for pricing*
V2782	Lens, index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbonate	$17.49
V2783	Lens, index greater than or equal to 1.66 plastic or greater than or equal to 1.80 glass, excludes polycarbonate	$17.49
V2799	Miscellaneous vision service	Submit invoice for pricing*

Repair and Refitting

92370	Repair and refitting spectacles, except aphakia	$15.00

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. Visual necessity must be documented in the patient's file. See **VSP New Hampshire Medicaid Client Details** for requirements.		Maximum allowance per eye
V2500	PMMA, spherical	$100.00
V2501	PMMA, toric or prism ballast	$150.00
V2502	PMMA, bifocal	$150.00
V2503	PMMA, color vision deficiency	$100.00
V2510	Gas permeable, spherical	$100.00
V2511	Gas permeable, toric or prism ballast	$150.00
V2512	Gas permeable, bifocal	$150.00
V2513	Gas permeable, extended wear	$150.00
V2520	Hydrophilic, spherical	$100.00
V2521	Hydrophilic, toric or prism ballast	$150.00
V2522	Hydrophilic, bifocal	$150.00
V2523	Hydrophilic, extended wear	$150.00
V2530	Scleral	$164.63
V2531	Scleral, gas permeable	$309.14
V2599	Contact lens, other type	Submit invoice for pricing*

Visually Necessary Contact Lens Fitting and Dispensing		
92072	Fitting of contact lens for management of keratoconus, initial fitting	$52.37
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	$25.00
92311	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, for aphakia, one eye	$42.00
92312	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, for aphakia, both eyes	$48.00
92313	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneoscleral lens	$36.00
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	$38.97
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	$27.00
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	$33.00
92317	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and fitting by independent technician; corneoscleral lens	$18.00
92325	Modification of contact lens (separate procedure), with medical supervision of adaptation	$9.20
92326	Replacement of contact lens, single or both; maximum two units	$29.28

Vision Therapy

92060	Sensorimotor examination with multiple measurements of ocular deviation with interpretation and report	$21.00

* Refer to the **Contacting VSP by Mail** section of the **VSP Manual**.

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