vsp vision care

VSP Washington Medicaid
Network Manual

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

Effective January 1, 2023

VSP'S MEDICAID PLAN

VSP's Medicaid Plan is based on contracts with health care organizations (clients) to provide the vision care portion of the state's Medicaid program.

Clients are required to provide the minimum benefits specified by your state's Medicaid program, but may also offer enhanced benefits.

Please refer to **Client Detail pages** and/or **Medicaid Fee Schedules** for details about administration of basic state benefits. For state information, refer to the State Medicaid Manual.

ENROLLMENT/DOCTOR PARTICIPATION

Participation is voluntary. Only VSP doctors who have signed a Medicaid Plan Acknowledgment may provide services to Medicaid Plan members. All participating doctors are required to have a state Medicaid identification number.

Eligibility & Authorization

When you contact VSP for an authorization, please provide the following information:

- Last four-digits of the member's Social Security Number and date of birth or the entire client-assigned ID number
- Member's Medicaid number if different from Social Security Number
- Patient's date of birth
- Patient's HMO name

There are several ways to obtain an authorization:

VSP's Electronic Claim Submission System—Enter member's Social Security Number or client-assigned ID number using eyefinity's website and select "Check Patient Eligibility" to access eligible plans. You may wish to print the plan information to discuss plan coverages with your patients.

Customer Service—Call VSP at **800.615.1883**. You may select "1" to contact our automated Interactive Voice Response (IVR) system, or you may speak with a Customer Service Representative who will verify the patient's current eligibility, provide plan information, and issue an authorization.

Note: When the member's eligibility has been verified, VSP will provide an authorization number that is effective through the last day of the current month.

Coordination of Benefits

If the Medicaid patient has vision care coverage through any carrier other than VSP or another VSP plan, you must bill that carrier or the other VSP plan first. The VSP Medicaid Plan should be billed as secondary, where appropriate. For electronic claim submission, be sure to provide the patient's responsibility for exam and refraction separately.

EXAM COVERAGE

Routine eye exam coverage and timeframes are established by State regulations.

In addition to coverage for routine vision care services, Medicaid members are typically covered for services under Essential Medical Eye Care or Integrated Primary EyeCare Program. Any exceptions to this coverage are described in the Client Detail pages and/or the Fee Schedule.

For Telemedicine information refer to: Telemedicine.

Referrals

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

HEDIS and Eye Exams for Patients with Diabetes

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

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

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

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

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

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

WHAT ARE CPT CATEGORY II CODES?

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

WHAT ARE CPT CATEGORY II CODES?

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

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

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

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

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

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

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

MATERIALS COVERAGE

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

Lenses

Lenses are available to the patient based on state regulations.

Covered basic lenses are established by state regulations.

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

Dispensing of Spectacles

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

Repair and Refitting Spectacles

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

Do not bill a dispensing code for repairs.

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

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

Replacement

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

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

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

Frames

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

Visually Necessary Contact Lenses

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

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

LABORATORY

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

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

Lab Price Schedule

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

COST

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

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

Base lenses include:

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

SUBMITTING CLAIMS/BILLING & REIMBURSEMENT

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

Submit Medicaid claims:

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

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

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

Exams:

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

Exams or Materials:

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

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

Any exceptions are noted in the Client Detail pages.

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

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

Coordination of Benefits

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

For Electronic Claims

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

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

For Paper Claims

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

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

WASHINGTON MEDICAID CLIENT DETAILS

PATIENTS ELIGIBILITY FOR SERVICES

Please review the benefit details below.

