Last Updated: July 15, 2024

vsp vision care

VSP Provider
Reference Manual

Effective January 1, 2024

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VSP MANUAL TABLE OF CONTENT

Introduction

Scope of the Manual

Use this manual in combination with your patient's Patient Record Report. If you participate in other VSP networks, we'll provide those manuals to you.

The **VSP Provider Reference Manual** contains guidelines for your partnership with VSP. The core sections and their contents are:

- **Eligibility and Authorization:** Processes for verifying patient eligibility for VSP coverage, determining which benefits apply, and submitting claims for reimbursement.
- **Plans and Coverages:** Covered services and administration of Vision Service Plan® eyecare plans.
- **Eye Exams:** Standard exam and supplemental test procedures for children and adults. Also includes processes for documentation requirements and referrals.
- **Dispensing and Patient Lens Enhancements:** Procedures for dispensing spectacle lenses and frames to patients. Also explains the use of contract labs and how to administer a necessary redo.
- **Client Details:** Specifics about benefits, coordination of benefits, and reimbursement.
- **Policies:** A listing of VSP's policies and procedures for quality management, reimbursement, office standards, advertising, and safety.

Tools for Locating Information

The **Table of Contents**, lists the main manual topics by section.

The Glossary of the manual, provides an alphabetical listing of common terms used throughout this manual. A concise definition is provided for each term.

Contacting VSP

Contacting VSP by Phone and Email

Service	Number	Notes
Provider Services Support Line (pre-claim submission)	**800.615.1883**	Representatives are available to answer questions: **Effective 12/1/2021:** Monday - Saturday - 6:00 a.m. – 5:00 p.m. PST Sunday - Closed You may also refer VSP members to vsp.com. After dialing, you'll be greeted by our Interactive Voice Response (IVR) system. After the salutation, you may reach a representative by selecting from the following options: Press 1: Eligibility and authorization information Press 2: All other inquiries
Provider Services Support Line (post-claim submission)	**844.344.3591**	For questions about claims that have **already been submitted**, representatives are available Monday through Saturday from 6:00 a.m. to 5:00 p.m. Pacific Time. After dialing, you'll be greeted by our Interactive Voice Response (IVR) system. Please enter your office phone number. Press 1: Look up claim information based on a claim number Press 2: Look up claim information based on a Member ID Press 3: Look up claim information based on a member's last four (4) of their Social Security Number (SSN)
Provider Relations	providernetworkdevelopment@vsp.com	Provider Relations will answer the following questions: Becoming a VSP Provider, revenue generating opportunities and training opportunities for doctors and staff. Credentialing/recredentialing and updating practice information.
Member Services (Patients)	**800.877.7195**	Representatives are available to answer questions from patients: Monday - Friday 5:00 a.m. – 8:00 p.m. PST Saturday - 7:00 a.m. – 8:00 p.m. PST Sunday - 7:00 a.m. – 8:00 p.m. PST **Effective 1/1/2022:** Monday - Saturday 6:00 a.m. – 5:00 p.m. PST Sunday - Closed Medicare members hours are Monday – Sunday, 8:00 a.m. – 8:00 p.m. in all time zones You may also refer VSP members to vsp.com.

Contacting VSP by Mail

Correspondence	In-Network Claims	Out-of-Network Claims
VSP PO Box 997100 Sacramento, CA 95899-7100	VSP PO Box 495907 Cincinnati, OH 45249-5907	VSP PO Box 495918 Cincinnati, OH 45249-5918

Ordering Supplies and Forms

Shipping Time

Most shipments will be sent UPS ground. Please allow the appropriate time for shipment. If you need faster delivery, please make note of the priority on your request.

Ordering Online

You may order supplies through **VSPOnline** on eyefinity.com.

Ordering by Phone

Call the Provider Services Support Line at **800.615.1883**.

Tools and Forms Index

- Plan Reference Chart
- CMS-1500 Claim Form Quick Reference Card
- Computer VisionCare Questionnaire
- Coordination of Benefits Acknowledgement
- Explanation of Payment Quick Reference Guide
- First-Time Redo Verification Form
- Frame Benefit Examples/Frame Calculator
- Interactive Voice Response Quick Reference Card
- Low Vision Verification Form
- Material Invoice Form
- Materials Invoice Quick Reference Card
- Materials Verification Form
- Member Complaint/Grievance Forms (National/California-Only/California-Spanish/California-Chinese)
- Primary Care Provider Communication Form
- Provider Dispute Resolution Request & Multiple Provider Dispute Resolution Forms
- Safety Requirements Questionnaire
- Vision Benefit Statement
- Vision Therapy Verification Form (ICD-10)
- VSP Savings Statement (with 20% discount) (without discount)
- Current VSP Signature Lens Enhancements Chart

Explanation of Payment Message Codes

Code	Message
01	Frame not authorized.
02	Lens not authorized.
03	Exam not authorized.
04	Fee reduced due to late submission.
05	Frame over limit.
06	Doctor's redo.
07	Secondary COB claim.
08	Adjustment
09	Value plan only – exam billed as new patient – downcoded to established.
10	Interest payment associated with late payment of a claim.
15	Your primary insurance coverage reimbursed expenses in full.
17	Primary COB claim.
20	Changed doctor information
21	Changed lab ID information
22	Changed benefit form (claim) number
23	Changed benefit form information
24	Changed assignee information
25	Additional changes made
26	Changed lab invoice number
27	Changed group information
28	In-Office Finishing Claim Adjustment.
2H	In-Office Finishing service is not allowed for the benefit type
2I	In-Office Finishing option code is not allowed with other options billed
2J	Unapproved lab was used for this In-Office Finishing service
2K	Service is not payable due to related In-Office Finishing service being denied
30	Deleted exam service
31	Deleted lens service
32	Deleted frame service
33	Deleted contact lens service
34	Deleted treatment service
35	Deleted lens option service
36	Deleted miscellaneous service
39	A material code is required with dispensing services.
3A	A valid date of service is required (CMS-1500 box 24a).
3B	Date of service is after the claim received date (CMS-1500 box 24a).
3C	Units exceed the allowed amount for this procedure (CMS-1500 box 24g).

Code	Message
3D	Anesthesia units must reflect the number of minutes spent with the patient (CMS-1500 box 24g).
3E	Service requires an appropriate modifier (CMS-1500 box 24d).
3F	Inappropriate billing of modifiers (CMS-1500 box 24d).
3G	Place of service is inappropriate for service billed (CMS-1500 box 32).
3H	Place of service and modifier combination is not appropriate (CMS-1500 boxes 32 & 24d).
3I	Place of service is not valid (CMS-1500 box 32).
3J	Service requires a primary medical eyecare diagnosis (CMS-1500 box 21).
3K	Diagnosis code is not appropriate for this benefit (CMS-1500 box 21).
3L	Diagnosis referenced is not appropriate for the service (CMS-1500 box 21).
3M	Diagnosis code combination is not appropriate (CMS-1500 box 21).
3N	At least one primary eyecare diagnosis is required (CMS-1500 box 21).
3O	A valid diagnosis code is required (CMS-1500 box 21).
3P	Service code is not valid (CMS-1500 box 24d).
3Q	Material code must be accompanied by the appropriate service code (CMS-1500 box 24d).
3R	An accompanying service code was not billed (CMS-1500 box 24d).
3S	Option/service code combination is not appropriate (CMS-1500 box 24d or Lab Information/Option Codes section of the Materials Invoice or the Basic Form).
3T	All claim lines must have a valid procedure code (CMS-1500 box 24d).
3U	Service code is not allowed with other services billed (CMS-1500 box 24d).
3V	Service is a non-specific code (CMS-1500 box 24d).
3W	If there is a lens HCPCS code, a corresponding lens type must be provided (Lens Type section of the Materials Invoice or the Basic Form).
3X	If there is a lens type, a corresponding lens HCPCS code must be provided, or the check box was not selected on the Materials Invoice form.
3Y	Lens HCPCS code does not match the corresponding lens type code (CMS-1500 box 24d and the Lens Type section of the Materials Invoice or the Basic Form).
3Z	A frame supplier must be indicated (Frame Service/Frame Supplied By section of the Materials Invoice or the Basic Form).
40	Added exam service
41	Added lens service
42	Added frame service
43	Added contact lens service
44	Added treatment service
45	Added lens option service
46	Added miscellaneous service
4A	A frame supplier and wholesale frame cost must be supplied (Frame Service/Frame Supplied By and Frame Cost sections of the Materials Invoice or the Basic Form).
4B	A frame HCPCS code must be provided.
4C	Frame service requires a wholesale frame cost (Frame Service/Frame Cost section of the Materials Invoice or the Basic Form).
4D	A lab ID is required (Lab ID Code section of the Materials Invoice or the Basic Form).
4E	Lab is not active on date of service.
4F	A lab invoice is required (Lab Information/Invoice # section of the Materials Invoice or the Basic Form).
4G	There is indication of another health plan (CMS-1500 boxes 9a-d or 11a-d). Submit the proper forms from the other insurance company.

Code	Message
4H	Copy of patient's membership card is required.
4I	Service requires supporting documentation.
4J	Documentation submitted does not support the medical necessity for this procedure.
4K	Patient's medical record is required.
4L	Submit documentation summarizing treatment to date and ongoing treatment plan.
4M	Service requires precertification from VSP.
4N	Service requires precertification and an invoice to be submitted.
4O	Claim billed with V58.69 or V67.51 requires a secondary diagnosis code that describes the disease state (CMS-1500 box 21).
4P	Indicate if patient is covered by another health plan (CMS-1500 boxes 9a-d or 11a-d).
4Q	Documentation was not submitted prior to providing services.
4R	Patient's date of birth is required (CMS-1500 box 3).
4S	A valid member ID is required (CMS-1500 box 1a).
4T	Patient's full name is required (CMS-1500 box 2).
4U	Patient's signature or signature on file is required (CMS-1500 boxes 12 & 13).
4V	Patient relationship does not match VSP records (CMS-1500 box 6).
4W	Name on the referral does not match the patient's name (CMS-1500 box 2).
4X	Service date is prior to the referral date (CMS-1500 box 24a).
4Y	A VSP referral is required.
4Z	Referring doctor's name and NPI are required (CMS-1500 boxes 17 & 17b).
50	Changed service date
51	Changed exam service
52	Changed lens service
53	Changed frame supplier
54	Changed contact lens service
55	Changed treatment service
56	Changed lens option service
57	Changed miscellaneous service
5A	Referral has expired for this service.
5B	Date on referral form is missing.
5C	Self-referral by rendering doctor is inappropriate.
5D	Your Medicaid ID number is not on file with VSP.
5E	Service requires the name of the VSP Primary Eyecare Doctor.
5F	Rendering doctor's full name is required (CMS-1500 box 31).
5G	Physical address is required (CMS-1500 box 32).
5H	Rendering doctor's signature is required (CMS-1500 box 31).
5I	Federal Tax ID is required (CMS-1500 box 25).
5J	Rendering doctor's NPI is required (CMS-1500 box 24J).

Code	Message
5K	Doctor’s signature date is later than the claim received date at VSP (CMS-1500 box 31).
5L	Doctor not eligible to provide services billed.
5M	Coordination of Benefit is not allowed per Client provisions.
5N	Service code is not a covered service for the patient.
5O	Patient is not eligible for the service provided.
5P	Service is not a covered benefit for the patient.
5Q	Service is not payable due to a related service paid in patient’s history.
5R	Service was previously paid in the last 12 month period.
5S	Billing address is required (CMS-1500 box 33).
5T	Service is not payable when billed in the global period of a related service.
5U	From/to dates of service exceed post-op care period (CMS-1500 box 24a).
5V	Comprehensive exam was found in history & was downcoded to an intermediate exam.
5W	Technical and Professional components should not be billed separately by the same provider.
5X	This service is included in the reimbursement of another procedure billed for this date of service.
5Y	Post-op/Pre-op visits are not separately payable within global period of surgery.
5Z	This procedure is not reimbursed when performed during a surgical global period.
60	Changed exam billed amount
61	Changed lens billed amount
62	Changed frame billed amount
63	Changed contact lens billed amount
64	Changed treatment billed amount
65	Changed lens option billed amount
66	Changed miscellaneous billed amount
68	Claim paid twice
69	Claim paid in error
6A	Procedure is included in reimbursement of a previously paid global service.
6B	Patient condition indicates third party liability.
6C	Patient is ineligible for VSP Medical Eyecare Benefits provided by a non-VSP provider/location.
6D	Services not a VSP covered benefit. Refer to health plan.
6E	Service has previously been paid.
6F	Service provided by assistant surgeon is not payable.
6G	VSP medical guidelines were not followed.
6H	Claim was submitted beyond allowed submission period.
6I	A VSP Referral from a primary care provider is required for this procedure.
6J	Option code is not allowed with the other options billed.
6K	Accompanying option code was not billed.
6L	Option code is not allowed with the billed lens type.

Code	Message
6M	Option code is not allowed for the benefit type.
6N	Option code is not valid at date of service.
6O	Criteria has not been met for the service code.
6P	Options are not allowed unless there is a lens service code.
6Q	Service code is not allowed for benefit type.
6R	Claim resubmitted beyond the VSP 180-day allowed re-submission period.
6S	Service is not payable due to related service being denied.
6T	Patient has exhausted allowance.
6U	Service exceeds frequency allowance.
6V	Service has been combined and processed under the exam for same date of services.
6X	Patient not covered by plan for date of service.
6Y	Rendering provider information for date of service doesn't match VSP systems.
6Z	Patient must be covered by more than one VSP Group.
70	Changed patient name
71	Changed patient relation code
72	Changed patient DOB
74	Changed group information
75	Changed deductible information
76	Changed exclusion information
77	Updated frame code
78	Updated contacts allowance
79	Updated grid code
7A	Date of service is not within the effective dates of the BR.
7B	Service code billed is not appropriate for patient.
7C	Service line amount is required.
7D	Billed amount was not entered or the service(s) is payable at $0.00 (CMS-1500 box 24f).
7E	Refraction service (92015) billed without an exam is not a payable service.
7F	Service is only payable to a licensed or qualified resident physician.
7G	Lens Dispensing was modified to match materials provided by Lab.
7H	Member is under the Access Plan which is a discount only benefit.
7I	Option code is only payable once per date of service.
7J	Remaining services will be processed on a separate claim.
7K	Refer to *Provider Reference Manual* under Covered and Non-Covered Options.
7L	Frame service requires a retail frame cost.
7M	Submit the birth date of each Member who provides coverage for this dependent.
7N	Submit a complete copy of the Explanation of Benefits (EOB), including the message code explanations, itemized services, amount(s) paid, applied to the deductible, or services denied.

Code	Message
7O	A copy of the original CMS-1500 or claim form that was submitted to the primary insurance carrier is needed.
7P	The name and address of the contract lab is necessary. If an independent lab was used, submit a copy of the optical invoice and include the wholesale cost of materials (Lab Information/Lab ID Code section of the Materials Invoice or the Basic Form).
7Q	Patient has no out-of-pocket expenses left to coordinate.
7R	Service code not billed to the primary insurance.
7S	COB allowed for co-pays only.
7T	Refer to *Provider Reference Manual*, COB Rules 2 & 3.
7U	Refer to Provider Reference Manual, COB Rule 7.
7V	Refer to Provider Reference Manual, COB Rule 5.
7W	Coordination of Benefits only allowed with Medicare.
7X	Claim or attachment(s) are not legible and cannot be processed. Resubmit a legible copy.
7Y	Documents indicate that VSP is tertiary. Itemized EOB from secondary carrier is required.
7Z	Add-on fees are necessary for non-covered options.
80	Changed member ID.
81	Changed member name
82	Changed member address
83	Changed member city
84	Changed member state
85	Changed member zip code
86	Changed COB total amount
87	Services reversed. Dr to pay lab.
88	Special lens
89	Per doctor's request
8A	Lens type is needed.
8B	Contact lens type is needed.
8C	The U&C contact lens fee is needed.
8D	Frames are dispensed by the lab for this client.
8E	Unapproved lab was used for this client.
8F	Polycarbonate option has been covered in full for monocular diagnosis.
8G	CMS-1500 billed amount and EOB billed amount does not match (CMS-1500 box 24f).
8H	Product name is required.
8I	Services can only be rendered by a VSP credentialed doctor.
8J	Diagnosis code is not allowed as primary (CMS-1500 box 21).
8K	Primary diagnosis code is blank (CMS-1500 box 21).
8L	Copay added to allowed amount for contact lens professional or material services if total billed charges exceed ECL allowance.
8M	Billed amount has been rolled up to a related service to maximize payment.
8N	Adjustment on Exam Plus or Access Indemnity to maximize provider payment.

Code	Message
8O	Standard option code is not allowed with a progressive option code.
8P	Glass option code is not allowed with a plastic option code.
8Q	Frame has been denied; therefore, frame case is not covered.
8R	Frame case has not been billed; therefore, frame case is not covered.
8S	Frame case is only covered if frame is supplied by the lab or doctor.
8T	Effective February 26, 2005, to be reimbursed for an eyeglass case, you must bill HCPCS code V2756 with your U&C fee for case. VSP will pay the billed amount up to $2.00.
8U	Service is not payable due to related service being denied.
8V	HCPCS service code added per material invoice.
8W	Documentation submitted does not support the necessity for this procedure.
8X	Claim denied per doctor’s request.
8Y	CLCP Qualified patient—initial supply
8Z	COB amount includes out-of-pocket expense from past service in the same service/calendar year.
90	Per lab’s request
91	N in grid
9A	Effective August 27, 2004, bill HCPCS code V2756 for an eyeglass case.
9B	Frame collection type is required.
9C	Does not meet qualification for special lens reimbursement.
9D	The patient's plan does not have an allowance for special lenses.
9E	Frame is not from the approved Titmus collection.
9F	COB amounts include out of pocket expenses using service for service application.
9G	Refer to Provider Reference Manual, COB Rule 4.
9H	The date of service billed on the CMS-1500 does not match the date of service on the Explanation of Benefits.
9I	Refraction is not allowed with the examination billed.
9J	Maximum allowance for materials has been met.
9K	Refraction service is not payable if billed without an exam or if the exam is denied.
9L	The secondary exam allowance includes exam and refraction overages.
9M	Second or subsequent lens re-dos are private transactions between you, the lab and the patient.
9N	Member share of cost has been deducted from the allowed amount.
9O	The member's share of cost must be entered in box 29 on the CMS-1500 form.
9P	Member share of cost exceeds claim allowance.
9Q	Original claim number previously submitted. New claim number assigned by VSP.
9R	The service billed was not issued on the claim authorization.
9S	The service billed was not issued on the claim authorization.
9T	Exam billed is not payable due to an exam in patient's history for the same date of service.
9U	Claim has been corrected to add fitting of spectacle and/or modifier.
9V	Misdirected claim, re-submit to: THMP, P.O. Box 200555, Austin, TX 78272.
9W	Routine ophthalmological examination reimbursement includes refraction.

Code	Message
9X	99xxx codes are not payable for routine/supplemental exams. Please bill using 92002-92014.
9Y	Frame is not allowed unless there is a payable lens service code.
9Z	Lens services have been reimbursed under fitting of spectacles.
A#	Contact lens program adjustment
A*	Paper claim processing charge adjustment
A0	Paid claim twice.
A1	Doctor fees on file incorrect.
A2	Lab fees on file incorrect.
A3	Nonmember fee schedule incorrect.
A4	Adjustment.
A5	Option amount on file incorrect.
A6	Not covered under PIA. Please refer to the eManual.
A7	Redo Transaction handled privately.
A8	Health Reimbursement Arrangement indicated. Submit copy of patient's HRA EOB.
AD	Non-covered polycarbonate option AD on safety claim
AI	Partnership Plus adjustment
B	Partnership Plus electronic auth & eClaim, $2.00 per claim.
B1	Partnership Plus electronic auth & eClaim with Altair level 1, $4.00 per claim.
B2	Partnership Plus electronic auth & eClaim with Altair level 2, $6.00 per claim.
C1	Exam has been denied. Your plan does not pay for service(s) from a non VSP Medicaid doctor in your state.
C3	Costco – Patient Paid Privately (OA Only).
C4	Under VSP redo guidelines, an addition or change in tint or coating by patient or doctor is not covered if this is the only reason for the redo.
C5	Your routine vision benefit does not cover medical vision services. The attached billed services are medical vision services.
C6	The attached claim needs to be submitted electronically in accordance with your VSP Laser VisionCareSM Program agreement.
C7	Exam processed by CIGNA Medical, COB for refraction only.
C8	The CMS-1500 claim form is not completely/accurately filled out. Please submit a new CMS-1500 claim form.
C9	Post authorization is required because of the lens type provided.
CA	The patient's plan does not allow contact lenses unless you receive prior authorization from VSP.
CM	IOF Uncut - Combined Material Reimbursement.
CP	Paper claim charge waived.
D1	Claim or service is denied. Refer to *Provider Reference Manual* for appeal process.
D2	Claim or service is denied as unprocessable because it contains incomplete and/or invalid information.
D3	Claim or service is denied as unprocessable because it contains incomplete and/or invalid information and no appeal rights are afforded. Please resubmit entire claim, including attachments, with the completed/corrected information.
E	Partnership Plus electronic authorization, $0.50 per paid claim.
E1	Partnership Plus electronic authorization with Altair level 1, $1.00 per paid claim.
E4	Patient Condition Hypertension or High Cholesterol, $2.00 additional payment on Exam service.

Code	Message
E5	Patient Condition Diabetes or Diabetic Retinopathy, $5.00 additional payment on Exam service.
F1	Partnership Plus Frame Program, $5.00 per claim.
FQ	Elective contact lenses
G	VSP Inspire Progressive Lens, $10 per claim
HA	Payment is made at contracted rate
IF	In-Office Finishing services performed
IL	IOF Option; refer to In-Office Finishing Fee Schedule for payment
IO	Option code is not allowed with In-Office Finishing
KA	Non-covered progressive option on safety claim
KD	Non-covered polycarbonate option on safety claim
ME	Exam Payment is made at contracted rate
OM	Billed amount over the maximum allowed for this service
OP	Patient pays VSP option price for this service
P3	Patient Paid Privately (OA Only)
PC	Paper claim charge $2.00 per claim
PM	*Asterisk – VSP is unable to provide Patient Pay Materials for this plan. Please refer to the PRM for appropriate billing
PU	Patient pays doctor’s U&C fee for this service
RD	Exam payment reduced by 20% of your comp exam payable. Bill 92015 with exam service for full payment.
RX	Refraction service (92015) billed without an exam is not a payable service.
SE	Patient not eligible for this service on service date
UA	Adjustment to pay UNITY Savings.
UD	Adjustment to reverse UNITY Savings.
UF	Uncut In-Office Finishing services performed.
UI	Total UNITY Savings paid.
UN	VSP is unable to calculate patient resp. Totals exclude unknown amounts.
US	Service eligible for UNITY Savings.

VSP Signature Plan® Lens Enhancements Charts

June 27, 2023 Signature Plan® Lens Enhancements Chart

VSP Signature Plan

Lens Enhancements Chart

vsp vision care

Effective June 27, 2023

Revised June 27, 2023

Use this chart to determine what to charge patients and reconcile your VSP® Vision Care Explanation of Payment.

Copay

All lens enhancements are covered after a copay. Charge patients the listed copay or your usual and customary fee (U&C), whichever is lower.

VSP Lab Allocation

This is the amount charged to you for lab fees. You won't be charged for covered lens enhancements.

Service Fee

You'll receive the listed service fee. VSP will reimburse this fee for covered lens enhancements. For other enhancements, this will be included in the copay you collect from the patient.

Use the following chart for what to charge your patients.

VSP Signature Plan®

Effective June 27, 2023

Charge patients the listed patient copay or your U&C fee, whichever is lower.

ASPHERICAL AND SPHERICAL LENS STYLES		SINGLE VISION			MULTIFOCAL		
Code	**Lens Enhancement Description**	**VSP Lab Allocation**	**Service Fee**	**Patient Copay**	**VSP Lab Allocation**	**Service Fee**	**Patient Copay**
AA	Aspheric Plastic 1.50	$10	$13	$23	$14	$14	$28
AB	High-index Plastic 1.53–1.60/Trivex	$29	$22	$51	$33	$22	$55
AH	High-index Plastic 1.66/1.67	$48	$28	$76	$58	$32	$90
AJ	High-index Plastic 1.70 and Above	$68	$34	$102	$78	$32	$110
AD	Polycarbonate	$19	$14	$33	$19	$14	$33
AE	(Lab Use Only)	--	--	--	--	--	--
AF	High-index Glass 1.60–1.80 (Clear)	$35	$20	$55	$85	$42	$127

DIGITAL ASPHERIC LENS STYLES		SINGLE VISION			MULTIFOCAL		
Code	**Lens Enhancement Description**	**VSP Lab Allocation**	**Service Fee**	**Patient Copay**	**VSP Lab Allocation**	**Service Fee**	**Patient Copay**
BA	Digital Aspheric Lenses – Plastic	$26	$14	$40	$31	$14	$45
BA + BB	Digital Aspheric Lenses – High-index Plastic 1.53–1.60/Trivex	$16	$11	$40 + $27	$16	$11	$45 + $27
BA + BH	Digital Aspheric Lenses – High-index Plastic 1.66/1.67	$37	$19	$40 + $56	$40	$25	$45 + $65
BA + BJ	Digital Aspheric Lenses – High-index Plastic 1.70 and Above	$57	$25	$40 + $82	--	--	--
BA + BD	Digital Aspheric Lenses – Polycarbonate	$10	$0	$40 + $10	$10	$0	$45 + $10

OCCUPATIONAL LENS STYLES		SINGLE VISION			MULTIFOCAL		
Code	**Lens Enhancement Description**	**VSP Lab Allocation**	**Service Fee**	**Patient Copay**	**VSP Lab Allocation**	**Service Fee**	**Patient Copay**
CA	(Lab Use Only)	--	--	--	--	--	--
CE	(Lab Use Only)	--	--	--	--	--	--

POLARIZED LENS STYLES		SINGLE VISION			MULTIFOCAL		
Code	**Lens Enhancement Description**	**VSP Lab Allocation**	**Service Fee**	**Patient Copay**	**VSP Lab Allocation**	**Service Fee**	**Patient Copay**
DA	Polarized Lenses – Plastic A	$36	$17	$53	$48	$23	$71
DA + DB	Polarized Lenses – High-index Plastic 1.53–1.60/Trivex	$47	$23	$53 + $70	$59	$29	$71 + $88
DA + DH	Polarized Lenses – High-index Plastic 1.66/1.67	$55	$27	$53 + $82	$67	$33	$71 + $100
DA + DJ	Polarized Lenses – High-index Plastic 1.70 and Above	$70	$30	$53 + $100	--	--	--
DA + DD	Polarized Lenses – Polycarbonate	$13	$14	$53 + $27	$13	$14	$71 + $27
DE	Polarized/Laminated Lenses – Glass	$49	$23	$72	$63	$30	$93

BIFOCAL LENS STYLES (MARK BIFOCAL BOX)		SINGLE VISION			MULTIFOCAL		
Code	**Lens Enhancement Description**	**VSP Lab Allocation**	**Service Fee**	**Patient Copay**	**VSP Lab Allocation**	**Service Fee**	**Patient Copay**
IA	Near Variable Focus – Plastic	--	--	--	$26	$20	$46
IA + IB	Near Variable Focus – High-index Plastic 1.53–1.60/Trivex	--	--	--	$11	$10	$46 + $21
IA + II	Near Variable Focus – High-index Plastic 1.66/1.67	--	--	--	$27	$18	$46 + $45
IA + IJ	Near Variable Focus – High-index Plastic 1.70 and Above	--	--	--	$36	$19	$46 + $55
IA + ID	Near Variable Focus – Polycarbonate	--	--	--	$7	$10	$46 + $17
GA	Blended Bifocal – Plastic	--	--	--	$14	$13	$27

PLASTIC DYES		SINGLE VISION			MULTIFOCAL		
Code	**Lens Enhancement Description**	**VSP Lab Allocation**	**Service Fee**	**Patient Copay**	**VSP Lab Allocation**	**Service Fee**	**Patient Copay**
MM	(Lab Use Only)	--	--	--	--	--	--
MN	Plastic Dyes – Solid Color (Except Pink I and II)	$5	$8	$13	$5	$8	$13
MP	Plastic Dyes – Gradient	$7	$8	$15	$7	$8	$15

+This lens enhancement code is always in conjunction with a base lens enhancement code [shaded], e.g., IB is charged with IA.
Please note: If the patient is covered for plastic dyes, glass tints, or photochromics, there is no Service Fee for those lens enhancements.
Additionally, for children or handicapped patients, there is no Service Fee for covered polycarbonate lenses when dispensed.

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Charge patients the listed patient copay or your U&C fee, whichever is lower.

GLASS TINTS AND COLOR COATINGS		SINGLE VISION			MULTIFOCAL		
Code	**Lens Enhancement Description**	**VSP Lab Allocation**	**Service Fee**	**Patient Copay**	**VSP Lab Allocation**	**Service Fee**	**Patient Copay**
MQ	(Lab Use Only)	--	--	--	--	--	--
MR	Glass Tints Solid (Except Pink I and II and Yellow)	$16	$14	$30	$24	$17	$41
MS	Glass Color Coatings – Solid	$22	$16	$38	$22	$16	$38
MT	Glass Color Coatings – Gradient	$25	$17	$42	$25	$17	$42

PHOTOCHROMICS		SINGLE VISION			MULTIFOCAL		
Code	**Lens Enhancement Description**	**VSP Lab Allocation**	**Service Fee**	**Patient Copay**	**VSP Lab Allocation**	**Service Fee**	**Patient Copay**
PM	Photochromics – Glass	$15	$14	$29	$23	$14	$37
PR	Photochromics – Plastic	$47	$23	$70	$47	$23	$70

OTHER COATINGS		SINGLE VISION			MULTIFOCAL		
Code	**Lens Enhancement Description**	**VSP Lab Allocation**	**Service Fee**	**Patient Copay**	**VSP Lab Allocation**	**Service Fee**	**Patient Copay**
QM	Anti-reflective Coating A	$21	$16	$37	$21	$16	$37
QT	Anti-reflective Coating C	$41	$20	$61	$41	$20	$61
QV	Anti-reflective Coating D	$52	$23	$75	$52	$23	$75
QP	Mirror – Solid and Single Gradient (Includes Base Color)	$26	$18	$44	$26	$18	$44
QR	Ski Type (Includes Base Tint and Backside Color)	$30	$20	$50	$30	$20	$50
QQ	Scratch-resistant Coating A – Factory Applied	$7	$8	$15	$7	$8	$15
QS	Scratch-resistant Coating B – Other Approved Coatings	$15	$14	$29	$15	$14	$29

OVERSIZE		SINGLE VISION			MULTIFOCAL		
Code	**Lens Enhancement Description**	**VSP Lab Allocation**	**Service Fee**	**Patient Copay**	**VSP Lab Allocation**	**Service Fee**	**Patient Copay**
RM	Frames Stamped 61mm Eye Size or Greater – Plastic	$5	$5	$10	$6	$6	$12
RN	Frames Stamped 61mm Eye Size or Greater – Glass	$7	$5	$12	$10	$6	$16

MISCELLANEOUS		SINGLE VISION			MULTIFOCAL		
Code	**Lens Enhancement Description**	**VSP Lab Allocation**	**Service Fee**	**Patient Copay**	**VSP Lab Allocation**	**Service Fee**	**Patient Copay**
SP	High Luster Edge Polish	$6	$8	$14	$6	$8	$14
SQ	Edge Coating	$17	$15	$32	$17	$15	$32
SR	Faceted Lenses (Includes Polishing)	$41	$20	$61	$41	$20	$61
SW	Rimless Drill	$25	$5	$30	$25	$5	$30
SV	UV Protection	$6	$8	$14	$6	$8	$14
BV	UV Protection – Backside	$7	$3	$10	$7	$3	$10
LF	Light Filter	$11	$4	$15	$11	$4	$15
TA	Technical Add-on	$8	$2	$10	--	--	--
SH	(Lab Use Only)	--	--	--	--	--	--
ST	(Lab Use Only)	--	--	--	--	--	--

DOCTOR SUPPLIED*		SINGLE VISION			MULTIFOCAL		
Code	**Lens Enhancement Description**	**VSP Lab Allocation**	**Service Fee**	**Patient Copay**	**VSP Lab Allocation**	**Service Fee**	**Patient Copay**
IM	Plastic Dyes – Solid Color (Pink I and II)	$5	--	--	$5	--	--
IN	Plastic Dyes – Solid Color (Except Pink I and II)	$5	$8	$13	$5	$8	$13
IP	Plastic Dyes – Gradient	$7	$8	$15	$7	$8	$15
IV	UV Protection	$6	$8	$14	$6	$8	$14

Please note: If the patient is covered for plastic dyes, glass tints, or photochromics, there is no service fee for those lens enhancements.
*In-office Lab: For the patient lens enhancements your office can fulfill in-house, you'll be reimbursed this listed fee for covered lens enhancements. For all other lens enhancements, this will be included in the patient copay you collect from the patient.

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Charge patients the listed patient copay or your U&C fee, whichever is lower.

PROGRESSIVE				
Code	**Lens Enhancement Description**	**VSP Lab Allocation**	**Service Fee[1]**	**Patient Copay**
CM	Custom Measurements (on Eligible Progressive N or O) Lenses	$2	$8	$10
NA	Progressive N – Plastic	$95	$65	$160
NA + NB	Progressive N – High-index Plastic 1.53–1.60/Trivex	$25	$17	$160 + $42
NA + NH	Progressive N – High-index Plastic 1.66/1.67	$48	$24	$160 + $72
NA + NJ	Progressive N – High-index Plastic 1.70 and Above	$77	$38	$160 + $115
NA + ND	Progressive N – Polycarbonate	$18	$15	$160 + $33
NA + NP	Progressive N – Polarized	$51	$25	$160 + $76
OA	Progressive O – Plastic	$75	$45	$120
OA + OB	Progressive O – High-index Plastic 1.53–1.60/Trivex	$25	$17	$120 + $42
OA + OH	Progressive O – High-index Plastic 1.66/1.67	$48	$24	$120 + $72
OA + OJ	Progressive O – High-index Plastic 1.70 and Above	$77	$38	$120 + $115
OA + OD	Progressive O – Polycarbonate	$18	$15	$120 + $33
OA + OP	Progressive O – Polarized	$51	$25	$120 + $76
FA	Progressive F – Plastic	$54	$36	$90
FA + FB	Progressive F – High-index Plastic 1.53–1.60/Trivex	$25	$17	$90 + $42
FA + FH	Progressive F – High-index Plastic 1.66/1.67	$48	$24	$90 + $72
FA + FJ	Progressive F – High-index Plastic 1.70 and Above	$77	$38	$90 + $115
FA + FD	Progressive F – Polycarbonate	$18	$15	$90 + $33
FA + FP	Progressive F – Polarized	$51	$25	$90 + $76
FE	Progressive F – Glass/High-index Glass (Clear)	$59	$36	$95
JA	Progressive J – Plastic	$46	$34	$80
JA + JB	Progressive J – High-index Plastic 1.53–1.60/Trivex	$25	$17	$80 + $42
JA + JH	Progressive J – High-index Plastic 1.66/1.67	$48	$24	$80 + $72
JA + JJ	Progressive J – High-index Plastic 1.70 and Above	$77	$38	$80 + $115
JA + JD	Progressive J – Polycarbonate	$18	$15	$80 + $33
JA + JP	Progressive J – Polarized	$51	$25	$80 + $76
JE	Progressive J – Glass/High-index Glass (Clear)	$56	$34	$90
KA	Progressive K – Plastic	$30	$20	$50
KA + KB	Progressive K – High-index Plastic 1.53–1.60/Trivex	$25	$17	$50 + $42
KA + KH	Progressive K – High-index Plastic 1.66/1.67	$48	$24	$50 + $72
KA + KJ	Progressive K – High-index Plastic 1.70 and Above	$77	$38	$50 + $115
KA + KD	Progressive K – Polycarbonate	$18	$15	$50 + $33
KA + KP	Progressive K – Polarized	$51	$25	$50 + $76
KE	Progressive K – Glass/High-index Glass (Clear)	$50	$20	$70

1. The Service Fee for progressives is paid in addition to your VSP Signature Plan bifocal dispensing fee.
Please note: For children or handicapped patients, there is no Service Fee for covered polycarbonate lenses when dispensed.

PROGRESSIVE CATEGORIES[2] AS OF 6/27/2023		
Custom	N	Unity® Via Elite II, Hoyalux iDMyStyle 2, Hoyalux iD LifeStyle 3, Maui Jim Passport 2.0, Shamir Autograph III^, Shamir Autograph Intelligence^, Varilux X Fit Technology^, ZEISS SmartLife Individual
	O	Unity Via Plus II/Mobile II/Wrap II, Array 2^, Kodak Unique DRO, Shamir Autograph II+^, Varilux Physio W3+, Varilux X Design Technology^, ZEISS SmartLife Superb^/Plus/Pure
Premium	F	Unity Via II, Hoyalux Summit, Shamir Spectrum+, Varilux Comfort Max, Varilux Physio DRx, ZEISS Progressive Light V
	J	Ethos® Plus, Amplitude BKS, Kodak Precise, Shamir Element, Varilux Comfort 2, ZEISS Progressive Light H
Standard	K	Ethos, Accolade, Hoyalux GP Wide, Image, Ovation, Shamir Genesis HD, synchrony Easy View HD, ZEISS Progressive Light D

2. For a full list of progressives, please refer to the Product Index in the Manuals on VSPOnline at **eyefinity.com**.
^This progressive lens is customizable for the most precise prescription.

The VSP formulary is administered by Plexus Optix, Inc. and Plexus reserves the right to make any modifications or adjustments to any or all of the fees in this chart at any time.

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Classification: Restricted

Determining a Patient's Eligibility

Authorizing Coverage and Benefits

Before providing services, make sure your patient is eligible for benefits by retrieving an authorization. At that time, you'll get information about your patient's plan, coverage, and current benefit eligibility. You'll also get a unique authorization number for your patient. Remember: an authorization number **doesn't** guarantee payment. Review any comments or notations at the bottom of the Patient Record Report to confirm patient eligibility. Confirmation is required to show that the services and materials provided meet our plan requirements before issuing payment.

There are two ways to get an authorization number:

1. **eClaim:** Log onto **eyefinity.com**, go to the eInsurance tab or select **Get Authorizations & Check Eligibility**.

Click **Member Search**. Enter any one of the following valid search combinations:

- Full Member ID only. (Member ID can be SSN or Client-Specific Employee ID)
- Member first name, member last name, and date of birth (DOB).
- Last 4 SSN, member last name, and member first name.
- Last 4 SSN, member last name, member first name, and date of birth (DOB).
- Last 4 SSN, member last name, and DOB.

Note:

Enter more information for best results. Try SSN or Member ID to locate all records.

Important!

Make sure you choose the correct member and patient prior to issuing an authorization. If you're not sure which member to choose, call VSP at **800.615.1883** for assistance.

2. **Customer Service:** Call VSP at **800.615.1883**. Select "1" to use our automated phone system. Or, you can talk with a Customer Service representative who'll check the patient's current eligibility, provide plan information, and issue an authorization number.

Important!

Authorizations are usually effective for 30 days from the issue date. You'll receive an 'Invalid Authorization' error message in eClaim if you submit a claim for a date of service not within the effective dates. If this happens, obtain a new authorization valid for the date of service and resubmit.

Refer to the Patient Record Report or the Lens Enhancements Charges Report for an explanation of your patient's coverage.

Important!

Before ordering or providing services, tell your patients that they're responsible for payment of non-covered services and materials.

VSP patients have the ability to access and/or print a Member Vision Card from **vsp.com**, and may provide a card when visiting your practice for services.

Note:

A Member Vision Card isn't required for services.

While the card will provide basic benefit/plan information, please don't rely on it solely for benefit coverage information. You must verify your patient's eligibility and obtain an authorization on **eyefinity.com**. To view what information is available on the card, please refer to the Member Vision Card Quick Reference Guide.

Submitting Claims/Timeliness

In most cases, we process claims that are received within 180 days of the date of service. Please note that when glasses are ordered, we won't receive a claim until the lab finishes the order and submits the claim to VSP.

Remember to bill your U&C fees on **all** claims. We'll pay the lesser of the billed amount or your assigned fee. To confirm claim status, visit eyefinity.com, or call VSP at **800.615.1883**.

A "clean" claim is a claim that can be processed without additional information from you, your patient, or someone else.

When any part of a claim is found to be false, VSP will deny payment for the entire claim. There is no entitlement to partial payment of a claim. Denial of the claim may occur when the claim is submitted or upon subsequent review during the course of an audit.

It's **your** responsibility to get an authorization and ensure the information is accurate. Payment could be delayed if you submit a claim without an authorization number. An incorrect authorization number could result in claim denial and/or you may incur lab charges. Authorization numbers can't be transferred between claims.
When submitting claims, please complete all fields to accurately show the services you provided.

When we request dates of service, we're looking for:

Exam: the date you performed your patient's eye exam.

Glasses: the date your patient ordered their glasses.

Contacts: the date the contact lens fitting and evaluation started. If you didn't perform a contact lens fitting and evaluation, use the date when contact lens materials were ordered by your patient.

It's **your** responsibility to get an authorization and ensure the information is accurate. Payment could be delayed if you submit a claim without an authorization number. An incorrect authorization number could result in claim denial and/or you may incur lab charges. Authorization numbers can't be transferred between claims.

When submitting claims, please complete all fields to accurately show the services you provided.

Important!

You're responsible for all claims submitted by you, your employees, and agents of your practice.

Please remember you can't disclose any information about your patient to any other person or organization without the written consent of your patient, legal guardian, parent, or his/her authorized representative unless:

- Your patient is unable to give written consent, or
- State or federal law requires disclosure.

Standard procedure requires you to collect and report encounter data, which is specific patient information that serves the purposes stated below:

- Supports the role of optometrists as healthcare providers.
- Meets reporting guidelines required by regulatory agencies.
- Documents the efficiency, quality, and cost effectiveness of care provided.
- Demonstrates the value of vision care in treating and managing diseases, as well as maintaining overall good health.

Submitting Patient Conditions Requirement

Doctors are required to submit patient conditions through eClaim on **eyefinity.com**, practice management software, or paper claims. Patient condition submission is monitored as part of the Quality Assurance (QA) Program and results are provided in the QA Review Summary. Outcomes identifying the need for improvement will require the doctor's acknowledgement of the results and an improvement action plan.

Refer to the following section to learn more about the importance of indicating patient conditions on your VSP claims, including the opportunity for additional reimbursement.

- **Policies**

Submitting Patient Conditions Requirement

You can easily indicate patient conditions using the eClaim form by checking the appropriate condition box(es) or by including the respective diagnosis code(s) under the "Check condition(s) patient is known to have" section.

For all practice management systems, including **Eyefinity Practice Management, OfficeMate®, and AcuityLogic™**, you can indicate patient conditions by checking one or more of the condition checkboxes or by using the applicable diagnosis codes included below.

Notes:

If you enter an equivalent diagnosis code, eClaim will check the box for you.
Patient Condition Sticky Notes are available for you to collect patient conditions and keep them top of mind throughout the exam process and serve as a reminder to indicate the condition when submitting the claim. Sticky notes can be ordered for free on the **Supply Request Form** on **VSPOnline** at **eyefinity.com**.

Check one or more of the boxes or enter diagnosis code(s) for the following:

- **Diabetes.** Patients who either self-reported having diabetes or are taking medications specifically for diabetes.
- **Diabetic Retinopathy.** Patients who have diabetic retinopathy, regardless of whether they have been diagnosed with diabetes.
- **Hypertension**. Patients who either self-reported being diagnosed with hypertension or those who are taking medications specifically for hypertension.
- **High Cholesterol.** Patients who either self-reported being diagnosed with high cholesterol or those who are taking medications specifically for high cholesterol.
- **Glaucoma.** Patients who have been diagnosed with glaucoma at any time, including the current visit.
- **ARMD (Age-related Macular Degeneration).** Patients who have been diagnosed with ARMD at any time, including the current visit.
- **At Risk for Prediabetes.** Patients who either self-report as having prediabetes or have been identified as being at risk for prediabetes using an online risk assessment.

Dilation

Choose Yes or No in the drop-down menu in eClaim when asked if dilation was performed. If dilation is not performed for a patient with diabetes, be sure to document the clinical rationale in the patient's medical record.

Primary Care Provider (PCP) Communication

Choose Yes or No in the drop-down menu when asked if the PCP Communication was completed. If you did not communicate with the PCP for a patient with diabetes, be sure to document the reason in the patient's medical record.

For more information on Eye Health Management visit **VSPOnline** at **eyefinity.com**, go to Programs, and click Eye Health Management Program.

Note:

Tools for communicating with your patients' PCP can be found on **VSPOnline**. Under **Administration** select **Submitting Patient Conditions** and then click on the **Resources** tab.