Benefit Type	Member Group	Frequency	Comment
Exam Benefit	Children (ages 0 – 20)	Eligible for exam every 12 months.	
	Adults (ages 21 and over)	Eligible for exam every 24 months.	
Material Benefit	Children (ages 0 – 20)	Order hardware from the agency's contractor CI Optical. Please refer to the Washington Apple Health Vision Hardware Program billing guide for further information.	VSP **will pay** a material dispensing fee for the fitting of spectacles or the fitting of contact lenses. Please refer to the VSP Washington Medicaid Plan Professional Fee Schedule.
	Adults (ages 21 and over) *Updated effective 7/1/21	Eyeglass frames and lenses are not covered. You can purchase eyeglass frames and lenses through Airway Heights Optical at a discounted price. Please refer to the Washington State Health Care Authority for further information.	VSP will pay a material dispensing fee for the fitting of spectacles or the fitting of contact lenses. Please refer to the VSP Washington Medicaid Plan Professional Fee Schedule.

Medicaid Appointment Availability Requirements

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

- 24-hour access to provide instruction on how and where to obtain services
- 30 calendar days (maximum) for scheduling or rescheduling routine, preventative eye exams
- Urgent care during office hours should be seen within 24 hours based on patient condition
- Emergent care should be directed to the appropriate emergency facility

EXAM

Children (ages 0 - 20): Molina Healthcare members are eligible for an eye exam every 12 months.

Adults (ages 21 and over): Members are eligible for an eye exam every 24 months.

MATERIALS ELIGIBILITY

Children (ages 0 – 20) are eligible for materials. All materials (frame, lens, contact lenses) are provided by the state's vision hardware contractor, CI Optical. For additional information, refer to the Washington Apple Health (Medicaid) Vision Hardware Program billing guide.

For adults - eyeglass frames and lenses are not covered. You can purchase eyeglass frames and lenses through participating optical providers at a discounted price. Refer to WA State Health Care Authority for more information.

VISUALLY NECESSARY CONTACT LENSES

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

- A spherical correction of plus or minus 6.0 diopters or greater in at least one eye.
- When contact lenses are required to correct or treat the following conditions:
  - High anisometropia (when refractive error difference between the two eyes is at least plus or minus 3.0 diopters, and eyeglasses cannot reasonably correct the refractive errors)
  - Aphakia
  - Keratoconus
  - Corneal softening
- Therapeutic contact bandage lenses only when needed immediately after eye injury or eye surgery.

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

Order NCL contact lenses from the agency's contractor CI Optical.

DISPENSING AND MATERIALS SERVICES

When billing for the dispensing of glasses or contact lenses, refer to the VSP Washington Medicaid Fee schedule for the appropriate fitting codes.

Dispensing can be billed with lens or frame or dispensing separate.

BACK-UP EYEGLASSES

The patient may receive one pair of back-up eyeglasses for eligible patients who wear contact lenses as their primary visual correction aid. Limited to once every two years.

INTERIM BENEFITS

- Is allowed for children for exam and/or dispensing
- Interim benefits are utilized for refractive change
- Are not allowed for adults
- Are not related to Repair/Refitting

REPAIR

Member may be eligible for incidental repairs. Refer to the Washington Apple Health (Medicaid) Vision Hardware Program billing guide for coverage requirements and eligibility.

VSP does not cover CPT codes 92370 and 92371 (spectacle repair and refitting).

REPLACEMENT

If the patient has a prescription change requiring an interim exam, please call VSP at **800.615.1883** for an authorization number. When billing for the dispensing of glasses or contact lenses, refer to the VSP Washington Medicaid Fee schedule for the appropriate fitting codes. Document the reason for replacement in the patient's file.

TIMELY FILING

File claims within 365 days of the date of service to ensure compliance with Washington Medicaid guidelines. Claims that are not filed within this timeframe may be denied.

VISION THERAPY

Vision Therapy is covered for children and adults, if visually necessary. Issue an authorization under Vision Therapy. Bill exam services (92060) and/or vision therapy sessions (92065) with appropriate diagnosis code(s), along with modifier KX. Visual necessity must be documented in the patient's medical record.

LOW VISION

Low Vision is covered for children and adults, fittings only, if visually necessary. Bill fitting services (92354, 92355) with appropriate diagnosis code(s), along with modifier KX. Visual necessity must be documented in the patient's medical record.