Use the check boxes to indicate patient conditions; diabetes, diabetic retinopathy, hypertension and/or high cholesterol on eClaim. Submit additional conditions like glaucoma, age-related macular degeneration, patients at risk for prediabetes, and other conditions using diagnosis codes.

Diabetes	Diabetes Retinopathy
E10.10 - E10.9	E10.311 - E10.3599
E11.00 - E11.9	E11.311 - E11.3599
E13.00 - E13.9	E13.311 - E13.3599
	H21.1X1 - H21.1X9
Glaucoma	**Age-related Macular Degeneration**
H40.001 - H40.009	H35.30
H40.011 - H40.019	H35.3110 - H35.3114
H40.021 - H40.029	H35.3120 - H35.3124
H40.051 - H40.059	H35.3130 - H35.3134
H40.061 - H40.069	H35.3190 - H35.3194
H40.10X0 - H40.10X4	H35.3210 - H35.3214
H40.1110 - H40.1194	H35.3220 - H35.3224
H40.1210 - H40.1294	H35.3230 - H35.3234
H40.1310 - H40.1394	H35.3290 - H35.3294
H40.1410 - H40.1494	H35.33
H40.151 - H40.159	H35.341 - H35.349
H40.20X0 - H40.20X4	H35.351 - H35.359
H40.211 - H40.219	**High Cholesterol**
H40.2210 - H40.2294	E78.00
H40.231 - H40.239	E78.01
H40.241 - H40.249	E78.1
H40.30X0 - H40.33X4	E78.2
H40.40X0 - H40.43X4	E78.3
H40.50X0 - H40.53X4	E78.41
H40.60X0 - H40.63X4	E78.49
H40.811 - H40.839	E78.5
H40.89	**Hypertension**
H40.9	H35.031-H35.039
H42	I10
Q15.0	I97.3
	Prediabetes
	R73.03

Glasses

- Complete the Invoice Services page first to provide the material order details.
- Select a VSP contract lab.
- Click on Calculate HCPCS & Continue.
- Enter refractive error reason(s), then any additional diagnosis codes for any other medical conditions.
- Select the appropriate patient condition checkbox(es).
- Complete the Diagnosis & Services page by entering your U&C fees next to the correct CPT/HCPCS code.

Contact lenses

- Select the type of contacts dispensed.
- Select the contact lens reason (see Contact Lens Plans in the “Plans & Coverages” section of this manual).
- If contact lens exam services (fitting and evaluation) were performed, include this in the correct drop-down box.
- Indicate the contact lens manufacturer
- Specify the contact lens brand
- Enter the number of boxes
- Specify the Modality
- Click on Calculate HCPCS
- Enter refractive error reason(s), then enter any additional diagnosis codes for other medical conditions.
- Select the appropriate patient condition checkbox(es).
- Complete the Diagnosis & Services page by entering your U&C fees next to the correct CPT/HCPCS code.

Flexible Spending Account (FSA)

Some of our clients have asked us to collect and report patients’ total FSA eligible out-of-pocket expenses to their flexible spending account vendors. For these patients, the Patient Record Report will indicate, “This patient may participate in a Flexible Spending Account (FSA) program.”

You’ll also notice a field titled FSA on eClaim to collect the patient's total FSA out-of-pocket expenses. This amount includes both the VSP out-of-pocket charges you calculated in Box 29 and any eligible charges for non-covered items you do not include on the VSP claim (like second pairs and contact lens solution). Report the total for the FSA after the secondary COB payment has been deducted from the patient's primary out-of-pocket charges.

Here’s a list of common FSA eligible expenses, which is subject to change based on IRS regulations:

- Copays
- Lens enhancements
- Frame overages
- Contact lens overages
- Contact lens solution
- Additional prescription glasses not covered by the benefit
- Prescription sunglasses not covered by the benefit
- Plano sunglasses not covered by the benefit (if deemed medically necessary by the doctor)

Here’s an example to help you calculate what should be entered in the FSA box for a patient who uses VSP benefits for glasses and pays for contact lenses, contact lenses services, and solution privately:

Expense	Cost
VSP copay	$20
Frame overage (VSP prescription glasses)	$50
Box 29: Total VSP Patient out-of-pocket expenses	**$70**
85% of contact lens exam services (fitting and evaluation) --private pay	$100
Contacts (private pay)	$150
Contact lens solution (private pay)	$20
Total non-VSP out-of-pocket expenses	**$270**
+ Total VSP out-of-pocket expenses (calculated above)	**$70**
TOTAL eligible FSA (reported in FSA box)	**$340**

We primarily use two paper claim forms: the CMS-1500 form and the VSP Materials Invoice form. Please refer to the CMS-1500 Claim Form Quick Reference Card and the Materials Invoice Quick Reference Card in the Tools & Forms section of this manual for instructions on completing these forms, including where to enter the Authorization Number and/or the Materials Verification number.

Using the CMS-1500 Form

Refer to the CMS-1500 Claim Form Quick Reference Card for detailed instructions. **We will only accept original, red copy CMS-1500 forms. Photocopies or faxed forms will be rejected.**

To expedite processing when submitting CMS-1500 claims, be sure to:

- Check that all patient information is complete and correct.
- Check that Boxes 12 and 13 have correct signatures or indicate a signature is on file.
- Use valid, complete diagnosis codes. Always code to the highest degree of specificity when indicating diagnosis.
- Enter additional diagnosis codes for any other medical conditions your patient may have.
- Enter the correct place of service in Box 24B.
- Include a letter in Box 24E that "points" to the appropriate diagnosis in Box 21.
- Include doctor NPI in Box 24J if multiple doctors are using the tax ID in Box 25.
- Complete Box 32 with the practice's physical address, not a PO Box.

CMS Plus Materials Invoice (CMS-Plus)

If a plan requires the use of a contract lab, and you dispense lenses and/or frames to an eligible patient, use a Materials Invoice Form with the CMS-1500 Claim Form. If you don't use a contract lab, or if you provide only an exam or dispense contact lenses, submit only the CMS-1500 Form.

If you need to submit a Materials Invoice Form with the CMS-1500 Form:

1. Complete both forms.

2. Attach the two completed forms.

3. Send both claim forms to the lab. (The lab will forward the claim to VSP for payment after the glasses have been made)

Contract Lab Orders

The lab will fill orders that contain lenses and frames, and forward the claims to us for payment.

If the lab contacts you about a missing or incomplete CMS-1500 Claim Form, submit a completed form to the lab as soon as possible. If a completed form isn't received within 10 working days of initial notification, the lab can't fill your order and will return the Materials Invoice Form to you.

It's your responsibility to check patient eligibility for materials and to correctly complete the forms. If a material claim is denied payment, any materials you order will be billed to you, and you'll be responsible for paying the lab.

In most cases, we process claims that are received within 180 days following the date of service.

Remember:

When lenses and frames are ordered, we don't get the claim until the lab completes the order and submits the claim to us.

Materials Codes on CMS-1500 Form

It's important that you list any materials sold (lenses, frames, and lens enhancements), with the appropriate V code, on the CMS-1500 Claim Form as we'll reimburse you only for services listed on the CMS-1500 Form. The information provided on the Materials Invoice Form is only for lab use. The following are samples of Comment Codes and the appropriate forms and actions:

CMS-1500 Form Comment Codes and Claim Filing Actions

Comment Code	Billed Service(s)	Type of Form(s)	Submit to
L064	Exam	CMS	VSP
L064	Exam and CL	CMS	VSP
L071	Any Service	CMS	VSP
L083	Exam w/ Lenses and/or Frame	CMS + Materials Invoice	Contract lab

If you're away for a period of time and use a substitute or fill in provider, you can submit a claim using eClaim or paper.

- Submit the claim under your NPI and Tax ID number
- Include the substitute or fill in provider's NPI or SSN in box 19 "Reserved for Local Use" and a modifier for each line – use modifier Q5

Claim Appeals

To dispute/appeal a claim based on an individual claim denial, a bundle of claims denial or dissatisfaction with a claim payment, you may appeal by filing a claim dispute or appeal. See Appeal Process below.

For other disputes, including disputes related to Network Doctor Adverse Actions and actions as a result of an audit conducted pursuant to VSP's Fraud, Waste and Abuse Policy, please see VSP's Dispute Resolution Policy under the **Policies** section of this manual. The Fraud, Waste and Abuse Policy can be found under this same section.

To check the status of a claim, call VSP at **800.615.1883** or access **eyefinity.com**.

For claim corrections, such as a diagnosis code, billed amount or service code, call VSP at **800.615.1883** or complete the claim correction form on **eyefinity.com**.

VSP considers you to be authorized to act on behalf of your patient in pursuing appeals of denied claims. It's your responsibility to:

- Inform patients of their right to appeal a claim denial.
- Explain the appeal process to your patients.
- Get your patients' approval to act as their authorized representative in the appeal process. If your patients don't agree to you representing them in the appeal process, please direct them to contact VSP Member Services at **800.877.7195**.

This Appeal process is for disputes/appeals related to individual claim denials, a bundle of claims denial or your dissatisfaction with a claim payment. All other disputes shall be submitted pursuant to VSP's Dispute Resolution Policy cited above.

All Appeals under this section can be submitted online, by mail, or by phone. Incomplete appeals will be returned.

A sample Provider Claim Dispute Request Form is provided in the Tools & Forms section of this manual. If you prefer to submit a written appeal without using the form, please include the following information with your written appeal:

1. Your name and Payment Arrangement ID number
2. Your contact information
3. Original claim number (listed on the Explanation of Payment)
4. Supporting documentation

You can appeal multiple "like" denials (i.e., numerous claims denied for untimely filing) at the same time by using the Multiple-Provider Claim Dispute Form with the Provider Claim Dispute Request.

For most states and plans, appeals must be submitted to us within 180 calendar days from the date of the Explanation of Payment. See state and plan exceptions for specific timeframes and rules.

- **Online:** Complete the Provider Claim Dispute Request Form available in the **Forms Library** under **Administration** on **VSPOnline** on **eyefinity.com**.
- **Mail:** Send appeals to: VSP Claim Appeals, PO Box 2350, Rancho Cordova, CA 95741-2350.
- **Phone:** Call VSP at **800.615.1883 (California and New Mexico Provider Disputes must be received in writing)**

We'll review your appeal and send a written response within 30 calendar days for most states and plans. Should the initial denial be upheld, you have the right to pursue a second-level appeal. Second-level appeals must be received within **60 calendar days** from the date of the letter stating that the appeal has been denied. Follow the same process listed above to submit second-level appeals.

Arizona

Arizona Medicaid has unique requirements. For more information, see Submitting Claims/Billing, Reimbursement, & Appeals section in the **Arizona Medicaid Manual.**

California

Appeals unrelated to Notices of Adverse Action and actions as a result of an audit conducted pursuant to VSP's Fraud and Abuse Policy (See above under "Claim Appeals") must be submitted to us within 365 calendar days from the date of the denial. Californa Medicare must submit to us within 60 calendar days from the date of the denial. We'll review your appeal and send a written response within 45 working days.

If you believe all or part of this claim has been wrongfully denied, you may have the matter reviewed by the California Department of Insurance at:
California Department of Insurance, Health Claims Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013, www.insurance.ca.gov
800.927.4357 (HELP) TDD: 800.482.4833.

Missouri

Appeals submitted from providers in Missouri must be received within 180 calendar days of original receipt of claim denial. We'll review your appeal and send a written response within 20 business days from the date of receipt of all information needed to process the appeal.

New Jersey

Appeals submitted from providers in New Jersey must be received within 90 calendar days of original receipt of claim denial. We'll review your appeal and send a written response within 10 business days from the date of receipt of all information needed to process the appeal.

Our internal second-level appeal is optional for New Jersey doctors. Following state law, New Jersey doctors have the right to use an external second-level appeal after participating in our first-level appeal process.

If you choose this option, we'll share the cost of the arbitration equally. To initiate this process, submit the appeal in writing to an independent arbitrator listed with the American Arbitration Association and send a copy to us at: VSP Claim Appeals, PO Box 2350, Rancho Cordova, CA 95741-2350.

Here is additional contact information if you need additional information:

American Arbitration Association
Customer Service: **800.778.7879**, **212.484.4181**
Web site: adr.org
NJ E-mail: casefiling@adr.org

ERISA is a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for people covered under these plans. If your patient's employer pays for all or part of the patient's benefits, the patient has additional appeal rights mandated by ERISA.

Under this law, patients can get copies of all documents, records, and other information relevant to their appeal free of charge.

Once all mandatory appeals have been completed, ERISA patients may have other voluntary alternative dispute resolution options, such as mediation. Your patients may refer to their Evidence of Coverage (EOC) or Standard Plan Description (SPD), contact their local U.S. Department of Labor Office or their State Insurance regulatory agency to find out what's available.

ERISA patients have the right to contest the decision of the appeal process. Under ERISA Section 502(a)(I)(B), patients have the right to bring civil actions. This right can be exercised when all required reviews of their claims (including the appeal process) have been completed, the claim wasn't approved (in whole or in part), and a patient disagrees with the outcome.

Some clients require VSP to provide their members with a Vision Benefit Statement (VBS) instead of the current VSP Savings Statement. The VBS provides patients with a summary of the amount they have been charged for the services received and will also provide any denial procedures directly to the patient. If a client requires VSP to provide a VBS, the Patient Record Report will state: Patient will receive Vision Benefit Statement (VBS) directly from VSP; a VSP Savings Statement will not be available.

View a sample of the Vision Benefit Statement.

Coordination of Benefits

Some patients have vision coverage from more than one benefits plan, either multiple VSP plans or a VSP plan and a medical plan. In these situations, coordinating benefits will help your patients maximize their coverage and lower costs. This section includes guidelines for coordinating benefits for your VSP patients. Every practice and patient is unique, and these guidelines are intended to provide best practices to help realize the full value of your patient's coverage. You can also find guidelines for supplemental plans under that plan's information in the **Plans and Coverages section**.

Please discuss billing options, including coordination of benefits (COB), with your VSP patient to identify ways to maximize value for them and create additional revenue opportunities for your practice.

If your patient requests COB, the following guidelines apply when your patient's coverage is with two VSP plans or when a non-VSP plan is primary and a VSP plan is secondary.

If your patient's VSP plan is primary and any other insurance plan is secondary, call VSP at **800.615.1883** to request a letter detailing your patient's out-of-pocket expenses that can be shared with the secondary insurer.

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Determining and Applying Benefits

There are several common COB situations, including VSP primary to another carrier, multiple VSP plans, health plan or Medicare with VSP coverage, routine versus medical services, and VSP secondary to another vision carrier. This section includes guidelines for coordinating benefits for your VSP patients.

Use the following to assist your patient in maximizing the eyecare benefits (vision or medical).

1. Based on your professional judgment, determine if the service is routine or medical.
2. Determine the primary and secondary plans.
3. Verify eligibility and available services under each plan.
4. Determine patient responsibility, based on primary insurance.
5. Submit the primary and secondary claims, following the appropriate Submitting Claim instructions.
6. Apply total COB secondary allowance, less any secondary copays, to patient's total primary out-of-pocket expense. Patient pays remaining balance, but not more than the allowed amount.

Review the scenarios below to help determine your patient's primary and secondary plans, if your patient is covered under multiple plans and isn't a dependent child. If none of the scenarios fit, the plan that's covered your patient longest is primary.

Patient has	and	then
VSP coverage	the spouse has non-VSP coverage	the patient's VSP plan is primary.
VSP coverage	the spouse has VSP coverage	the patient's VSP plan is primary.
non-VSP coverage	the spouse has VSP coverage	the patient's non-VSP plan is primary. The spouse's VSP plan is secondary.
VSP and non-VSP coverage	none of the Coordination of Benefits Rules listed below apply	the plan covering your patient longest is primary*
Medicaid coverage through VSP	has other coverage (through a health plan or Medicare)	Medicare or the other coverage is primary. The VSP Medicaid plan is secondary
one or more VSP plans	is not eligible for Medicare	the plan covering your patient longest is primary*
VSP coverage as an active employee	VSP coverage as a retiree under another VSP plan	the active employee VSP plan is primary. The VSP retiree plan is secondary.
COBRA coverage (a continuation plan)	is active with another plan as an employee or dependent	the active employee or dependent VSP plan is primary. The COBRA VSP plan is secondary.
VSP coverage as a retiree	is active under a COBRA plan	the COBRA plan is primary. The retiree plan is secondary.
VSP coverage as a dependent of a retired employee	is an active employee in another VSP plan	the plan covering the patient as an active employee is primary. The VSP plan covering the patient as a dependent is secondary.
VSP or non-VSP coverage through self or spouse	is covered under parents' plan	patient's or spouse's plan is primary. Parents' plan is secondary.

Use the following chart if your patient is a dependent child with VSP coverage as primary and secondary.

Patient is	and	then
dependent child	the parents are NOT separated or divorced	The plan of the parent whose birthday is first in the year is primary* If both parents have the same birthday, the plan that's covered a parent longer is primary* If the other plan doesn't have a birthday rule, the gender rule applies (the father's plan is primary).
dependent child	the parents ARE separated or divorced with NO court decree	the custodial parent's plan is primary* The plan of the custodial parent's spouse (if any) is secondary. Followed by the plan of the non-custodial parent, and then the plan of the non-custodial parent's spouse.
dependent child	the parents ARE separated or divorced WITH a court decree	the plan decreed by the court as primary is primary* If the decree states both parents have joint custody without stating who's responsible for healthcare expenses, follow the birthday rule.

***Important!**

Obtain the length of coverage or custody information from your patient or member. Parental custody information may apply when determining coverage for a child.

VSP primary to another carrier

When a VSP plan is primary, apply benefits as you would in the absence of any other plan. If needed, call VSP at **800.615.1883** to request a letter detailing your patient's out-of-pocket expenses that can be shared with the secondary insurer.

Quick Tip:

If your patient isn't eligible for a service under the primary plan, the secondary plan may be used as primary for that service.

Multiple VSP plans for routine services:

1. **Determine** the primary and secondary plans.
2. **Review** Coordination of Benefits between Multiple VSP Plans to verify VSP plans can coordinate.
3. **Verify** eligibility and if any services are exhausted under either plan.

Quick Tip:

If your patient isn't eligible for a service under the primary plan, the secondary plan may be used as primary for that service.

4. **Determine** the patient's out-of-pocket expenses from the primary plan.
5. Refer to the Secondary Allowances schedule to determine the COB amount for each service payable under the primary plan that is also available under the secondary plan.

Quick Tip:

Be sure to review COB rules on primary and secondary authorizations prior to calculating COB secondary allowance.

6. Deduct total available COB secondary allowance from patient's total primary out-of-pocket expense. Patient pays remaining balance.

Quick Tip:

You can also access the COB Calculator on VSPOnline to help determine the amounts a patient can coordinate for routine services when VSP is secondary.

7. Bill VSP using the primary plan authorization number and reference the secondary plan's authorization. See Submitting COB Claims for detailed instructions.

When a VSP plan is secondary, follow these steps:

1. Verify eligibility and if any services are exhausted under either plan.

Quick Tip:

If your patient isn't eligible for a service under the primary plan, the secondary plan may be used as primary for that service.

2. Determine whether your patient is eligible for benefits under the secondary plan
3. Refer to the Secondary Allowances schedule to determine the COB amount for each service payable under the primary plan that is also available under the secondary plan.

4. Deduct total available COB secondary allowance from patient's total primary out-of-pocket expense. Patient pays remaining balance, but not more than the allowed amount.

Quick Tip:

You can also access the COB Calculator on VSPOnline to help determine the amounts a patient can coordinate for routine services when VSP is secondary.

5. Bill VSP as secondary. See Submitting COB Claims for detailed instructions.

Members may have coverage under both VSP and a health plan or Medicare.

Common scenarios:

- If you participate on the patient's health plan and the exam is medical, bill the health plan or Medicare as primary.
- If the exam is routine, bill VSP as primary unless the patient has routine coverage through their health plan*
- If the health plan covers the exam only, submit the exam claim to the health plan as primary and the materials claim to VSP as primary.

Quick Tip:

Be sure to obtain two separate authorizations – one to submit your exam to coordinate benefits and one to submit the materials to VSP as primary.

Medical plans generally have higher copays than VSP and may have deductibles. They also don't typically cover a refraction. To save money for your patient, coordinate benefits with VSP to help cover unpaid portions of the medical eye exams, if any, including the refraction and other medical services. Plus, you now have options to help maximize your patient's plan.

- If another insurance carrier is primary to VSP, you can now coordinate both their routine and medical benefits (i.e. medical exam and refraction using a WellVision exam benefit and Essential Medical Eye Care) – a medical and refractive diagnosis is required.

Quick Tip:

Be sure to include applicable medical diagnosis codes for the eye exam and any medical procedures with a routine diagnosis code for the refraction.

*Patients covered under the Federal Employees Dental and Vision Insurance Program may have routine coverage through their health plan. For more information, check the Federal Government Client Details in the Choice Network Manual.

Description	Eligible VSP Coverage	Billing
Patient comes in for routine exam and is also seen for a medical eye issue. Provider determines chief complaint is medical. Refraction is performed with medical and refractive diagnosis. Member has coverage through a health plan or Medicare. Has **both** a WellVision **and** VSP medical benefit (i.e., Essential Medical Eye Care).	Medical and WellVision	Bill the health plan or Medicare as primary (if on their panel). Use VSP's medical plan (i.e., Essential Medical Eye Care) as the secondary VSP benefit to coordinate benefits for medical exam (and any medical procedures). **AND** add the WellVision exam authorization in the COB Secondary Authorization field if a refractive diagnosis code is billed to pay toward the refraction.
Patient comes in for routine exam and is also seen for a medical eye issue. Provider determines chief complaint is medical. Refraction is performed with medical diagnosis, no refractive diagnosis. Member has coverage through a health plan or Medicare. Has a VSP medical benefit (i.e., Essential Medical Eye Care). Member is **not eligible** for WellVision exam.	Medical only (WellVision not eligible)	Bill the health plan or Medicare as primary. Use VSP's medical plan as secondary benefit for the medical exam, refraction will be denied. Submit claim electronically, keep copy of EOP in patient chart.
Patient comes in for routine exam and is also seen for a medical eye issue. Provider determines chief complaint is medical. Refraction is performed with medical and refractive diagnosis. Member has coverage through a health plan or Medicare. Has a VSP WellVision exam benefit (**no VSP supplemental medical coverage**).	WellVision	Bill the health plan or Medicare as primary. Use WellVision as the secondary VSP benefit to coordinate benefits if refractive diagnosis code is billed, including refraction. Submit claim electronically, keep copy of EOP in patient chart.
Patient comes in for routine exam and a medical condition is identified. Provider performs medical exam. Refraction is performed with medical diagnosis, refractive diagnosis. Member has coverage through a health plan or Medicare AND **two VSP plans** with WellVision **and** medical eyecare plan (i.e., Essential Medical Eye Care).	Medical only	Determine primary VSP plan. Bill VSP under the primary plan's Essential Medical Eye Care/DEP Plus claim electronically with the secondary authorization to coordinate benefits. Use Essential Medical Eye Care as the secondary VSP benefit for medical only exam, refraction will be denied.

Important!

The primary and secondary plans must be under different ID numbers or different clients, unless there are special comments, or if COB rule 11 applies.
Interim benefits are not available for coordination under any plan benefit type whether considered primary or secondary.
If another insurance carrier is primary to VSP, you can now coordinate both their routine and medical benefits (i.e. medical exam and refraction using a WellVision exam benefit and Essential Medical Eye Care) – a medical and refractive diagnosis is required.

Note:

If your patients have plano coverage available on the primary benefit, they must have plano coverage available on the secondary benefit to coordinate both plans when receiving plano materials.

COB Routine Secondary Allowances

Service	VSP Signature and VSP Choice	Advantage
Eye exam	$66 less secondary plan copays	$50 less secondary plan copays
Lenses	$51 less secondary plan copays	$36 less secondary plan copays
Frame	$76 less secondary plan copays	$58 less secondary plan copays
Maximum for Exam, Lens and Frame	$193 less secondary plan copays	$144 less secondary plan copays

Secondary allowances are less secondary plan copays and are cumulative.

Other Secondary Allowances:

- For patients with an Elective Contact Lens Benefit, refer to the Patient Record Report for the contact lens allowance. (Note: A covered-in-full contact lens exam does not have a secondary COB dollar value).
- For patients with allowance plans, refer to the Patient Record Report for the material allowance.
- You can coordinate the secondary exam allowance with the exam, refraction and/or retinal screening out-of-pocket expense from the primary plan.

Medicaid Network Coordination of Benefits Secondary Allowances

Refer to your Medicaid Manual for state-specific Medicaid COB guidelines.

VSP to VSP for Exam, Lens and Frame

Here's a VSP Signature Plan example:		
Calculate the patient's out-of-pocket expenses under their primary plan		
Exam copay	$10	
Lens copay + lens enhancements	+ $133	
Frame overage:	+ $122	**=$265**
VSP will COB the patient's out-of-pocket expenses up to secondary allowance:		
Maximum for Exam, Lens and Frame secondary allowance:	$193	
Lens secondary plan copay	- $20	**-$173**
Patient pays remaining balance		**= $92**

Health Plan or Medicare, VSP secondary for Exam and Refraction using WellVision Exam benefit

Here's a VSP Choice Plan example:	Exam	Refraction
Bill the health plan or Medicare your U&C fee	$120	$35
Determine Other Insurance **Allowed Amount**	$100	Not covered
Subtract the **Other Insurance Paid Amount**:	- $75	$0
VSP will COB the patient's out-of-pocket expenses up to this amount (Other Insurance Pat Responsibility):	= $25	= $35
Balance submitted as secondary claim to VSP		**$60**
VSP pays up to the secondary allowance $66, less secondary plan copays		- $60
Patient pays remaining balance		= $0
Note: Provider is paid **$135 for exam and refraction** ($75 from health plan/Medicare + $60 VSP). If the primary plan's allowed amount is lower than U&C, subtract the primary plan's paid amount from allowed amount to determine the patient's responsibility.		

Health Plan or Medicare, VSP secondary using WellVision Exam and Essential Medical Eye Care

Here's a VSP Choice Plan example:	**Exam**	**Refraction**	**Fundus Photo**
Bill the health plan or Medicare your U&C fee	$120	$35	$80
Determine Other Insurance **Allowed Amount**	$100	Not Covered	Not Covered
Subtract the **Other Insurance Paid Amount**:	- $75	$0	$0
VSP will COB the patient's out-of-pocket expenses up to this amount (Other Insurance Pat Responsibility):	= $25	= $35	=$80
Balance submitted as secondary claim to VSP		**$35**	**$80**
VSP pays up to the secondary allowance $66, less secondary plan copays		- $35	Essential Medical Eye Care Fees*
Patient pays remaining balance		= $0	=$0

Note: Provider is paid **$135 for exam and refraction** ($75 from health plan/Medicare + $60 VSP) plus Essential Medical Eye Care Fee Schedule for medical service(s). If you perform a medical eye exam and services along with a refraction, you may now maximize the patient's VSP coverage to coordinate using BOTH their medical and routine benefit to reduce their out-of-pocket.
*VSP will pay up the Essential Medical Eye Care fee schedule, less applicable copay. If the service is not covered by the Other Insurance plan, VSP will process service as primary.

With the exception of the secondary allowances, the VSP Advantage Plan, VSP Enhanced Advantage Plan, and VSP Essentials Plan COB guidelines are the same as the VSP Signature Plan and VSP Choice Plan. If you're not participating in the Advantage Network and the member wants to use their secondary plan to coordinate benefits, we'll reimburse the patient based on their non-VSP provider reimbursement schedule (if out-of-network coverage is available).

Patient's primary plan	**Patient's secondary plan**	**Your network participation is**	**Then**
VSP Advantage Plan or VSP Essentials Plan	VSP Signature Plan or VSP Choice Plan	Advantage Network	You'll be reimbursed based on the VSP Signature and Choice COB allowances. (See COB Client Exception Rules for exceptions).
VSP Advantage Plan or VSP Essentials Plan	VSP Signature Plan or VSP Choice Plan	Non-Advantage Network	We'll reimburse the patient based on their non-VSP provider reimbursement schedule if out-of-network coverage is available.
VSP Signature Plan or VSP Choice Plan	VSP Advantage Plan or VSP Essentials Plan	Advantage Network	You'll be reimbursed according to the Advantage Secondary Allowances.
VSP Signature Plan or VSP Choice Plan	VSP Advantage Plan or VSP Essentials Plan	Non-Advantage Network	We'll reimburse the patient based on their non-VSP provider reimbursement schedule if out-of-network coverage is available.

COB Client Exception Rules

There may be a client exception to how you would handle your patient's COB. Before providing services to your patient, please obtain a **Patient Record Report** from **eClaim** on **eyefinity.com**. The Patient Record Report will highlight the rules from the following list that may apply to your patient's coverage and ability to coordinate benefits. Call VSP at **800.615.1883** if you have questions.

- **COB rule 1:** If both members are covered by the same client, COB isn't allowed for either of the members or their children. If the member is covered twice by the same client, COB isn't allowed.
- **COB rule 2:** If both members are covered by the same client, children are covered only under one parent's plan. COB can't be applied and the child may only receive one set of services. This applies both to biological parents and step-parents.
- **COB rule 3:** If both members are covered by the same client, the secondary plan can be used to cover copays only, which will use all service areas.
- **COB rule 4:** This rule applies only when the patient has an insurance carrier other than VSP as primary. If both plans are through VSP, this rule doesn't apply. However, other COB rules may still apply. COB reimbursement is calculated by subtracting what the primary carrier paid from what VSP would have paid as primary.

Here's an example:	
Calculate the amount VSP would pay your practice if VSP was primary:	$100
Subtract the amount paid by the primary insurance carrier:	- $75
VSP will COB the patient's out-of-pocket expenses up to this amount:	= $25

- **COB rule 5:** A married couple, or domestic partners, who are covered by the same client may coordinate benefits, but can't receive two sets of services.
- **COB rule 6:** COB isn't allowed for Computer Vision Care (CVC), Repair, Safety Eyecare, or ProTec Safety benefit types.
- **COB rule 7:** A married couple, or domestic partners, who work for the same client may either use both of their benefit plans separately to receive two sets of services, **OR** COB their secondary benefits to pick up only the primary copays (using all services).
- **COB rule 8:** If a member's dependents have vision coverage through their own employment, coverage through that employment is primary. If dependents have coverage under Medicaid State Children's Healthy Insurance Program (SCHIP), there's no COB.
- **COB rule 9:** COB isn't allowed. Call VSP at 800.615.1883 for client exceptions and specific instructions.
- **COB rule 10:** A child covered under both parents' plans will always use the father's plan as primary.
- **COB rule 11:** Employees and dependents can use their second-pair coverage towards overages from their first-pair coverage.
- **COB rule 12:** If both members are covered by the same client, COB is allowed to cover out-of-pocket expenses only, but the patient can't receive two sets of services.

Submitting COB Claims

When VSP is Primary

Submit the claim as you would in the absence of any other plan.

Quick Tip:

If your patient isn't eligible for a service on the primary plan, the secondary plan may be used as primary for that service

Submitting the claim electronically:

1. Get authorizations for both primary and secondary benefits.
2. On the primary authorization, enter the services performed, calculate the HCPCS codes and enter your usual and customary fee(s).
3. Mark "No" for question 11d in the Insured section.
4. Enter the secondary authorization number in the **VSP COB Coordination of Benefits Secondary Authorization** field.

Quick Tip:

If your patient isn't eligible for a service on the primary plan, the secondary plan may be used as primary for that service

Recognizing the complex nature of COB can be a barrier to adoption. VSP has simplified the process when Medicare, a health plan or a non-VSP insurance carrier is Primary and VSP is Secondary:

- **Maximize member benefits** – You can now coordinate both their routine and medical benefits (i.e. medical exam and refraction using a WellVision exam benefit and Essential Medical Eye Care).
- **Expanded electronic filing capabilities** – You can now submit secondary COB claims electronically, regardless of services provided, with new fields to enter the primary plan's payment (no more paper, just keep a copy of EOP in the patient's chart).
- **Simplified claim submission** – you can now coordinate secondary benefits in a single claim submission when VSP is secondary and tertiary or when using the patient's medical and routine eye care plans (just key the 2nd auth in the COB Secondary Authorization box)

How it works:

If we're the secondary payor, bill us for your patient's out-of-pocket expenses. Examples are copays, coinsurance, deductibles on High Deductible Health Plans or charges for non-covered services by the primary carrier.

If a member has medical benefits under another health plan, that plan is primary and VSP is secondary. If you participate on the patient's health plan, coordinate benefits between the health plan and VSP. In these situations, coordinating benefits will help your patients maximize their coverage. You're responsible for verifying other coverage, as well as billing and collecting from other carriers.

VSP will coordinate the non-covered portion of the services (exam, refraction, materials) with a patient's routine benefits, if the claim includes a routine diagnosis – in addition to a medical diagnosis code, if applicable. We'll only coordinate Essential Medical Eye Care and Diabetic Eyecare Plus Program℠ benefits with services provided for medical eyecare and this requires a medical diagnosis is the first position.

If both routine and medical services were submitted to the primary carrier with corresponding routine and medical diagnosis codes, you can now coordinate using a patient's VSP routine and medical plans to pay toward patient out-of-pocket expenses. We follow plan policies for reimbursing these charges. However, we don't pay more for approved services than what you would have received if we were the primary carrier.

Tips:

- If you can verify the health plan or Medicare's eligible services and non-covered patient responsibility amount at the time of billing, you can now submit the Secondary Plan exam only claim electronically on the same day. You'll still need to keep a copy of the original claim and Explanation of Payment or Explanation of Benefits in the patient's file.
- If you are unable to verify the patient responsibility, wait until you receive payment from the health plan or Medicare before submitting the Secondary claim to avoid unnecessary claim corrections, as you are responsible for reconciling payments. For Medicare or Medicaid patients, overpayments must be corrected within 60 days.

Submitting the claim electronically (new eClaim):

Download our step-by-step guide to filling out your claim electronically

1. Provide the same diagnosis and CPT/HCPCS codes to match the claim to insurance carrier.

2. Select Yes (Box 11d) there is another health benefit plan for eyecare. This will open a new section.

- Leave the field for **Secondary Authorization blank** – unless there is a second VSP plan to COB.

3. Complete the **Other Insured** section:

- Enter the first and last name of the insured person on the patient's primary insurance plan in box 9
- Enter "NA" in box 9a
- Enter the patient's primary insurance plan name in box 9d

4. Scroll to the Services section to enter the following in the COB fields for each service based on your Explanation of Payment (EOP):

- In the **Other Ins Allowed** field, enter the maximum amount allowed by the other insurance.
- In the **Other Ins Paid** field, enter the amount paid by the other insurance.
- In the **Other Ins Pat Resp** field, enter the remaining balance the patient is responsible to pay

Important:

If VSP is tertiary, enter the allowed amount from the primary EOP and the combined paid amounts from the primary and secondary carriers, along with the patient's final out-of-pocket expense.

- In the Denied or Paid $0.00 Reason drop-down menu, select the reason the primary EOP indicated that the claim was denied or paid $0.00. If the reason isn't listed, submit on paper.

Option	Reason for Selecting
Not Covered	Primary EOP indicates that the claim was denied due to the patient not being covered on the date of service or services billed not being covered by the primary insurance.
Deductible	Primary EOP indicates that the service was applied to the deductible and paid $0.
Max Allowance Met	Primary EOP indicates that the maximum allowance was met and paid $0.
Bundled Service	Primary EOP indicates that the payment for this service is included in the reimbursement of another service/procedure billed.
Timely Filing	Primary EOP indicates that the claim was denied due to untimely filing.
Capitation	Primary EOP indicates that the claim was denied due to capitation.

5. In the Additional Information section, enter "Secondary COB claim" in box 19. Additional Claim Information.

6. If you need a copy of the claim with the COB details, click Print in the top navigation bar; it's not on the CMS Report or Service Report.

Download our step-by-step guide to filling out your claim electronically

Submitting the Claim on paper

When you receive payment from the primary Vision Plan, submit the following information to us within six months from the issue date of the Explanation of Payment (EOP) or Explanation of Benefits (EOB) of the primary plan (Medicare, Health Plan or Vision Plan):

1. A copy of the EOP indicating patient expenses and/or service denials from the primary carrier. Don't send a summary.

2. A copy of the original CMS-1500 claim form. Enter VSP's authorization number in Box 23.

3. If an additional benefit will be used, enter "Tertiary COB auth ########" (additional authorization #) in Box 19.

COB Resources

The following are resources to help you when coordinating benefits for your patients.

COB Billing Guide

Download our step-by-step guide to filling out your claim electronically

Download and print in your office today

The COB Calculator is available to providers in the **Calculators** section on **VSPOnline**.

Available for Signature, Choice, Advantage and MESSA plans.

Be sure to verify who is primary versus secondary before using the calculator.

Since some clients have restrictions, check for COB rules that would over-ride the COB Calculator.

For Exam-only claims, you can select either the Glasses or the Contacts tab.

- Be sure to check for eligible services:
- Verify whether the patient has already used or is using all applicable services under the primary plan to maximize their coverage.
- Verify service availability on the Secondary Plan that the patient will use toward the Primary Plan's out-of-pocket expenses.

Steps to Using the Calculator

1. On the appropriate Tab (Glasses or Contacts), uncheck any services the patient does not want to use or is not eligible.

2. Calculate the patient’s out-of-pocket expenses from the primary plan and enter them into the calculator.

3. Select the Secondary Plans Benefit type, enter secondary copays, and select calculate to determine the COB amount.

- For contact lenses, providers can refer to the patient record report and enter the secondary contact lens allowance, except for MESSA.
- Uncheck the Exam for Total Plans. This will block the value for the exam, which is only available for Exam And plan.

4. The results section will summarize the Primary Plan's out of pocket, the eligible Secondary Allowances (based on the services checked to coordinate) and Payable amounts.

VSP will apply secondary allowances to similar services first. If any allowance remains, VSP will apply the amount to any other eligible services.

How do I determine primary versus secondary?

- Please refer to the Coordination of Benefits section of the Provider Reference Manual.

Which services can coordinate?

- The secondary plan may COB using only those services that were provided under the primary plan, as long as the patient is eligible for those services under the secondary plan. For example, if the patient receives exam and lenses, the secondary plan can only COB the exam and lens services, if eligible.
- Secondary allowances are cumulative. The value of the secondary plan's eligible services can be applied to all applicable services received on the primary plan.

How does the calculator know what the secondary allowances are?

- The calculator has been designed with the secondary allowances for each service checked under “Service to Coordinate” section based on the VSP Secondary plan type.
- The calculator is not available for Allowance, Medicaid or secondary plans with another carrier.

How does the calculator know the patient's contact lens allowance for the Secondary plan?

- Since it varies by each group's plan, enter the Secondary Contact Lens Allowance for all plans, except if MESSA is the Secondary Plan (MESSA 1, 2, 3, 3+, Bronze/Silver/Gold or Platinum). Note: Effective 1/1/2021, MESSA Choice plans use the Choice Secondary Plan allowances, less copay.
- Enter the contact lens copay for the Secondary plan, if the client has one. This is not common. Do not include the Secondary plan’s copay for a covered contact lens exam.

VSP Signature Plan®
Enrollment/Doctor Participation

All VSP doctors are part of the VSP Network.

COPAYS

Note:

You may not waive copays.

Copays are indicated on the Patient Record Report when you receive an authorization. There are two types of copays:

- **Exam and Materials:** Separate copays are applied to the exam and to the materials.

Exam and Material copays are collected as the service is provided. For example, the exam copay will be collected when exam is performed, and the materials copay at the time materials are chosen.

- **Total:** A one-time copay is applied once per service frequency to exam or materials (glasses or visually necessary contact lenses).

A Total copay is collected in full as the exam and materials are provided. If all services are not provided on the first visit, collect the copay on the first visit and do not collect a copay for any subsequent visits during the same benefit period. Refer to the Patient Record Report to determine if/when copay applies.

Please do not split authorizations when the patient has a total copay unless necessary. If the authorization was split, please follow these guidelines:

- Refer to the Patient Record Report to determine if/when copay applies to the service being provided.
- If a patient receives an exam through one doctor and materials through another (either same office or different offices), the copay would apply to the first authorization requested. Refer to the Patient Record Report to determine if/when copay applies.

Note:

In some cases, the copay may appear on both the exam and material authorizations when services are split. If this happens, VSP will only apply the copay to the first claim received. Be sure to check your explanation of payment. If a copay was collected from the patient and not applied by VSP, refund the patient the copay.

Fully covered comprehensive eye exams are generally available to the patient once every 12 or 24 months, calculated on a service year, calendar year or fiscal year basis. Refer to Eye Exams for levels of service.

Coverage typically includes necessary prescription lenses and a frame up to a client-specified wholesale/retail allowance, or an allowance toward contact lenses. Please review the Patient Record Report for complete coverage details before providing materials.

Patients are also eligible for established benefits on additional services and materials (see Value-Added Benefits, below).

Lenses

- Single vision, bifocal, trifocal, or lenticular lenses in glass or plastic.
- Eye sizes up to and including 60mm.
- Lined multifocal lenses in all segment widths, including occupational lenses. See the Dispensing & Patient Lens Enhancements section for specific details on occupational lenses.
- Prism and slab off.
- Base curves (regardless of curve).

Note:

VSP only covers lenses that meet the minimum prescription criteria. Lenses that do not meet VSP's minimum prescription criteria are considered to be plano lenses. Plano lenses, including plano sunwear, are not considered to be covered materials, unless the patient is eligible for such materials under their plan benefit coverage.

VSP's minimum prescription criteria:
The combined power in any meridian is ±0.50 diopters or greater in at least one eye or one of the following exceptions occurs:
—Necessary prism of 0.50 diopters or greater in at least one eye
—Anisometropia is 0.50 diopters or greater in at least one eye
—Cylinder power is ±0.50 diopters or greater in at least one eye

If the patient chooses a lens enhancement not covered by the plan, charge the patient either the fee shown on the VSP Signature Plan Lens Enhancements Chart or your U&C fee, whichever is lower. (See Patient Lens Enhancements Fees Instructions for information on determining your U&C fee for lens enhancements.)

Frames

Note:

VSP only covers frames when the lenses meet VSP's minimum prescription criteria, unless the patient is eligible for plano lenses under their plan benefit coverage. Most VSP Signature Plan patients who've had laser correction surgery may use their frame benefit for plano sunglasses. Exclusions are noted in the Patient Record Report.

Under most VSP plans, your patient's frame allowance is represented by a combination of the wholesale frame amount and corresponding retail amount for which your patient is covered. Although patients will only be informed of their retail allowance, they're covered for any in-network (or covered) frame less than or equal to their wholesale or retail allowance. You receive your frame dispensing and the wholesale cost up to their wholesale allowance, plus collect any overage according to our frame overage procedures.

Note:

Some patients have a covered in full frame allowance. For these plans, you receive your frame dispensing and the wholesale cost.

Most patients will have a minimum extra $20 on top of their frame allowance when they select Marchon® or Altair® frames. Look for the wholesale and retail allowances for Marchon/Altair and all other frames indicated on the Patient Record Repot at authorization. You'll be reimbursed based on the wholesale equivalent of the patient's retail allowance for Marchon and Altair frames.

Your patient can apply the frame allowance to any frame, listed or unlisted, (except for out-of-network frames in which case the patient's out-of-network frame allowance should be applied). If patients choose unlisted frames, use your acquisition cost instead of the *Frames* catalog price when submitting the "wholesale cost" to VSP.

There is no charge to patients for standard frame cases; however, you may charge patients for special orders or for deluxe frame cases.

VSP does not provide a dispensing fee when a patient-supplied frame is used and patients can't be charged any additional fees.

Frame Overages

Charge the patient according to our frame overage procedures. When the selected frame exceeds both the wholesale and equivalent retail allowance coverage, your patient is responsible for the overages exceeding his or her retail frame allowance at 80% of U&C. Don't charge your patient more than 80% of U&C on frame overage, plus any applicable sales tax.

For more information, refer to the **Providing Frames** section in the VSP Manual.

Contact Lenses

Many clients provide coverage for contact lenses in lieu of prescription glasses. To be eligible for contact lens coverage, a patient must usually first be eligible for eyeglasses. Refer to the Contact Lens Benefits in this section.

Lab

The VSP Signature Plan does not cover fabrication or supply of lenses from your office. Covered lenses dispensed to VSP patients must be fabricated entirely by a participating VSP Lab or VSP contract lab (unless you are providing a Doctor In-Office Lens Enhancements or there is an emergency).

- You may bill WellVision Exams® using S0620 (routine ophthalmological examination, including refraction, new patient) or S0621 (routine ophthalmological examination, including refraction, established patient). Be sure to complete a comprehensive exam when using these codes, VSP pays at the comprehensive level.
- If you choose to use 920XX codes to bill your WellVision Exams, please remember to bill refraction (92015) separately for accurate reimbursement.
- WellVision® Exams should be billed with the appropriate refractive error diagnosis code. Reasons for encounters diagnosis codes are also acceptable.
- Reasons for encounters diagnosis codes are payable for WellVision® Exams only. Reasons for encounters diagnosis codes may not be billed as primary or as the sole diagnosis code for materials.
- Materials must be billed with the appropriate refractive error diagnosis code.
- Enter additional diagnosis codes if other medical conditions exist.
- Bill non-covered materials on a private invoice, even if a VSP contract lab is used. Non-covered lenses may be fabricated at any lab of your choice, including in-office labs.
- When billing progressive lenses remember to bill your U&C fee on two lines, one for the base bifocal lenses and the second for the progressive add-on.