Refer to the Low Vision Coverage page on the Provider Reference Manual.

PATIENT RESPONSIBILITY

Covered Services/Materials

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

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 the following requirements are met. For exceptions, please refer to Covered Services section above.

- Refer to the Washington Apple Health Vision Hardware Program billing guide for material coverage criteria and exceptions.

- 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.

Client Exceptions

Community Health Plan of WA (40150354) – Adult Coverage

LENSES

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

FRAMES

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

A patient has the option of supplying their own frame or purchasing a non-Genesis frame. There is no allowance toward non-Genesis frames. Non-Genesis frame purchases would be a private transaction, and the frame will not be covered by VSP. Regardless of the frame brand that's purchased, the benefit for lenses will still follow Advantage Plan pricing and orders must be submitted to VSPOne™ Columbus. In-office finishing equipment or stock lenses may not be used.

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

LAB

Orders must be sent to VSPOne Columbus.

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

Molina Healthcare 30084744 – Essential Medical Eye Care Services

Essential Medical Eye Care

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

The following medical eye care services should be billed to VSP. For a complete list of covered services and billable diagnosis codes, please refer to Essential Medical Eye Care Plan in the Provider Reference Manual.

If your patient needs additional treatment, not covered by VSP and you're not contracted with Molina Healthcare of Washington, please refer the patient to an appropriate physician within Molina Healthcare of Washington's network.

Essential Medical Eye Care

VSP WASHINGTON MEDICAID PLAN

PROFESSIONAL FEE SCHEDULE

Effective July 1, 2021

Routine Vision Services

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

Exam Services

92002	Intermediate exam, new patient	$53.00
92004	Comprehensive exam, new patient	$68.00
92012	Intermediate exam, established patient	$53.00
92014	Comprehensive exam, established patient	$68.00
92015	Determination of refractive state	$10.00

Ordering Vision Hardware

Washington State Health Care Authority's vision hardware contractor is CI Optical, which is part of the Washington State Department of Correctional Industries. Providers must obtain all hardware through CI Optical. The agency does not pay any other optical manufacturer or provider for frames, lenses, or contact lenses.

Dispensing for Material Services

Single Vision Dispensing Services:		
92340	Fitting of spectacles, except for aphakia; monofocal,	$20.78
92352	Fitting of spectacle prosthesis for aphakia; monofocal	$27.34
Bifocal Dispensing Services:		
92341	Fitting of spectacles, except for aphakia; bifocal	$23.60
92353	Fitting of spectacle prosthesis for aphakia; multifocal	$31.05
Trifocal Dispensing Services:		
92342	Fitting of spectacles, except for aphakia; multifocal other than bifocal	$25.42
92353	Fitting of spectacle prosthesis for aphakia; multifocal	$31.05

Visually Necessary Contact Lens Services

In addition to the routine eye examination, a contact lens examination is reimbursable with CPT codes 92310 – 92313 and 92072 when visually necessary according to Medicaid's guidelines. Service must be billed with modifier KX. See VSP Washington 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	$77.88

92310	Prescription of optical and physical characteristics of and fitting of contact lenses, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia	$57.10
92311	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, for aphakia, one eye.	$60.12
92312	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, for aphakia, both eyes.	$69.81
92313	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneoscleral lens.	$57.10

Vision Therapy

Vision Therapy 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.		
92060	Sensorimotor examination with multiple measurements of ocular deviation with interpretation and report	$38.33
92065	Orthoptic training; performed by a physician or other qualified health care professional.	$32.08

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. Aids must be obtained through CI Optical.		
92354	Fitting of spectacle mounted low vision aid; single element system	$8.01
92355	Fitting of spectacle mounted low vision aid; telescopic/other compound lens system	$12.50

vsp vision care

PO Box 997100
Sacramento, CA 95899-7100
800.615.1883

vsp.com