For Post-Lasik patients only: When billing plano sunglasses for VSP Signature Plan members:

- Bill as frame only (don't include lenses). The patient is responsible for the cost of lab supplied plano lenses and lens enhancements.
- Indicate "frame only" in the box.
- Document your patient's LVC history in their medical file.

The Value-Added benefits* below are considered a private transaction between you and the patient. The patient is fully responsible for the payment of any additional items.

Exam Services

Deduct 20% on additional eye exams, including if only a refraction is performed.

Materials

Under the VSP Signature Plan, patients are eligible for additional materials at 70% U&C when they purchase a complete pair of prescription or non-prescription glasses/sunglasses, on the same day as their eye exam from your office. If a patient purchases a complete pair of prescription or non-prescription glasses/sunglasses, within 12 months of the exam, charge 80% of U&C. This includes proprietary lenses and frame, plano sunglasses, and non-prescription ready-made blue light filtering glasses.

For all other plans, charge 80% of U&C for additional materials when complete pairs of prescription, or non-prescription glasses, plano sunglasses, or non-prescription ready-made blue light filtering glasses are dispensed within 12 months of the exam. Includes proprietary lenses and frame, plano sunglasses, and non-prescription ready-made blue light filtering glasses.

Benefits should:

- be based on your total U&C fee,
- be unlimited for 12 months on or following the date of the last covered eye exam,
- be available through a VSP Network Doctor. Use professional judgment when evaluating prescriptions from another provider. You may request an additional exam at 80% of your U&C fee,
- apply to prescription and non-prescription lenses,
- not apply to cleaning products or repairs of prescription lenses or frames.

Note:

If eligible for lens only or frame only and a complete pair of glasses is purchased, charge 80% of U&C for the non-covered material.

Contact Lens Service Benefit

Charge 85% of U&C on all elective, and replacement contact lens services. The benefit:

- is subtracted from your U&C fee for evaluation/fitting services;
- is unlimited for 12 months on or following the date of the covered eye exam;
- is available only through a VSP Network Doctor. Use professional judgment when evaluating prescriptions from another provider. You may request an additional exam at 80% of your U&C fee;
- does not apply to materials, solutions, cleaning products, and service agreements.

Retinal Screening Value Added Feature

- Patients are eligible for routine retinal screening as a value added feature to complement their WellVision Exam® benefit.
- Please see the Retinal Screening section on the **VSP Manual** for more information.

VSP Laser VisionCare℠ Program

- The program includes access to either Photorefractive Keratectomy (PRK) or Laser In-Situ Keratomileusis (LASIK) at a reduced cost, up to a maximum fee to the patient of $1,500 per eye for PRK, $1,800 per eye for LASIK, and $2,300 per eye for Custom LASIK with wavefront technology using microkeratome, Custom PRK, or Bladeless LASIK.
- Members receive a complimentary screening as well as preoperative and postoperative services through participating VSP network doctors. Most VSP Signature Plan patients who've had laser correction surgery can use their frame benefit for plano sunglasses.
- If the laser center is offering a temporary price reduction, VSP members will receive 5% off the advertised price if it is less than the usual discount price.
- Please see the **Laser VisionCare Program** section under **Programs** on **VSPOnline** for information on how to participate or for a list of participating facilities.

Diabetic Eyecare Plus Program℠

- The Diabetic Eyecare Plus Program provides medical eye care services for members with diabetic eye disease, glaucoma, or age-related macular degeneration (AMD). Retinal screening is also available to eligible patients who have diabetes but don't show signs of diabetic eye disease.
- Please see the Diabetic Eyecare Plus Program℠ section for more information

*VSP does not require providers to provide discounts on non-covered services in states where it's prohibited by law to require it. However, unless you've opted out, you should continue to provide all Value Added Benefits to all VSP members. For more information, including details regarding how to opt out, call VSP at **800.615.1883**.

Refractive Error Diagnosis Codes

Code:	
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

Reasons for Encounters Diagnosis Codes

Reasons for encounters diagnosis codes are payable for WellVision® Exams only. Reasons for encounters diagnosis codes may not be billed as primary or as the sole diagnosis code for materials.

Code:	
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
Z82.1	Family history of blindness and visual loss
Z83.511	Family history of glaucoma
Z83.518	Family history of other specified eye disorder

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

Contact Lens Benefits

VSP patients may have the following contact lens benefits:

- Contact Lens Exam Copay with Materials Allowance: The routine eye exam is covered separately. Your patient has a not-to-exceed patient copay for a contact lens exam (prescription and fitting of contact lens) and a separate allowance for contact lens materials.
- Exam And (Combined Contact Lens Allowance): The routine eye exam is covered separately. Your patient has a combined allowance for a contact lens exam and materials.
- Total Allowance: Your patient has a single allowance for the routine eye exam, contact lens exam, and materials.
- Visually Necessary Contact Lenses: With an approved diagnosis or condition, your patient is covered for a contact lens exam and an annual supply of visually necessary contact lenses. See Visually Necessary Contact Lenses in this section for specific benefit coverage criteria.
- Covered Contact Lenses: Your patient is covered for a contact lens exam and an annual supply of contact lenses.

Note:

For Visually Necessary Contact Lenses and Covered Contact Lenses, VSP will only cover an annual supply of materials based on the manufacturer's replacement schedule. No additional reimbursement for Visually Necessary Contact Lenses and Covered Contact Lenses shall be reimbursed by VSP through additional VSP plans/coverage the patient may have.
You may only coordinate benefits up to the annual supply of contact lens materials if plans permit. See Coordination of Benefits Between Multiple VSP® Plans in the VSP Manual.
Visually Necessary Contact Lenses and Covered Contact Lenses include the contact lens exam services and an annual supply of contact lens materials. Bill contact lens exam services with materials.

A contact lens exam (prescription and fitting of contact lens) is separate from the WellVision Exam® and should be provided only to patients who wear or want to wear contact lenses and specifically request a contact lens exam. Contact lens insertion and removal training services are not separately reimbursed.

Note:

The "initial" contact lens fitting period for all contact lens benefits is 90 days. Any additional or excluded (i.e., CRT, Ortho-K and myopia management) contact lens fitting services should be handled privately between you and the patient.

You can find client-specific exceptions in the special comments section of the Patient Record Report.

Contact Lens Exam Copay with Materials Allowance: Your patient pays an exam copay if you provide a WellVision Exam. Patients who request a contact lens exam pay a contact lens exam copay or 85% of your U&C fees, whichever is less. There is no copay for contact lens materials, which are covered under a separate allowance.

Exam And (Combined Contact Lens Allowance): Patient pays an exam copay if you provide a WellVision Exam. There is no copay for contact lens materials.

Total Allowance: No exam or materials copay is required if materials are purchased on the same date of service. The exam copay may apply if the WellVision Exam is given on a different date of service.

Covered Contact Lenses: Your patient pays the contact lens copay.

VSP covers contact lenses that meet the minimum prescription criteria. Contact lenses that do not meet VSP's minimum prescription criteria are considered to be plano lenses.

VSP's minimum prescription criteria:
The combined power in any meridian is ±0.50 diopters or greater in at least one eye or one of the following exceptions occurs:
—Necessary prism of 0.50 diopters or greater in at least one eye
—Anisometropia is +0.50 diopters or greater in at least one eye
—Cylinder power is ±0.50 diopters or greater in at least one eye

Exclusions

Some materials aren't covered under VSP's contact lens benefits. There are no benefits for professional services or materials connected with the following:

- Corneal refractive therapy, orthokeratology, and contact lenses for myopia management are not covered under Visually Necessary Contact Lenses, Covered Contact Lenses, or the VSP Elements Plan. Patients can use their elective contact lenses allowance towards the cost of corneal refractive therapy, orthokeratology, or myopia management contact lens materials only. The contact lens fitting and evaluation portion of the treatment is a private transaction between you and the patient.
- Replacement of lost or damaged lenses
- Modifications of lenses
- Routine maintenance such as polishing, cleaning, etc.
- Refitting after the initial (90-day) fitting period

- Insurance policies or service agreements
- Plano (non-prescription) lenses or lenses that don't meet our minimum prescription requirement
- Plano lenses to change eye color cosmetically
- Office visits to treat contact lens pathology
- Solutions and other contact lens supplies
- Bandage contact lenses aren't covered under VSP® plans but can be submitted under Essential Medical Eye Care for eligible patients. See Essential Medical Eye Care in this section.

A visually necessary contact lens exam and an annual supply of visually necessary contact lenses are covered in full for patients meeting the established conditions and requirements below. Those patients must be eligible for materials on the date of service. Coverage is limited and may require special handling to ensure proper reimbursement. Exam and material copays for contact lenses apply unless otherwise specified.

Note:

Visually necessary contact lenses aren't typically covered for patients who have received refractive surgery (e.g., LASIK, PRK, or RK). However, patients with underlying conditions such as corneal, ectasia, corneal deformity, scarring or irregularity that require contact lenses to provide vision improvement, may be covered for visually necessary contact lenses, if they meet the approved criteria. Treatment for corneal abrasion is covered under Essential Medical Eye Care.

- Nystagmus – H55.00 through H55.09
- Anisometropia greater than or equal to 3.00 diopters difference based on the spectacle prescription.
- High ametropia greater than or equal to ±10.00 diopters in either eye based on the spectacle prescription.
- Please see Visually Necessary Specialty Contact Lenses below for a complete listing of covered diagnosis codes.

Note:

Patients meeting criteria for nystagmus, anisometropia or high ametropia do not require an improvement in best corrected visual acuity (BCVA) by two lines compared to spectacles.

- Achromatopsia – H53.51
- Albinism – E70.30, E70.310, E70.311, E70.318, E70.319
- Aniridia – Q13.1
- Polycoria; anisocoria (congenital) – Q13.0
- Pupillary abnormalities – H21.561 through H21.56

Note:

Patients meeting criteria for colored contact lens do not require an improvement in best corrected visual acuity (BCVA) by two lines compared to spectacles.

To submit visually necessary contact lens claims through eClaim for any of the conditions above, do the following:

Select Necessary Contact Lens as the Contact Lens Reason. Indicate the appropriate diagnosis code and/or spectacle prescription verifying the condition. For anisometropia and/or high ametropia, enter the spectacle prescription on the lab invoice for verification purposes. Not all conditions can be verified on Eyefinity. See Submitting Claims for additional instructions.

Scleral Lenses (For Covered Contacts and Visually Necessary Contacts)

Bill scleral lenses using HCPCS V2530 or V2531. Hybrid contact lenses are not scleral lenses and will not be reimbursed as sclerals. Bill hybrid lenses using V2599.

When submitting a claim for Visually Necessary Contacts using V2531, you must provide the following information in Box 19:

- Type of lens – Scleral
- The scleral lens manufacturer or brand

If this information is missing or incomplete, it will result in claim reimbursement at the V2599 rate.

Other Type of Contact Lenses (For Covered Contacts and Visually Necessary Contacts)

Use HCPCS code V2599 for other types of contact lenses, such as hybrid lenses.

When submitting a claim using V2599 (contact lens, other type) you must provide the following information in Box 19:

- Type of lens
- The lens manufacturer or brand
- For example, hybrid contact lens, SynergEyes® iD

If the information is missing or incomplete, it will result in claim reimbursement at the V2510 rate.

Note:

Bill scleral lenses using HCPCS V2530 or V2531. Hybrid contact lenses are not scleral lenses and will not be reimbursed as scleral.

Piggyback Lenses Benefit

Piggyback lenses are a covered benefit for patients meeting one of the conditions above, and who aren't able to tolerate rigid gas permeable contact lenses. This requires the use of soft contact lenses and rigid gas permeable contact lenses, in the manner of a piggyback fitting.

When submitting a claim for piggyback lenses, you must provide the following information in Box 19:

- Piggyback lenses

Spectacle lenses to wear over contacts benefit

Contacts with spectacle lenses to wear over contacts are covered benefits for patients with the following conditions:

- Aphakia – H27.01 - H27.03 or Q12.3
- High ametropia greater than or equal to ±10.00 diopters in either eye based on the spectacle prescription.
- Presbyopia – H52.4
- Pseudophakia – Z96.1
- Accommodative disorder
- Binocular function disorder
- Different prism requirements for distance and near vision

A prescription is required for the lenses. Plano lenses aren't a covered benefit.

When your patient qualifies for spectacle lenses to be worn over contact lenses, request the spectacle lenses claim number at the same time or within 30 days of the contact lens claim submission date. For patients with keratoconus, request a claim number for spectacle lenses to be worn over contact lenses within 12 months of the contact lens claim submission date. Frames are private transaction between you and your patient.

If your patient meets the benefit criteria for visually necessary contact lenses above and also requires spectacle lenses to wear over the contacts, please verify that the above criteria is met, and call VSP at **800.615.1883** to obtain a claim number. Please have the relevant criteria information available when calling.

Submitting Claims

Request a case number when your patient meets the benefit coverage criteria above, but you can't submit your claim through eClaim at **eyefinity.com**. To get a case number so you can submit your claim through eClaim, complete a Materials Verification Form, which must include at least one of the qualifying criteria listed above. Please allow five (5) business days for a response. Put your case number in Box 23.

The following situations **also** require the submittal of a Materials Verification Form:

- NCL claims with DOS **over** 6 months
- Physical condition of ears or nose which prohibits the use of eyeglasses
- Physical symptoms associated with paraplegia or quadriplegia (be specific)

Fax the Materials Verification Form to us at **916.851.4733**. Or mail to VSP, PO Box 385020, Birmingham, AL 35238-5020. You can find the form in the VSPOnline section of **eyefinity.com** or in the Tools and Forms section of this manual.

Reimbursement for Visually Necessary Contact Lenses and Covered Contact Lenses

An annual supply of contact lenses is covered in full for patients. Visually Necessary Contact Lenses must meet the stated benefit criteria. We'll reimburse you:

- Your assigned fee for the examination
- Up to allowed amount for the type and quantity of contacts provided (Maximum allowed amount applies to the combination of 85% of your U&C fee for the contact lens exam and your U&C fee for contact lens materials)

Do not balance bill your patient the difference between VSP's allowed amounts and your U&C fee for materials. Exam and material (spectacle lenses and frame) copays apply unless otherwise specified. Any contact lens fitting fees incurred after the initial 90 day period are considered a private matter between you and the patient. Do not submit a separate claim for a contact lens exam.

Note:

Fees submitted to VSP for all contact lens plan benefits must be consistent with your U&C charges, regardless of the patient's coverage or allowances.

HCPCS	HCPCS Description	Annual Replacement[1]	Planned Replacement[1]	Daily Replacement[1]
V2500*	Contact lens, pmma, spherical, per lens	$251	—	—
V2501*	Contact lens, pmma, toric or prism ballast, per lens	$385	—	—
V2502*	Contact lens, pmma, bifocal, per lens	$491	—	—
V2503*	Contact lens, pmma, color vision deficiency, per lens	$405	—	—
V2510*	Contact lens, gas permeable, spherical, per lens	$450	—	—
V2511*	Contact lens, gas permeable, toric, prism ballast, per lens	$650	—	—
V2512*	Contact lens, gas permeable, bifocal, per lens	$750	—	—
V2513*	Contact lens, gas permeable, extended wear, per lens	$500	—	—
V2520	Contact lens, hydrophilic, spherical, per lens	$375	$525	$750
V2521	Contact lens, hydrophilic, toric, or prism ballast, per lens	$525	$650	$870
V2522	Contact lens, hydrophilic, bifocal, per lens	$537	$650	$1000
V2523**	Contact lens, hydrophilic, extended wear, per lens	$475	$600	—
V2530*	Contact lens, scleral, gas impermeable, per lens	$499	—	—
V2531*	Contact lens, scleral, gas permeable, per lens	$987	—	—
V2599**	Contact lens, other type	$1,150	$1,500	—
Piggyback		$1,150	$1,500	—

[1]Annual Replacement is 1-2 units. Planned Replacement is 3-360 units. Daily Replacement is 361+ units.

*These services shouldn't be billed for more than 2 units. If billed with higher unit counts, we'll pay up to the Annual Replacement lens maximum. Refer to billing instructions for scleral lenses above.

**These services shouldn't be billed for more than 360 units. If billed with higher unit counts, we'll pay up to the Planned Replacement lens maximum. Refer to billing instructions for hybrid and proprietary lenses above.

Visually Necessary Specialty Contact Lenses

Beginning June 1, 2024, an improvement in best corrected visual acuity (BCVA) by two lines compared to spectacles is required for Visually Necessary Contact Lenses specialty conditions. BCVA findings for specialty conditions must be recorded on the patient's medical exam records and demonstrate a two-line improvement compared to spectacles and are subject to review and audit. Conditions notated with "**" are excluded from the BCVA requirement.

If billing with CPT code 92072*, 92310* 92311*, 92312* or 92313* – for one of these diagnosis codes:

*Codes may not be billed together on the same claim.

Description	ICD-10 Codes:
Absence of iris (Aniridia)**	Q13.1
Achromatopsia**	H53.51
Adherent leukoma**	H17.01 - H17.03
Albinism**	E70.30
Aphakia**	H27.01 - H27.03
Band keratopathy	H18.421- H18.423
Bullous keratopathy	H18.11 - H18.13
Central corneal opacity	H17.11 - H17.13
Coloboma of iris**	Q13.0
Congenital aphakia**	Q12.3
Congenital corneal opacity	Q13.3
Corneal ectasia	H18.711 - H18.713
Corneal scars and opacities	H17.00 - H17.9, A18.59
Corneal staphyloma	H18.721 - H18.723
Corneal transplant failure	T86.8411 - T86.8413
Corneal transplant rejection	T86.8401 - T86.8403
Corneal transplant status	Z94.7
Deep vascularization of cornea	H16.441 - H16.443
Endothelial corneal dystrophy	H18.511 - H18.513
Enophthalmos due to atrophy of orbital tissue**	H05.419
Epithelial (juvenile) corneal dystrophy	H18.521– H18.523
Folds and rupture in Bowman's membrane	H18.311 - H18.313
Granular corneal dystrophy	H18.531 – H18.533
Keratoconus, stable	H18.611 - H18.613
Keratoconus, unspecified	H18.601 - H18.603
Keratoconus, unstable	H18.621 - H18.623
Keratoconjunctivitis sicca, in Sjogren’s syndrome	M35.01
Keratomalacia	H18.441 - H18.443
Lattice corneal dystrophy	H18.541 - H18.543
Localized vascularization of cornea Covered for significant cases only where corneal neovascularization is a complication of inflammatory, infectious or autoimmune corneal pathologies	H16.431 - H16.433

Description	ICD-10 Codes:
Macular corneal dystrophy	H18.551 - H18.553
Minor opacity of cornea	H17.811 - H17.813
Nodular corneal degeneration	H18.451 - H18.453
Other calcerous corneal degeneration	H18.43
Other congenital corneal malformations	Q13.4
Other corneal degeneration	H18.49
Other corneal scars and opacities	H17.89
Other hereditary corneal dystrophies	H18.591 – H18.593
Other keratitis	H16.8
Other tuberculosis of eye	A18.59
Peripheral corneal degeneration Covered for marginal corneal degenerations, such as pellucid and Terrien, or as a result of previous ocular disease or trauma	H18.461 - H18.463
Peripheral opacity of cornea	H17.821 - H17.823
Pupillary abnormality**	H21.561 - H21.563
Recurrent erosion of cornea	H18.831 - H18.833
Unspecified corneal deformity	H18.70
Unspecified corneal degeneration	H18.40
Unspecified corneal membrane change	H18.30
Unspecified corneal scar and opacity	H17.9
Unspecified hereditary corneal dystrophies	H18.501 - H18.503
Vitamin A deficiency with xerophthalmic scars of cornea	E50.6

****** Condition does not require an improvement in best corrected visual acuity (BCVA) by two lines compared to spectacles.

Note:

To substantiate billing for keratoconus, your records must include: patient history; K readings; BCVA with refraction; slit lamp examination of the cornea; corneal topography or anterior OCT of the cornea.

Visually Necessary Contact Lens Specialty Maximums

HCPCS	HCPCS Description	Annual Replacement[1]	Planned Replacement[1]	Daily Replacement[1]
V2500*	Contact lens, pmma, spherical, per lens	$451	—	—
V2501*	Contact lens, pmma, toric or prism ballast, per lens	$585	—	—
V2502*	Contact lens, pmma, bifocal, per lens	$691	—	—
V2503*	Contact lens, pmma, color vision deficiency, per lens	$605	—	—
V2510*	Contact lens, gas permeable, spherical, per lens	$657	—	—
V2511*	Contact lens, gas permeable, toric, prism ballast, per lens	$800	—	—
V2512*	Contact lens, gas permeable, bifocal, per lens	$900	—	—
V2513*	Contact lens, gas permeable, extended wear, per lens	$825	—	—
V2520**	Contact lens, hydrophilic, spherical, per lens	$500	$650	—
V2521**	Contact lens, hydrophilic, toric, or prism ballast, per lens	$679	$804	—
V2522**	Contact lens, hydrophilic, bifocal, per lens	$750	$863	—
V2523**	Contact lens, hydrophilic, extended wear, per lens	$650	$775	—
V2530*	Contact lens, scleral, gas impermeable, per lens	$700	—	—
V2531*	Contact lens, scleral, gas permeable, per lens	$2,300	—	—
V2599**	Contact lens, other type	$1,300	$1,650	—
Piggyback		$1,300	$1,650	—

[1]Annual Replacement is 1-2 units. Planned Replacement is 3-360 units. Daily Replacement is 361+ units.

*These services shouldn't be billed for more than 2 units. If billed with higher unit counts, we'll pay up to the Annual Replacement lens maximum.

**These services shouldn't be billed for more than 360 units. If billed with higher unit counts, we'll pay up to the Planned Replacement lens maximum.

Submitting the Claim

Important!

Global fees are not appropriate. Fees must be itemized and include separate charges for contact lens exam and materials. You must bill for both the contact lens exam and materials, to be reimbursed.

Important!

DO NOT BILL VSP FOR PROFESSIONAL SERVICES ASSOCIATED WITH CRT, ORTHO-K OR MYOPIA MANAGEMENT.

	Contact Lens Exam Copay with Materials Allowance	Exam And (Combined Contact Lens Allowance)	Total Allowance	Covered Contacts or Visually Necessary Contact Lenses
Eye Exam (WellVision Exam)	Use your patient's routine benefit for exam services.		Bill the appropriate CPT code and your U&C fee. Bill with contact lens exam if provided, and materials.	Use your patient's routine benefit for exam services.
Contact Lens Exam Services	Bill the appropriate CPT code and your U&C fee for the contact lens exam provided.		Bill the appropriate CPT code and your U&C fee for the contact lens exam provided. Bill with materials.	Contact lens exam services are covered under the materials claim. Bill the appropriate CPT code and your U&C fee for the contact lens exam provided. Bill with materials.
Contact Lens Materials	For Visually Necessary Contact Lenses, regardless of plan type, member must be eligible for materials. Visually Necessary Contact Lens coverage includes the contact lens exam services and an annual supply of contact lens materials up to the maximum allowed for the type of contact lenses provided. • Member must be eligible for materials. • Bill the appropriate HCPCS code(s) for the materials provided. • Submit your U&C fee and indicate the number of units (contacts) dispensed. To maximize your patient's benefit, dispensing an annual supply of contact lenses at one time is required under the Covered Contact Lenses and the Necessary Contact Lenses benefits. • Each contact lens is considered one unit. Bill the total number of units provided based on the type of lenses dispensed: **Unit Count, Type of contacts** 1–2 units, Conventional (non-disposable) contacts 3–52 units, Planned replacement (month/quarter) or 14-day disposables 53–106 units, 7-day disposables 107–361+ units, 1-day disposables To ensure proper payment for piggyback contact lenses, bill all the appropriate HCPCS code(s) for materials provided. For hybrid contacts, bill with the miscellaneous contact lens code.			

Reimbursement

Important!

Determine your U&C fees for a contact lens exam, then add taxes if applicable (see chart below). Bill this amount on the claim. Follow your state tax guidelines.

New Mexico doctors: Determine your total fees for services and materials. Bill this amount on the claim.

	Contact Lens Exam Copay with Materials Allowance	Exam And (Combined Contact Lens Allowance)
VSP Payment	You'll receive your assigned fee for the eye exam. In addition, we'll pay you 85% of your U&C fees, less the patient copay, for a contact lens exam We will also pay your U&C fees for materials up to your patient's contact lens materials allowance.	You'll receive your assigned fee for the eye exam. In addition, we'll pay 85% of your contact lens exam U&C fee and your U&C fee for materials up to your patient's Exam And contact lens allowance. Contact lens exam only (no materials): VSP will reimburse you up to $60. Contact lens materials only (contact lens exam services received elsewhere): If your patient is not eligible for services, contact VSP at 800.615.1883 for more information.
Balance Billing	Your patient is responsible for the contact lens exam copay or 85% of your U&C fees, whichever is less, and the difference between their contact lens materials allowance and U&C fee for materials.	Your patient is responsible for the difference between their allowance and 85% of U&C fee for a contact lens exam fee and 100% of your U&C fee for materials. Contact lens exam only (no materials): Your patient is responsible for your U&C fee for a contact lens exam at 85% of U&C, less the $60 paid by VSP.

	Total Allowance	Visually Necessary Contact Lenses	Covered Contact Lenses
VSP Payment	We'll pay your exam and contact lens exam fees at 85% of U&C plus your U&C fees for materials up to the patient's total contact lens allowance.	You'll receive your assigned fee for the eye exam. In addition, on the Visually Necessary Contact Lens claim, we'll pay up to the maximum allowed for the HCPCS code and quantity of contact lenses provided. Maximum allowed amount applies to the combination of 85% of your U&C fee for the contact lens exam and your U&C fee for materials.	We'll pay up to the maximum allowed for the HCPCS code and quantity of contact lenses provided. Maximum allowed amount applies to the combination of 85% of your U&C fee for the contact lens exam and your U&C fee for materials.
Balance Billing	Your patient is responsible for the difference between their allowance and your discounted fees for the eye exam and contact lens exam plus your U&C fee for materials.	For an annual supply, don't balance bill your patient for the difference between your U&C fee and our allowable amount.	For an annual supply, don't balance bill your patient for the difference between your U&C fee and our allowable amount.

Note:

Failure to record your contact lens exams, fittings and follow-ups may result in the denial of payment for services.
Ensure that your medical records accurately support the diagnosis submitted on the claim when billing for Visually Necessary Contact Lenses. By doing so your payment will not be denied if the diagnosis billed is substantiated by the clinical findings documented in the patient's record.

See Contact Lens Case Management Procedures for contact lens fitting documentation criteria.

VSP Access Plan® & VSP Access Indemnity Plan℠

VSP's Access Plan is a vision savings program on an eye exam and eyewear through a VSP network provider. The Access Indemnity Plan combines the Access Plan with an indemnity schedule of allowances, established by the client.

Eligibility & Authorization

Eligibility can be obtained on **eyefinity.com** or by calling VSP at **800.615.1883**.

Exam Services

- Patients are eligible for eye exams, including if only a refraction is performed at 80% of U&C.
- Coverage only applies to services and procedures included in a WellVision® Exam. It doesn't apply to additional diagnoses and treatment.

Materials

Charge patients 80% of U&C for frames, lenses, and lens enhancements when a complete pair of prescription glasses or non-prescription sunglasses is dispensed. The benefit:

- Is unlimited for 12 months on or following the date of an eye exam from a VSP doctor.
- Doesn't apply to cleaning products or repairs of prescription lenses or frames.

When dispensing materials, use professional judgment in evaluating prescriptions from another doctor. If necessary, you can request additional routine exams at 80% of U&C

Contact Lens Services

Charge patients 85% of U&C for contact lens exam services (F&E) and follow-up services. The benefit:

- Applies to services for prescription contact lenses only.
- Is unlimited for 12 months on or following the date of an eye exam from a VSP Network Doctor.
- Doesn't apply to contact lens materials, solutions, cleaning products or service agreements.

The benefits are considered a private transaction between you and your patient; your patient is responsible for paying for the services or materials.

VSP Laser VisionCare℠ Program

- The program includes access to either Photorefractive Keratectomy (PRK) or Laser In-Situ Keratomileusis (LASIK) at a reduced cost, up to a maximum fee to the patient of $1,500 per eye for PRK, $1,800 per eye for LASIK, and $2,300 per eye for Custom LASIK with wavefront technology using the microkeratome, Custom PRK, or Bladeless LASIK.
- Members receive a complimentary screening as well as preoperative, and postoperative services through participating VSP doctors.
- If the laser center is offering a temporary price reduction, VSP members will get 5% off the advertised price if that's less than the usual discount price.
- Please see the **Laser VisionCare** section under **Programs** on **VSPOnline** on **eyefinity.com** for information on how to participate or for a list of participating facilities.

Eligibility & Authorization

Eligibility can be obtained on eyefinity.com or by calling VSP at **800.615.1883**.

Allowances are paid by us only once during each eligibility period.

Exam Coverage

- Patients are eligible for an eye exam and additional eye exams, including if only a refraction is performed at 80% of U&C. However, the allowance schedule applies only once.
- Coverage only applies to services and procedures included in an eye exam. It doesn't apply to additional diagnoses and treatment.
- Deduct 20% from the exam first, then apply the allowance.

Materials Coverage

Patients are eligible for prescription lens, lens enhancements **and/or** frame (complete pair not required) at 80% of U&C, plus a group-specific schedule of allowances. The benefit:

- Is unlimited for 12 months on or following the date of the last covered eye exam.
- Doesn't apply to cleaning products or repairs of prescription lenses or frames.
- Deduct 20% from the materials first, then apply the allowance.

When dispensing materials, use professional judgment in evaluating prescriptions from another doctor. If necessary, you can request additional routine exams at 80% of U&C

Contact Lenses Services & Materials

Patients are eligible for contact lens exam services (evaluation/fitting services and follow-up services) at 85% of U&C. You may charge your U&C fees for contact lens materials. Elective or visually necessary contact lenses are chosen in place of a complete pair of prescription glasses. You may bill the patient for any fees over the allowance and any applicable copay amount. The benefit:

- Applies to services for prescription contact lenses only.
- Is unlimited for 12 months on or following the date of the last covered eye exam, however the allowance schedule apples only once.
- Use professional judgment when evaluating prescriptions from another doctor.
- Doesn't apply to contact lens materials, solutions, cleaning products or service agreements.
- Deduct 15% from contact lens exam services (F&E) charge, then add your U&C fees for contact lens materials and apply the allowance.

When dispensing materials, use professional judgment in evaluating prescriptions from another doctor. If necessary, you can request additional routine exams at 80% of U&C.

Lab

Lab work is handled privately. You may provide lenses through any lab, including in-office labs.

Value-Added Benefits

The value-added benefits below are considered a private transaction between you and your patient; your patient must pay for any additional items:

- Patients are eligible for additional complete pairs of prescription glasses or non-prescription sunglasses and blue light filtering glasses, from any VSP doctor within 12 months of the last eye exam at 80% of U&C. The benefit:
  - Is based on your total U&C fee.
  - Is unlimited for 12 months on or following the date of the last covered eye exam.
  - Use professional judgment when evaluating prescriptions from another doctor.
  - You can request an additional routine exam at 80% of U&C.
  - Doesn't apply to cleaning products or repairs of prescription lenses or frames.
- Patients are eligible for contact lens exam services (evaluation/fitting services and follow-up services) at 85% of U&C. The benefit:
  - Is based on your total U&C fee.
  - Applies to services for prescription contact lenses only.
  - Is unlimited for 12 months on or following the date of the last covered eye exam.
  - Use professional judgment when evaluating prescriptions from another doctor.
  - Doesn't apply to solutions, cleaning products or service agreements.

VSP Laser VisionCare℠ Program

- The program includes access to either Photorefractive Keratectomy (PRK) or Laser In-Situ Keratomileusis (LASIK) at a reduced cost, up to a maximum fee to the patient of $1,500 per eye for PRK, $1,800 per eye for LASIK, and $2,300 per eye for Custom LASIK with wavefront technology using the microkeratome, Custom PRK, or Bladeless LASIK.
- Members receive a complimentary screening as well as preoperative, and postoperative services through participating VSP doctors.
- If the laser center is offering a temporary price reduction, VSP members will get 5% off the advertised price if that's less than the usual discount price.

VSP Access Plan®

Apply the VSP Access Plan vision savings, as follows: exam at 80% of U&C; glasses at80% of U&C; contact lens exam at 85% of U&C. Handle the visit as a private pay transaction. Don’t submit a claim to VSP. Collect the appropriate fees from the patient.

VSP Access Indemnity Plan℠

- Apply the vision savings noted above for VSP Access Plan to your U&C professional fees.
- Subtract your patient’s Access Indemnity Plan allowance (found on the **Patient Record Report**) from adjusted U&C fees.
- Bill your patient for the difference between your adjusted U&C fees and the indemnity allowance.
- Bill VSP for services.
- Your patients may use their benefits for prescription glasses (lens and/or frame) or contact lens fitting/materials.
- For your patients with combined allowances, bill all services at the same time so your patients get their full benefits.

Glasses: Bill using eClaim.

- Complete the Invoice Services page and select “Non-VSP lab (Private Invoice).”
- Click on the “Calculate HCPCS and Continue” button.
- Complete the Diagnosis and Services page by entering your full U&C fees next to the appropriate CPT/HCPCS code.

Contact Lenses: Bill using **eClaim.**

- Choose the type of contacts dispensed.
- Click on the “Calculate HCPCS and Continue” button.
- Complete the Diagnosis and Services page by entering your full U&C fees next to the appropriate CPT/HCPCS code.
- Please see the Necessary Contact Lens Benefit Criteria section of your VSP Provider Reference Manual for more information regarding benefit criteria and claim submission.

Following is an example of an exam, prescription lenses and frame provided under the VSP Access Indemnity Plan. The indicated U&C fees and indemnity allowance amounts are examples only.

	Eye Exam	**Lenses**	**Tint**	**Frame**
Your U&C fee is:	$65	$45	$20	$100
Subtract 20% from your U&C fee:	-$13	-$9	-$4	-$20
Subtract indemnity allowance:	-$30	-$30	-$0	-$40
Patient pays:	**$22**	**$6**	**$16**	**$40**

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

VSP Integrated Primary EyeCare Program℠

The Integrated Primary EyeCare Program lets VSP network doctors work directly with VSP's health plan clients to obtain eligibility, authorizations, and submit claims for medical eyecare. The program is an addition to the VSP medical product portfolio that supports the ability of all VSP network doctors to practice to their full scope of licensure.

Through Integrated Primary EyeCare, enrollees of VSP-contracted health plan clients will gain access to VSP network doctors. At the time a health plan client contracts with VSP to provide this program in your area, you will be provided with specific health plan client information, including the negotiated reimbursement rate.

Enrollment will be automatic for each network in which a doctor participates (e.g., VSP, Select, Advantage, Choice, and Medicaid). Integrated Primary EyeCare patients can only be referred to another doctor or refused service, if you're not licensed to perform the service needed.

To render services through this program, VSP network doctors agree to:

- Maintain an active status with VSP.
- Follow each health plan client's policies and procedures relating to the delivery of medical eyecare.
- Be listed in the health plan's provider directory.
- Accept compensation that is based on a percentage of the Medicare or Medicaid fee schedule for your locality and/or state, and which may vary by client. (See **Client Details** pages of the VSP Provider Reference Manual for specific details.)
- See all eligible members of VSP-contracted health plan clients.
- Submit Integrated Primary EyeCare claims to the patient's health plan carrier, not to VSP.
- Accept payment for services under the program from the patient's health plan carrier or its administrative services provider, not VSP.
- Accept payment, less any copays or coinsurance by the VSP-contracted health plan client, as payment in full for services covered under the Integrated Primary EyeCare Program.
- Submit all complaints and grievances regarding Integrated Primary EyeCare patients and claims to the health plan client, and hold VSP harmless from such complaints and grievances.

Please refer to **Client Details** for additional information.

Compensation is based on a percentage of either the Medicare RBRVS allowables for your location or the state Medicaid fee schedule. VSP will negotiate the reimbursement rate with the health plan client on the doctors' behalf. Each client contract requires clients to follow state and federal guidelines when paying doctors.

VSP Exam Plus Plan[SM] and VSP Exam Plus with Allowances Plan[SM]

Exam Coverage

Exam Plus patients are covered for a comprehensive eye exam.

Materials

The benefits below are considered a private transaction between you and your patient. Your patient must pay for any additional items.

- Patients are eligible for complete sets of prescription glasses or non-prescription sunglasses from a VSP doctor within 12 months of the last eye exam at 80% of U&C. The benefit:
- Patients are eligible for contact lens exam services (F&E) and follow-up services at 85% U&C. The benefit:
- Is unlimited for 12 months on or following the date of the last eye exam.
- Use professional judgment when evaluating prescriptions from another doctor. You can request an additional routine exam at 80% of U&C.
- Deduct 20% on additional eye exams, including if only a refraction is performed.
- Doesn't apply to cleaning products or repairs of prescription lenses or frames.
- Applies to services for prescription lenses only.
- Is unlimited for 12 months on or following the date of the last eye exam.
- Use professional judgment when evaluating prescriptions from another doctor. You can request an additional routine exam at 80% of U&C.
- Doesn't apply to contact lens materials, solutions, cleaning products, or service agreement

Exam Coverage

VSP Exam Plus With Allowance patients are covered for a comprehensive eye exam.

Materials Coverage

Lenses and Frames

Patients are eligible for prescription lens, lens enhancements **and/or** frame (complete pair not required), plus they have a group-specific schedule of allowances. The lens allowance is applied to the complete lens service—including both the base lens and any lens enhancements selected.

VSP only covers frames that are used for prescription lenses that meet VSP's minimum prescription criteria (refractive error is at least +/- 0.50 diopter), unless the patient has plano coverage.

The benefit is available for 12 months on or following the date of the last covered eye exam, however the allowance schedule apples only once. Deduct 20% from the materials first, then apply the allowance.

Contact Lenses

Charge patients with Elective Contact Lens (ECL) or Visually Necessary Contact Lens (NCL) coverage 85% U&C for contact lens exam services (evaluation/fitting services and follow-up services). You may charge your U&C fees for contact lens materials. Elective or visually necessary contact lenses are chosen in place of a complete set of prescription glasses. Your patient must pay any costs over the allowances listed in their client-specific schedule of allowances.

Lab

Lab work is handled privately. You may provide lenses through any lab, including in-office labs.

Value-Added Benefits

The Value-Added benefits below are considered a private transaction between you and your patient. Your patient must pay for any additional items.

- Patients are eligible for additional complete pairs of prescription glasses and non-prescription sunglasses and blue light filtering glasses, from any VSP doctor within 12 months of the last eye exam at 80% of U&C. The benefit:
  - Is unlimited for 12 months on or following the date of the last eye exam.
  - Use professional judgment when evaluating prescriptions from another doctor. You can request an additional routine exam at 80% of U&C.
  - Deduct 20% on additional eye exams, including if only a refraction is performed.
  - Doesn't apply to cleaning products or repairs of prescription lenses or frames.
- Patients are eligible for contact lens exam services (F&E) and follow-up services at 85% of U&C. The benefit:
  - Applies to services for prescription lenses only.
  - Is unlimited for 12 months on or following the date of the last eye exam.
  - Use professional judgment when evaluating prescriptions from another doctor.
  - Doesn't apply to contact lens materials, solutions, cleaning products, or service agreements.

Submitting Claims/Billing & Reimbursement

VSP Exam Plus With Allowances

- Your patient pays the amount above their allowance. You may charge your U&C fees for contact lens materials. Progressive lenses are reimbursed at the bifocal allowance.
- For patients with combined allowances, bill all services at the same time so your patients get their full benefits. Remaining allowances can't be carried forward. The combined allowance applies to only one set of services. Your patients may use their benefits for a complete pair of prescription glasses or contact lens fitting/materials.

Submitting the Claim Electronically

Glasses:

Bill using our electronic claims submission system.

- Complete the Invoice Services page and select Non-VSP lab (Private Invoice).
- Click on the Calculate HCPCS and Continue button.
- Complete the Diagnosis and Services page by entering your full U&C fees next to the appropriate CPT/HCPCS code.

Contact Lenses:

Bill using our electronic claims submission system.

- Choose the type of contacts dispensed.
- If contact lens evaluation/fitting services were provided, show this in the dropdown.
- Click on the Calculate HCPCS **and Continue** button.
- Complete the Diagnosis and Services page by entering your full U&C fees next to the appropriate CPT/HCPCS code.
- Please see the Necessary Contact Lens Benefit Criteria section of your VSP Provider Reference Manual for more information regarding benefit criteria and claim submission.

Submitting the Claim on Paper

Glasses:

- Enter your full U&C fees next to the right CPT/HCPCS code.
- Complete the **CMS-1500 Claim Form** by entering your full U&C fees next to the right CPT/HCPCS code for lens and frame.
- Enter all **eight** digits of the authorization number in **Box 23**.

Contact Lenses

- Enter your full U&C fees next to the right CPT/HCPCS code.
- Select the type of contacts dispensed.
- Enter all **eight** digits of the authorization number in **Box 23**.
- The program includes access to either Photorefractive Keratectomy (PRK) or Laser In-Situ Keratomileusis (LASIK) at a reduced cost, up to a maximum fee to the patient of $1,500 per eye for PRK, $1,800 per eye for LASIK, and $2,300 per eye for Custom LASIK with wavefront technology using microkeratome, Custom PRK, or Bladeless LASIK.
- Members receive a complimentary screening as well as pre-operative and post-operative services through participating VSP doctors.
- If the laser center is offering a temporary price reduction, VSP members will get 5% off the advertised price if that's less than the usual discount price.
- Please see the **Laser VisionCare** page under **Programs** on **VSPOnline** at **eyefinity.com** for information on how to participate or for a list of participating facilities.

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

ProTec Safety® Plan

The ProTec Safety Plan provides a range of hazardous work environment coverage options for clients and members. With ProTec Safety, your patients can see you for their safety eyewear needs, which provide continuity of care for your patients.

Safety Requirements Questionnaire

ProTec Safety patients should complete a questionnaire about their work environments and related safety requirements before receiving safety services. You can use VSP's Safety Requirements Questionnaire if you'd like or one you've created. Keep a copy of the completed questionnaire in your patients' record.

Coordination of Benefits

There's no coordination of benefits under the ProTec Safety plan.

ProTec Safety patients may have routine VSP coverage that covers their routine exam where work safety needs may additionally addressed, as appropriate. Please refer to the Patient Record Report for exam coverage and benefit information because your patients may have different coverage.

If a patient would like their safety prescription filled, it must be under two years old. Additional you can choose to require a new exam prior to providing materials based on your professional judgment. If you decide that an exam is necessary and the patient's exam is not covered through their routine benefit or they do not have supplemental exam coverage under their ProTec Safety Plan, deduct 20% from the usual and customary (U&C) exam fee.

Necessary corrective lenses (i.e. single vision, bifocal, trifocal, or lenticular) in glass or plastic (CR-39) that meet the American National Standards Institute (ANSI) standards are detailed below for safety eyewear.

ANSI Requirements

The lenses and frames provided under this plan are certified as safe for the work environment by meeting the necessary requirements set forth by ANSI effective April 20, 2020.

Lenses	Frames
• No safety lenses can be less than 2mm thick at the thinnest point. This applies to any lens used in a frame marked Z87-2 and all Impact Rated Protector prescription lenses. • General Purpose Protector: Lens must be engraved with the manufacturer's logo. General Purpose Protector lenses can't be less than 3.0 mm thick. • Impact Rated Protector: Minimum of 2.0 mm thickness. Lens must be marked with the manufacturer's logo and with a plus sign (+), indicating that it meets Impact Rated Protector test requirements. • If the finished product meets the General Purpose Protector requirements, the lab is no longer required to attach a hangtag stating, "This eyewear meets the Basic Impact Requirements..."	• Prescription spectacles must be tested as a complete device. • Frames that meet the Impact Rated Protector requirement must bear the mark Z87-2 (a + will be required once manufacturers can change their markings and existing inventory is depleted) and may be used for both General Purpose Protector and Impact Rated Protector applications. • Note: Detachable side shields are marked with Z87+. If side shields are permanent they don't need to be marked.

Lenses

Covered Lens Enhancements

Covered lens enhancements are available and will vary depending on the patient's benefit. VSP will pay the lab for any covered lens enhancement and there's no charge to the patient. Refer to the Patient Record Report for lens enhancement coverage. In most cases, ProTec Safety patients will be covered for polycarbonate lenses.

Other Enhancements

If your patient selects a lens enhancement that is covered with copay,charge the patient your usual and customary fee (U&C) for the lens enhancement or their lens enhancement copay. (refer to the VSP Signature Plan Lens Enhancement Chart), whichever is lower. Refer to the Patient Record Report for lens enhancement coverage.

Non-covered Items

These options and items aren't covered under the ProTec Safety plan and VSP will deny the claim if submitted for reimbursement:

- Contact lenses
- Everyday eyewear instead of safety materials

- Materials obtained from a non-VSP doctor, unless the group has out-of-network coverage
- Plano or non-prescription lenses, unless otherwise indicated on the Patient Record Report (minimum prescription ±0.50 diopters required for lenses)

Frames

Covered Frames

ProTec Safety patients can choose one of the 30 ANSI-approved frames from the ProTec Eyewear collection. Some member plans have a frame benefit that allows for choice of a ProTect Frame Retail Frame Allowance to use towards any Safety Rated frame outside of the ProTec Eyewear collection. These plans will have the detailed information on the Patient Record Record Report with the wholesale and retail allowances for the plan. ProTec Eyewear frames from the collection are fully-covered for the patient and will be supplied by a participating lab (see the Lab section for more details). Depending on the patient's frame allowance, if the patient chooses a frame outside of the ProTec Eyewear collection, overages should be determined using the VSP Signature Plan frame overage policy. If the patient does not have a retail frame allowance as part of their benefit, the patient must select a frame from the ProTec Eyewear collection or online catalog.

Non-Covered Frames

For patients that do not have a retail frame allowance and are required to select from the ProTec Eyewear collection and one of the following occurs:

- The needed eye size isn't available in any of the covered frames
- None of the frames meets the hazardous work environment of your patient.
- The patient has an allergy to the standard safety frame materials used in the covered frames.

The non-ProTec Eyewear frame is not covered in full and you must submit a ProTec Safety Verification Form to document the exception. Once the exception is documented, then the patient will have a retail frame allowance of $65 (wholesale of $25). If the member chooses a frame with a cost that exceeds both the wholesale and retail allowances, deduct 20% from the retail overage. Determine the patient's cost (if any) as you do today and collect any overages from the patient.

Important!

You must submit a ProTec Safety® Verification Form to VSP to document the exception.

Note:

You'll need to scroll to box 19 and select "yes" for #23. If you have a pre-certification or prior authorization number, a pop-up number will appear which must be provided to VSP. If you do not have an authorization number, please call VSP Customer Service to obtain one.

Additional Materials

When a complete pair of glasses, including plano sunglasses, is dispensed within 12 months from the date of the last eye exam, charge the patient 80% of U&C for non-covered materials. Refer to the **Value-Added Benefits** in the VSP Signature Plan® section for details.

All ProTec Safety orders must be sent to a participating lab:

VSP**One** Columbus
800.251.5150
2065 Rohr Road, Lockbourne, OH 43137

VSP**One** Sacramento
800.952.5518
151 Blue Ravine Rd., Folsom, CA 95630

When billing electronically, eClaim will only offer these lab choices for ProTec Safety orders. If you don't already have an account with the lab, you may submit the order, but they may contact you for more information.

Paper claim practices: You must order lab-supplied materials from the any of the participating labs listed above.

Emergency Situations

In emergencies, you can use any lab capable of producing ANSI certified safety eyewear (see the National Contract Lab List); choose lab 100 when billing on **eClaim**.

The following situations are considered emergencies. Include the reason for the emergency when submitting claims to VSP:

Use one of the following comments when indicating emergency status by selecting Lab Special Instructions:

- Patient's safety glasses are lost, stolen, or broken and he or she doesn't own a back-up pair.
- Patient needs safety glasses to work or drive, is unable to see well enough to do so, and doesn't have a back-up pair of safety glasses.
- Patient's safety and well-being will be jeopardized without the immediate delivery of his or her prescription safety eyewear.

Note:

To obtain wholesale costs of ProTec Eyewear safety frames please see the Frame Data® Price Book, available through Jobson, or contact the manufacturer directly for the list price.

Uvex by Honeywell (formerly Titmus) at **800.446.1802**
OnGuard (Hilco) at **800.955.6544**
Wiley X at **800.776.7842**

Refer to the Frame section for complete details and instructions on emergency situations.

Supplemental ProTec Safety Exams

The level of eye exam or the evaluation and management service that you provide depends on the location and the time elapsed since the patient's last routine eye exam:

Time Since WellVision® Routine Exam	**Reimbursement Percentage**
Same day	No reimbursement
1 day or more	65% of the doctor's comprehensive exam fee when supplemental exam is billed*

When possible, perform your supplemental and comprehensive or intermediate exams in the same visit.

*If you choose to use 920XX codes to bill your WellVision Exams, please remember to bill refraction (92015) separately for accurate reimbursement.

Stand-Alone ProTec Safety Plan Exams

Exams for Stand-Alone Safety EyeCare Plans are reimbursed at your Signature Plan comprehensive or intermediate exam payable fee.

Lenses

You'll receive a flat rate dispensing fee of $25 for covered lenses. There are no additional reimbursements for dispensing progressive lenses or covered lens enhancements Use CPT code 99022 (for shipping) when submitting for progressive lenses to be reimbursed up to the maximum allowable.

Frame

When patients choose a covered ProTec Eyewear frame, it will be supplied by a participating lab. You won't receive a dispensing fee or material reimbursement for the frame. When submitting the claim, be sure to look for the Collection with ProTec next to it (i.e. Baseline Collection – ProTec) when entering frame information on EasyFind, or use the UPC number listed on the online catalog to select the appropriate ProTect frame.

Note:

To obtain wholesale costs please see the Frame Data® Price Book, available through Jobson, or contact the manufacturer directly for the list price.

Uvex by Honeywell (formerly Titmus) at **800.446.1802**
OnGuard (Hilco) at **800.955.6544**
Wiley X, Inc. at **800.776.7842***

*If a patient that does not have the ProTec Safety Plan, is interested in a Wiley X, Inc. frame, you must contact Wiley X directly. Wiley X requires an account to be set up to sell their frames outside of the ProTec Safety Plan.

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

Safety EyeCare Plan

There are two types of Safety EyeCare plans: the Safety Supplemental Plan and the Safety Stand-Alone Plan. Most clients that provide safety benefits purchase the Safety Supplemental Plan, in addition to our VSP Signature Plan®.

The Safety Stand-Alone Plan is similar to our Signature Plan, with two exceptions:

- Prescribed materials must meet American National Standards Institute (ANSI) standards for safety eyewear.
- Value-Added benefits don't apply to non-covered materials.

Safety Requirements Questionnaire

Safety EyeCare Plan patients should fill out questionnaires about their work environments and related safety requirements before exams. A sample Safety Requirements Questionnaire is located in the **Tools and Forms** section of the **Manuals** on **VSPOnline** on **eyefinity.com**. Keep a copy of the questionnaire or the information it contains in your patient's record.

Coordination of Benefits

There's no coordination of benefits under most Safety EyeCare Plans.

When your patient has Safety Supplemental coverage, use the patient's Signature Plan coverage for a routine eye exam and the Safety Supplemental Plan for supplemental exams. Give an intermediate or comprehensive eye exam under your patient's Safety Supplemental Plan only if that patient isn't eligible for an eye exam under the Signature Plan.

Necessary corrective lenses (i.e. single vision, bifocal, trifocal, or lenticular) in glass or plastic (CR-39) that meet the American National Standards Institute (ANSI) standards are detailed below for safety eyewear.

Certified safety eyewear, lenses and frames must meet the following standards set by ANSI, effective April 20, 2020:

Lenses	Frames
• No safety lenses can be less than 2mm thick at the thinnest point. This applies to any lens used in a frame marked Z87-2 and all Impact Rated Protector prescription lenses. • General Purpose Protector: Lens must be engraved with the manufacturer's logo. General Purpose Protector lenses can't be less than 3.0 mm thick. • Impact Rated Protector: Minimum of 2.0 mm thickness. Lens must be marked with the manufacturer's logo and with a plus sign (+), indicating that it meets Impact Rated Protector test requirements. • If the finished product meets the General Purpose Protector requirements, the lab is no longer required to attach a hangtag stating, "This eyewear meets the Basic Impact Requirements..."	• Prescription spectacles must be tested as a complete device. • Frames that meet the Impact Rated Protector requirement must bear the mark Z87-2 (a + will be required once manufacturers can change their markings and existing inventory is depleted) and may be used for both General Purpose Protector and Impact Rated Protector applications. • Detachable side shields are marked with Z87+. If side shields are permanent they don't need to be marked.

Other Lens Enhancements

If your patient selects a lens enhancement that is covered with copay, . charge your patients the amount listed on the VSP Signature Plan Lens Enhancements Chart or your U&C, whichever is lower. Check the Patient Record Report.Examples of lens enhancements for patients:

Lens Enhancements:	
Anti-reflective coating	Tints (Solid or Gradient)
UV coatings	Oversize lenses
Blended lenses	Polycarbonate lenses
Progressive lenses	Frames that exceed the frame allowance

Non-covered Items

The items below aren't a benefit under the Safety EyeCare plan and VSP will deny the claim if submitted for reimbursement:

- Contact lenses
- Everyday eyewear instead of safety materials
- Materials obtained from a non-VSP doctor, unless the group has out-of-network coverage
- Plano (non-prescription) lenses (unless otherwise indicated)
- Rimless mounting

Frames

After determining patient eligibility and lens needs, have your patient choose a frame from your safety selection or the ProTec Eyewear® online catalog. ProTec Eyewear offers ANSI Z87-2 certified frames in a variety of styles and colors, including Titanium and wrap-around. If your practice carries ProTec Eyewear, please note that the frames in the kit are for display purposes only. All ProTec Eyewear should be ordered through a participating lab and will be supplied by the labs.

Side shields and a frame case are included with ProTec Eyewear frames at no additional cost. If a client requires permanent side shields, a comment on the Patient Record Report will indicate the requirement.

Under the Safety EyeCare plan, patients can choose a frame with detachable or permanent side shields. If the frame and shields are priced separately, add the cost of the shields to the cost of the frame to determine the total cost. Depending upon the patient's frame allowance, ProTec Eyewear frames may not be fully covered under the VSP Safety EyeCare Plan. Refer to the Patient Record Report for more information on the patient's frame allowance. Overages should be determined using the VSP Signature Plan frame overage policy
Note:

If a patient with or without the VSP Safety Eyecare Plan is interested in a frame from the ProTec Eyewear kit, you'll need the wholesale cost of the frame. To obtain wholesale costs please see the Frame Data® Price Book, available through Jobson, or contact the manufacturer directly for the list price.

Uvex by Honeywell (formerly Titmus) at **800.446.1802**
OnGuard (Hilco) at **800.955.6544**
Wiley X, Inc. at **800.776.7842***

*If a patient that does not have the ProTec Safety Plan, is interested in a Wiley X, Inc. frame, you must contact Wiley X directly. Wiley X requires an account to be set up to sell their frames outside of the ProTec Safety Plan.

All safety orders must be sent to a participating lab:

VSP**One** Columbus
800.251.5150
2605 Rohr Road, Lockebourne, OH 43137

VSP**One** Sacramento
800.952.5518
151 Blue Ravine Rd., Folsom, CA 95630

Paper claim practices: You must order lab-supplied materials from one of the participating labs listed above.

Emergency

In emergencies, you can use any lab capable of producing ANSI certified safety eyewear (see the National Contract Lab List); choose lab 100 when billing on eClaim.

Use one of the following comments when indicating emergency status:

- Patient's safety glasses are lost, stolen, or broken and he or she doesn't own a back-up pair.
- Patient needs safety glasses to work or drive and is unable to see well enough to do so and doesn't have a back-up pair of safety glasses.
- Patient's safety and well-being will be jeopardized without the immediate delivery of his or her prescription safety eyewear.

Supplemental Safety EyeCare Exams

The level of eye exam or the evaluation and management service that you provide depends on the location and the time elapsed since the patient's last routine eye exam:

Time Since WellVision® Routine Exam	Reimbursement Percentage
Same day	No reimbursement
1 day or more	65% of the doctor's comprehensive exam fee when supplemental exam is billed*

When possible, perform your supplemental and comprehensive or intermediate exams in the same visit.

*If you choose to use 920XX codes to bill your WellVision Exams, please remember to bill refraction (92015) separately for accurate reimbursement.

Stand-Alone Safety EyeCare Plan Exams

Exams for Stand-Alone Safety EyeCare Plans are reimbursed at your Signature Plan comprehensive or intermediate exam payable fee.

Dispensing Fees

Supplemental Safety EyeCare Plans have a lens dispensing fee only. The lens dispensing is reimbursed at a flat rate of $25.

Stand-alone Safety Eyecare Plans have a lens and frame-dispensing fee that is also reimbursed at a flat rate. Both lens and frame dispensing are reimbursed at $25 each.

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

LightCare™ Enhancement

Eligible members can use the LightCare enhancement for plano (non-prescription), ready-made sunglasses or blue light filtering glasses instead of contact lenses or prescription glasses, exhausting both their lens and frame eligibility.

Eligible members will be indicated with the following comment on the **Patient Record Report**:

Note:

Members may receive plano (non-prescription) ready-made sunglasses or plano blue light filtering glasses instead of prescription glasses. This will exhaust both lens and frame benefits.

Frames

Coverage includes any ready-made, doctor-supplied plano sunglasses or plano blue light filtering glasses. Apply the patient's retail frame allowance to the cost of the complete pair (lens and frame). Deduct 20% from any amount over their retail allowance. Sunglasses can be ordered if not available at the time of the member's visit. If you do not supply an inventory of ready-made blue light glasses, you can refer patient to Eyeconic. The $20 and $40 Marchon/Altair frame promotions apply to LightCare.

Lenses

To cover the lenses, the patient must select the lenses included in the frame with no additional enhancements or coatings.

When submitting claims for non-prescription sunglasses or blue light filtering glasses on eClaim, indicate the order as a "frame only" order.

A diagnosis code is required for claim submission. For frame-only claim submission, use Z46.0 (Encounter for fitting and adjustment of spectacles and contact lenses) or other relevant diagnosis code(s), as appropriate. Including a diagnosis code will ensure correct claims processing.

For all eligible LightCare Plan Enhancement claims, you'll be reimbursed both your frame dispensing fee and a frame material fee (up to the patient's wholesale/retail frame allowance).

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

Computer VisionCare℠ Plan

Computer VisionCare services are usually provided at the same time as your patient's routine eye exam to treat Computer Vision Syndrome (CVS). There are two Computer VisionCare plans: Supplemental Computer VisionCare and Computer VisionCare Only.

Coordination of Benefits

There's no coordination of benefits for services provided under the Computer VisionCare Plan.

Computer VisionCare patients should complete a questionnaire about their work environments and viewing distance from the computer before the exam. A sample Computer VisionCare Questionnaire can be found in the **Patient Education** section in the **Forms Library** area under **Administration** on **VSPOnline** on **eyefinity.com**. Keep a copy of the questionnaire or the information in your patient's record.

Supplemental Computer VisionCare patients are eligible for a supplemental exam to determine computer vision requirements in addition to the tests listed below.

Computer VisionCare Only: Patients receive a comprehensive exam and the tests listed below.

Additional Tests and Records

In addition to services provided under the VSP Signature Plan®, include the following tests and records with the Computer VisionCare eye exam:

- history, including viewing distances, lighting, viewing angles, and symptoms
- vision assessment (at least two of the following):
- Function (at least two of the following):
- determination at computer viewing distance eye discussion, when indicated (only during initial visit; no coverage for ongoing treatment)
- testing as indicated, to support the diagnosis
- Near point of convergence test
- Cover test or heterophoria test at the near working distance of the computer monitor
- Fusion quality (assessment of fusion ranges when indicated)
- Facility of accommodation
- Amplitude of accommodation
- Plus and minus lenses to blur at the computer monitor working distance

Treatment requirements

- if computer glasses are indicated
- prescription, if indicated
- regarding the visual environment and workstation
- eye discussion, when indicated
- therapy, when indicated

Patients qualify for Computer VisionCare materials only if they have one of the following diagnoses. Claims require at least one of the following diagnosis codes.

Diagnosis	Code
Presbyopia	H52.4
Hyperopia	H52.01, H52.02, H52.03
Disorder of Accommodation	H52.511, H52.512, H52.513 H52.521, H52.522, H52.523 H52.531, H52.532, H52.533
Heterophoria	H50.50, H50.51, H50.52, H50.53, H50.54, H50.55
Astigmatism	H52.201, H52.202, H52.203 H52.211, H52.212, H52.213 H52.221, H52.222, H52.223
Disorder of Convergence	H51.0, H51.11, H51.12, H51.21, H51.22, H51.23, H51.8

Lenses

Under both plans, patients are eligible for covered lenses and a wholesale/retail frame allowance. Value-Added benefits don't apply. Materials prescribed are for **computer use only**.

Spectacle lens coverage includes:

- prescription of ±0.50 diopters or greater required for lenses.
- vision, bifocal, and trifocal specifically designed for working at a computer glass/plastic.
- Variable Focus lenses (VSP lens enhancement code IA or IL) are covered

Note:

Although rare, some clients may choose to cover all progressives. Check the patient record report for coverage details.

- sizes up to and including 60 mm.
- prescription for supplemental Computer VisionCare materials must differ by ±0.50 diopters or greater at any distance from the patient's everyday eyewear.

Note:

Recognizing the advances in lens technologies, digital lenses with a built in "bump" lens attribute (minimum +0.50 diopter ADD power) offered for computer use but not for a patient's everyday use, may be used to satisfy the ±0.50 diopters prescription difference.

- I, II or Rose tints, up to 20% absorption level.

Frame

Most VSP plans provide a blended wholesale/retail allowance toward the purchase of a new frame. Patients may also use a serviceable existing frame. If the member chooses a frame with a cost that exceeds both the wholesale and retail allowances, deduct 20% from the retail overage

Other Lens Enhancements

If your patient selects a lens enhancement that is covered with copay, charge your patient according to the VSP Signature Plan Lens Enhancements Chart or your U&C, whichever is lower. Examples of lens enhancements patients can choose:

Lens Enhancements	
• Blended lenses	• Oversize lenses
• Polycarbonate	• Non-pink or non-rose tints, up to 20% absorption level
• Mid or Hi-Index	• Scratch resistant coating
• UV coating	• Edge treatment
• Anti-reflective coating	

Non-covered Materials

The following items aren't benefits under the Computer VisionCare Plan. Clients may make exceptions to this list. Please check the Patient Record Report for coverage. If these items are provided, the lenses and frame will be denied.

• Blended lenses	• Oversize lenses
• Polycarbonate	• Non-pink or non-rose tints, up to 20% absorption level
• Mid or Hi-Index	• Scratch resistant coating
• UV coating	• Edge treatment
• Anti-reflective coating	

- VSP contract labs.
- orders through eClaim at eyefinity.com.
- redos, please check the First-Time Doctor Redos policy in Dispensing and Patient Lens Enhancements section.
- can use non-contract labs in emergency situations only.
- in-office lens enhancements are acceptable if they follow Computer VisionCare guidelines for tints. See Doctor In-Office Lens Enhancements for details.

Claims submitted under the Computer VisionCare Plan must meet the following criteria:

- materials prescribed are for computer use only.
- include at least one of the diagnoses listed above
- prescription for Computer VisionCare materials must differ by more than ±0.50 diopters from your patient's everyday eyewear
- patient can't get Computer VisionCare glasses that are the same as everyday eyewear.

VSP will verify that Computer VisionCare glasses meet all requirements. Paid materials claims that don't meet the above criteria may be reversed. You may not bill your patients for claims that are reversed.

If your patient can't adjust to occupational progressive lens, benefits won't be reinstated. Payment becomes a private transaction between you and your patient.

Claim Reimbursement

Supplemental Computer VisionCare: When your patient has Supplemental Computer VisionCare coverage, use their routine benefit for the eye exam and the Computer VisionCare coverage for supplemental Computer Vision Syndrome testing.

Please refer to the chart below to determine your reimbursement:

Time Since WellVision® Routine Exam	Reimbursement Percentage
Same day	30% of comprehensive exam payable fee*
1 day or more	65% of comprehensive exam payable fee*

When possible, perform your supplemental and comprehensive or intermediate exams in the same visit.

*If you choose to use 920XX codes to bill your WellVision Exams, please remember to bill refraction (92015) separately for accurate reimbursement.

Computer VisionCare Only: We'll reimburse you for exams at your VSP Signature Plan comprehensive or intermediate exam payable fee.

Computer VisionCare-related vision therapy provides evaluations and orthopic and/or pleoptic sessions for patients with one of the following conditions:

- insufficiency— H51.11
- insufficiency— H52.521, H52.522, H52.523
- spasm— H52.531, H52.532, H52.533

Computer VisionCare-related vision therapy provides evaluations and orthopic and/or pleoptic sessions for patients with one of the following conditions:

- insufficiency—378.83
- insufficiency—367.50
- spasm—367.53

If your patient meets the benefit criteria above and is eligible for Computer VisionCare-related vision therapy, please refer to the Vision Therapy section of this manual for billing instructions.

Coverage:

- will pay up to a maximum of $200.
- $200 allowance includes any supplemental testing. VSP does not provide coverage for supplemental testing without treatment.
- patient is responsible for additional therapy above the $200 allowance.
- additional copay is required.

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

VSP EasyOptions

VSP EasyOptions is an enhancement to the VSP Signature and Choice, Enhanced Advantage and Advantage plans that enables doctors and patients to customize VSP materials coverage to meet the patient's lifestyle and visual needs.

Obtain eligibility on **eyefinity.com** or by calling VSP at **800.615.1883**.

When retrieving an authorization, an alert box will appear on **eyefinity.com** and the VSP Patient Record Report will show VSP EasyOptions under Plan Details.

The VSP EasyOptions enhancement does not affect exam coverage. Refer to the VSP Patient Record Report for exam coverage information.

Potential materials coverage upgrades with VSP EasyOptions vary by client, and are shown on the VSP Patient Record Report. Patients are eligible to pick one (1) upgrade from the selection. Example upgrades include but are not limited to:

- Fully covered progressive lenses, or
- Fully covered photochromic lenses, or
- Fully covered anti-reflective coating, or
- Increased frame allowance, or
- Increased contact lens allowance

Assist the patient with frame and lens selection as normal, and then determine which upgrade provides the best value for the patient. Charge the patient for the other choices/upgrades as normal for their plan.

Note:

If the client already covers Standard Progressive under the base plan, then only Premium and Custom Progressives are available under EasyOptions.

You'll be reimbursed for exam and materials according to the patient's Signature or Choice Plan coverage as normal. The best value for the patient will be calculated upon claim submission, and this selection will show on your VSP Explanation of Payment as "EasyOptions—[name] Upgrade." Other upgrades will show as "EasyOptions—No Upgrade."

Some clients may also have an additional $50 frame allowance upgrade for Marchon/Altair frames. You will see this upgrade on the VSP Patient Record Report under Plan Details.

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

Repair/Replace Benefits

Repair/Replace Benefits cover materials your patients get when they're not eligible for materials under their core plan. Refer to the Patient Record Report to determine if the patient is eligible for repair or replacement coverage. Patients are eligible if their spectacle lenses or frames are broken or damaged and need repair or replacement.

It also covers materials your patients receive when they're not eligible for materials under the core plan and they can no longer use their glasses.

Patients covered under this additional benefit may be entitled to eyeglass lens and frame repair. Frame repair includes temples only, front only, hinge, and miscellaneous repairs. The Repair Benefit may also include replacement of a complete frame and/or basic lens.

- Patients need to bring the glasses to you before obtaining an authorization.
- You'll determine if glasses can be repaired. If they can't, replacement may be covered.

Exam	Lenses	Frames
Exams aren't covered.	New lenses are allowed if: • repair or replacement for single vision or multifocal lenses will be approved if the doctor determines the glasses can't be repaired; • the benefit is limited to the patient's core plan lens coverage. **Note:** Contact lens repair or replacement isn't covered under this plan.	Replacement parts are covered if: • frame temples, front, and/or hinges are damaged beyond repair; • the benefit is limited to the patient's core plan wholesale frame allowance. Replacement of the complete frame is covered if: • frame is damaged beyond repair or the cost of repairing the parts exceeds the cost of replacement; • the benefit will be limited to the patient's core plan wholesale/retail frame allowance

Inform your patients that they must pay for services and/or materials provided if they:

- Aren't eligible for the services/materials requested;
- Have Repair/Replace benefits but don't meet the criteria for repair or replacement services/materials.

Contact VSP at **800.615.1883** to obtain an authorization for repair/replace benefits.

VSP Elements Program®

VSP Elements is a covered-in-full program that supports the pediatric vision essential health benefit under the Affordable Care Act (ACA). Featuring Otis & Piper™ Eyewear, VSP Elements offers a covered-in-full annual eye exam and quality eyewear from a collection of frames designed specifically for children.

VSP Elements can be offered to patients with a Signature, Choice, or Advantage Plan. Only participating Choice Network doctors can provide services to VSP Elements patients with the Choice Plan. Only participating Advantage Network doctors can provide services to VSP Elements patients with the Advantage Plan.

Refer to the Patient Record Report to determine which Plan type the patient has. For Cigna Vision Patients, refer to the Cigna Quick Reference Chart on VSPOnline at eyefinity.com.

Copays

Copay information is provided on the Patient Record Report when you obtain an authorization.

Exam Coverage

Covered comprehensive eye exams are generally available to patients once every 12 months on a calendar year basis. Other exam frequencies can also be accommodated. Refer to the Patient Record Report for specific coverage details.

Materials Coverage

VSP Elements coverage is for children typically age 0 to 19 and includes covered prescription lenses and a frame. Covered-in-full frames are available from the Otis & Piper Eyewear Collection. Patients can select a non-Otis & Piper frame, but it will not be covered (see Out-of-Kit Frames below). Contact lenses in lieu of eyeglasses are also covered with a minimum three-month's supply for varying modalities (see Contact Lenses below). Please review your patient's coverage before providing materials.

Patients are also eligible for savings on additional services and materials (see Value-Added Benefits below).

Lenses

Single vision, bifocal, trifocal, or lenticular lenses in polycarbonate, plastic or glass are covered, as well as UV protection and scratch-resistant coatings. You receive a combined $25 lens and frame dispensing fee for covered lenses.

All orders for VSP Elements patients must be fulfilled at VSPOne™ Columbus.

Note:

VSP only covers lenses that meet the minimum prescription criteria.

VSP's minimum prescription criteria:
The combined power in any meridian is ±0.50 diopters or greater in at least one eye or one of the following exceptions occurs:
—Necessary prism of 0.50 diopters or greater in at least one eye
—Anisometropia is 0.50 diopters or greater in at least one eye
—Cylinder power is ±0.50 diopters or greater in at least one eye

Lens Enhancements

In addition to polycarbonate, UV protection and scratch-resistant coatings, some clients may also cover the following tints. Refer to the Patient Record Report for specific coverage details.

- Photochromic lenses
- Solid and gradient tints

If the patient chooses a lens enhancement not covered by the plan, charge the patient according to the appropriate Lens Enhancements Charts (Signature, Choice, or Advantage) depending on the network selected as indicated on the Patient Record Report.

Covered Frames

Frames from the Otis & Piper Eyewear Collection are covered for patients and will be lab supplied through VSP**One** Columbus. You will receive a combined $25 lens and frame dispensing fee.

To ensure correct claims processing, enter $0.00 for both wholesale and retail amounts and choose lab supplied frame option.

To request an Otis & Piper frame kit, contact Altair® at **800.505.5557.**

Frame Warranty:

An unlimited warranty is included with the frame.

Out-of-Kit Frames

Elective Frame

A patient has the option of providing their own frame or purchasing a non-Otis & Piper frame from you at 80% of U&C. If the patient purchases a non-Otis & Piper frame, it would be a private transaction and the frame will not be covered by VSP. You'll still receive a combined $25 dispensing fee for the lens and frame, regardless of the frame brand selected. The benefit for lenses and a frame will be exhausted for the patient's eligibility period. An out-of-kit frame selected due to cosmetic reasons, such as style, color and/or design are not covered and a private transaction at 80% of U&C.

Lenses, as outlined in the lens section, will still be covered under VSP Elements.

Medically Necessary Frame:

Out-of-kit frames are allowed and covered if medically necessary due to frame material allergies and/or the appropriate eye size is unavailable within the kit selection. For Signature and Choice plans, you receive your dispensing for lenses and frame, plus the wholesale cost. Advantage frames are reimbursed up to 55% of your billed amount.

Use a KX modifier to indicate medical necessity and be sure to complete the frame section and provide your wholesale frame cost. Document the reason for medical necessity in the patient's chart for audit purposes.

Contact Lenses

Elective Contact Lenses

VSP Elements provides coverage for contact lens services and materials in lieu of prescription glasses with a minimum three-month's supply (limited to two boxes of lenses) for the following modalities:

- Standard (one pair annually) – 1 contact lens per eye (total 2 lenses)
- Monthly (six-month supply) – 6 lenses per eye (total 12 lenses/2 boxes)
- Bi-weekly (three-month supply) – 6 lenses per eye (total 12 lenses/2 boxes)
- Dailies (three-month supply) – 90 lenses per eye (total 180 lenses/2 boxes)

To qualify, patients must first be eligible for contact lenses and meet the minimum prescription requirement. Refer to the Patient Record Report for the patient's specific type of coverage. The contact lens exam (fitting and evaluation) is covered in full. Providers will be reimbursed 85% of their U&C fees for the contact lens exam, and 100% for materials up to the quantity allowed.

Standard contact lens coverage exclusions apply, including corneal refractive therapy, orthokeratology, contact lenses for myopia management, plano, and replacement of lost or damaged lenses.

When submitting a paper claim, please indicate the contact lens modality and number of boxes in Box 19 on the CMS-1500 claim form.

***Washington State Requirement**

Washington state regulation (WAC 284-43-5782) requires pediatric vision services to cover a calendar year's equivalent of contact lenses for any modality dispensed. To maximize your patient's benefit, dispensing an annual supply of contact lenses at one time is required. Refer to the Contact Lens Benefits section in the VSP Manual for more information on Covered Contact Lenses.

Note:

Contact lens exam services are also known as the contact lens fitting and evaluation, or F&E. These services are separate from the WellVision Exam and should be dispensed only to patients who wear or want to wear contact lenses and specifically request a contact lens exam.

Visually Necessary Contact Lenses

We'll cover contacts in full for patients meeting the established necessary contact lens benefit criteria if those patients are eligible for materials on the date of service. Refer to the Visually Necessary Contact Lenses section in the VSP Manual for more information.

Don't balance bill your patient. Apply material (spectacle lenses and frame) copays for necessary contact lenses, unless otherwise specified.

Visually necessary contact lenses aren't typically covered for patients who've received any elective cosmetic surgery, such as LASIK, PRK, or RK.

Note:

For Visually Necessary Contact Lenses and Covered Contact Lenses, VSP will only cover an annual supply of materials based on the manufacturer's replacement schedule.

Use of private labs or In-Office Finishing equipment is not permitted for VSP Elements patients. All orders must be submitted to VSP**One** Columbus, regardless of frame brand selected.

Some VSP Elements clients provide this coverage. Low vision evaluations and aids are covered for eligible enrollees. Pre-service verification is required. Submit a Low Vision Verification Form.

A low vision evaluation is covered for members who present with moderate, severe, or profound visual impairment. A low vision evaluation includes, but is not limited to, a detailed case history, effectiveness of any low vision aids in use, visual acuity in each eye with best spectacle correction, steadiness of fixation, assessment of aids required for distance vision and near vision, evaluation of any supplemental aids, evaluation of therapeutic filters, development of treatment, counseling of patient, and advice to patient's family (if appropriate).

Note:

The diagnosis code describes the level of visual impairment in each eye. The AMA defines the level of visual impairment using best corrected visual acuity (BCVA) and/or visual field limitation. For example, severe visual impairment ranges are BCVA from 20/200 to 20/400, or visual field of 20 degrees or less, whichever is worse. Profound visual impairment ranges are BCVA 20/500 to 20/1000, or visual field of 10 degrees or less. VSP follows these guidelines for low vision coverage.

Low Vision Evaluation and Aids Coverage

We'll cover an annual low vision evaluation and aids if your patient's best corrected visual acuity is 20/70 or worse in at least one eye, or if there is a visual field of 20 degrees or less, or a hemianopsia. The request and claim should contain the correct low vision diagnosis code(s).

Don't use the low vision coverage to provide conventional glasses or additional contact lenses. Lenses must be either specialty low vision lenses, or glasses specifically designed for use in conjunction with low vision aids. VSP's minimum prescription requirements apply. Please include a manufacturer's invoice when submitting a Low Vision Verification Form.

Eligibility & Authorization

If your patient meets the benefit criteria above and is eligible for low vision services, obtain a case number. To get one, complete a Low Vision Verification Form. A copy of the invoice or catalog page is needed for each low vision aid requested. Fax the form to **916.851.4733**. Or mail this form to: VSP, PO Box 997100, Sacramento, CA 95899.

Low Vision Exam Coverage

Coverage includes an annual low vision evaluation. There's no copay.

Low Vision Materials Coverage

Coverage includes all appropriate low vision aids, including prescription services and optical/non-optical aids.

Submitting Claims/Billing & Reimbursement

Submit low vision claims using our electronic claims submission system. You'll need an authorization number, which can be found on the Benefit Authorization notice. Indicate the case number in Box 23 located on the Diagnosis and Services screen.

For proper payment, bill all covered services with the appropriate CPT or HCPCS codes from this list.

Important!

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

Low Vision Evaluation	
92499	Unlisted ophthalmological service or procedure
Fitting of Low Vision Aids (not reimbursed separately; payment is bundled with aids)	
92354	Fitting of spectacle mounted low vision aid; single element system
92355	Fitting of spectacle mounted low vision aid; telescopic or other compound lens system
Low Vision Aids	
V2600	Hand held low vision aids and other non-spectacle mounted aids
V2610	Single lens spectacle mounted low vision aids
V2615	Telescopic and other compound lens systems, including distance vision, telescopic

Note:

Low vision claims must be submitted on a separate claim from routine vision. CPT and HCPCS codes are not selectable from the drop-down box and must be manually entered.

The following are considered a private transaction between you and your patient. Your patient is fully responsible for the payment.

Exam Services

Deduct 20% on additional eye exams, including if only a refraction is performed.

Materials

Charge 80% of U&C for additional materials when complete pairs of prescription glasses and non-prescription sunglasses or blue light filtering glasses, are dispensed within 12 months of the exam. The benefit:

- is based on your total U&C fee.
- is unlimited for 12 months on or following the date of the last covered eye exam.
- is available through any VSP doctor. Use professional judgment when evaluating prescriptions from another provider. You may request an additional exam at a 80% of your U&C fee.
- applies to prescription and non-prescription lenses.
- doesn't apply to cleaning products or repairs of prescription lenses or frames.

Contact Lens Service Benefit

Charge 85% of U&C on all elective, and replacement contact lens services. The benefit:

- is subtracted from your U&C fee for evaluation/fitting services;
- is unlimited for 12 months on or following the date of the covered eye exam;
- is available only through a VSP Network Doctor. Use professional judgment when evaluating prescriptions from another provider. You may request an additional exam at 80% of your U&C fee;
- does not apply to materials, solutions, cleanings, and service agreements.

VSP Laser VisionCare℠ Program

- Members receive a complimentary screening as well as preoperative and postoperative services through participating VSP doctors.
- The program includes access to either Photorefractive Keratectomy (PRK) or Laser In-Situ Keratomileusis (LASIK) at a reduced cost, up to a maximum fee to the patient of $1,500 per eye for PRK, $1,800 per eye for LASIK, and $2,300 per eye for Custom LASIK with wavefront technology using microkeratome, Custom PRK or Bladeless LASIK.
- If the laser center is offering a temporary price reduction, VSP members will receive 5% off the advertised price if it is less than the usual discount price.
- Please see the **Laser VisionCare** program page on **VSPOnline** for information on how to participate or for a list of participating facilities.

Charge sales tax to your patients, as you normally would, based on your state's sales tax laws and regulations. Refer to Sales Tax under Dispensing and Patient Options on VSPOnline for more information.

Coordination of Benefits is not allowed when VSP Elements is the secondary benefit.

For some VSP Elements patients, authorizations will expire on the last day of the month in which they are issued. You'll receive an "Invalid Authorization" error message in eClaim if you submit a claim for a date of service not within the effective dates. If this happens, obtain a new authorization valid for the date of service and resubmit.

VSP Elements claims for exam, lenses and frames may be submitted through a Practice Management Software System. Claims for contact lens materials may NOT be submitted through a Practice Management Software system, at this time, even if integrated with Eyefinity because they will not process for correct payment. To ensure proper payment, submit contact lens claims directly through **eClaim** on Eyefinity or on paper. Contact Eyefinity for questions at **800.942.5353.**

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

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

Redos due to lab error

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

Redos due to doctor or staff error

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

Redos due to prescription changes

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

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

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

Retinal Screening

What is Retinal Screening?

Retinal screening are retinal fundus image(s) acquired by a retinal imaging device, that are used as baseline documentation of a healthy eye or to screen for potential disease(s). These images are reviewed by a Doctor of Optometry for the detection of diseases that manifest in the posterior segment of the eye.

- Retinal screening is a separate service from a patient's WellVision Exam®.
- Retinal screening is not required by medical necessity.
- Retinal screening can be incorporated as part of a patient's overall wellness care to check for disease(s) that may otherwise go undetected.
- Patients should be informed prior to services performed of any out-of-pocket cost.
- Patients have the right to decline retinal screening services.
- Retinal screening only pertains to routine, retinal fundus imaging. Scanning laser procedure such as optical coherence tomography (OCT), Heidelberg Retinal Tomography (HRT), and GDx are excluded.

Please use your best clinical judgment to determine if this service is appropriate for your patient.

Important!

Retinal screening does not replace pupil dilation.

VSP offers different coverage options related to retinal screening. The table below provides a summary of the services.

	Description	Billed to VSP	Reimbursement	Billing Notes
1	Routine Retinal Screening (Value-Added Feature)	No	N/A – Private Transaction up to $39	
2	Routine Retinal Screening Covered Benefit (Enhanced Covered in Full or Set Copay)	Yes – Wellvision authorization	Up to $39 less any applicable patient copay	CPT Code with modifier/52
3	Fundus Photography with Interpretation and Report	Yes – Essential Medical Eye Care authorization	VSP Allowable	CPT Code 92250 no modifier required. Can be billed same day as the routine WellVision exam with a separate Essential Medical Eye Care authorization
4	Diabetic Retinal Screening (Covered in full for members with diabetes that show no diabetic eye disease)	Yes – Essential Medical Eye Care authorization DEP+ Program authorization	Up to $39	CPT Code with modifier/52

Retinal screening and fundus photography are two separate services that share the same CPT code, 92250.

- Bill CPT code 92250 with modifier 52 to report retinal screening. Modifier 52 signifies that the service is reduced. This provides a means of reporting a reduced service without disturbing the identification of the basic service.
- Bill CPT code 92250 (without modifier 52) to report fundus photography with interpretation and report.

For a summary of how to bill retinal screening to VSP please download this one-page billing guide.

Routine retinal screening is offered as standard coverage on VSP Signature Plan®, VSP Choice Plan® and VSP Advantage Plan® as a value-added feature to complement the WellVision Exam® benefit.

Eligibility

Retinal screening is an enhancement to a patient's WellVision Exam; therefore, patients are typically eligible every 12 months. However, there are no restrictions to the number of procedures performed each year.

Charging the Patient

Charge the patient $39 or your U&C fee (whichever is lower) for each routine retinal screening.

Submitting Claims and Reimbursement

For the value-added feature, you do not need to submit a claim. This charge is considered a private transaction between you and the patient**.** Be sure to check for retinal screening coverage before your patient pays out-of-pocket. Bill the WellVision Exam and any materials as you normally would.

Covered in full or with a set copay, routine retinal screening is offered to VSP clients for purchase as an optional benefit enhancement to the WellVision Exam under VSP Signature Plan®, VSP Choice Plan® and VSP Advantage Plan®.

Eligibility

Please refer to the Patient Record Report for eligibility. Retinal screening is an enhancement to a WellVision Exam; therefore, patients are typically eligible every 12 months.

Charging the Patient

Please refer to the Patient Record Report for coverage amount and/or applicable copays.

Submitting Claims

Covered routine retinal screening must be billed with a patient's WellVision Exam.

When submitting claims for routine retinal screening, use CPT code 92250 with modifier 52.

Reimbursement

For eligible routine retinal screening covered benefit claims, you'll be reimbursed up to $39 or your U&C fees (whichever is lower) less any applicable patient copay.

If retinal screening reveals disease(s) or abnormalities, the image(s) can be billed as fundus photography with interpretation and report with appropriate documentation requirements.

Eligibility*

Please refer to the Patient Record Report for Essential Medical Eye Care eligibility and coverage.

Charging the Patient

When a patient has Essential Medical Eye Care and a valid medical diagnosis, there is no copay and the fundus photography service is covered-in full.

Submitting Claims

Fundus photography with interpretation and report can be billed on the same day as the WellVision Exam for eligible patients. This service is covered under VSP's supplemental medical eye care plans and must be billed with Essential Medical Eye Care authorization.

When submitting claims for fundus photography, use CPT code 92250 and a valid ICD-10-CM diagnosis code that best describes the patient's condition for which the service was performed. No Modifier is required.

Detailed information about payable diagnosis codes and documentation requirements are available in the Essential Medical Eye Care Provider Reference Manual sections.

Reimbursement

For eligible claims, you'll be reimbursed 80% of your U&C fee, up to the Essential Medical Eye Care maximum allowables.

Covered-in-full retinal screening (use CPT code 92250 and modifier 52) is available to patients who have diabetes but don't show signs of diabetic eye disease.

For full coverage details, please refer to the Essential Medical Eye Care or Diabetic Eyecare Plus Program Manual.

In addition to the digital image(s) the medical record should contain:

- The patient's name and date of the test,
- Interpretation and report, and
- The signature of the physician

Appropriate documentation includes interpretation of the test results and a notation of the findings and assessment. When the results do not identify pathology or abnormalities, it is sufficient to document "normal fundus" (Z13.5 – Encounter for screening for eye and ear disorders).

Note:

Interpretation and report is required for all retinal screening images.

If pathology is identified, the image(s) can be billed as fundus photography with interpretation and report with appropriate documentation requirements. Documentation should include, but is not limited to, relevant medical history, physical examination, findings and/or diagnosis, and treatment plan recommendations.

Fundus photography with interpretation and report is covered under VSP's supplemental medical eye care plans and can be billed with an Essential Medical Eye Care or Diabetic Eyecare Plus authorization.

Detailed information about payable diagnosis codes is listed in the Essential Medical Eye Care and Diabetic Eyecare Plus Program Provider Reference Manual sections.

Essential Medical Eye Care

Essential Medical Eye Care provides supplemental medical eye care coverage. The patient's medical insurance plan should be billed as the primary payer when you are contracted with the medical insurance plan's network. Please refer to coordination of benefits in this section for more information.

Essential Medical Eye Care covers detection, treatment, and management of ocular and/or systemic conditions that produce ocular or visual symptoms.

Examples of conditions that may be covered under the Essential Medical Eye Care include, but aren't limited to:

Conditions:	
• Age-related macular degeneration (AMD)	• Glaucoma and cataracts
• Conjunctivitis	• Ocular discomfort and pain
• Diabetic eye disease	• Ocular surface disease
• Foreign body and abrasions	• Recent onset of flashes, floaters, and visual field loss

The Essential Medical Eye Care Core Benefits List describes all services covered under the Essential Medical Eye Care plan. Covered services are subject to change at VSP's discretion. Some services are limited to certain conditions/diagnosis codes and have frequency limitations. The established frequencies should accommodate the required quality care needs of most patients.

The following services are not covered under Essential Medical Eye Care:

- General anesthesia surgical procedures.
- Preoperative and postoperative surgical procedures, cataract extractions, or retinal surgery.
- Refractive surgery. Services provided for refractive diagnoses may be covered under your patient's routine benefit.
- Prescription medication or supplies of any type.
- Eyeglasses or contact lenses.

Copays, if required, apply to medical eye exams only (92002-92014, 99202-99205, 99211-99215, 99421-99423, 99441-99443). Copays do not apply to non-exam services (e.g., diagnostic testing including fundus photography and optical coherence tomography).

Check the VSP Patient Record Report to confirm Essential Medical Eye Care coverage. Patients choosing non-covered medical services should be informed of any out-of-pocket cost and asked to sign the Patient Responsibility Statement prior to receiving services. You can find the form under the **Forms** section of the **Administration** menu on **VSPOnline** on **eyefinity.com**.

Coding and Billing Documentation Standards
Providers are responsible for accurate documentation and claim submission of services performed. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to American Medical Association (AMA), Centers for Medicare and Medicaid Services (CMS), Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), International Classification of Diseases (ICD-10 CM), and National Correct Coding Initiative (NCCI).

Claim submissions are subject to review including but not limited to, terms of benefit coverage, provider contract language, scope of licensure, coding policies, clinical payment guidelines, and coding software logic. All information required to support the services and medical necessity submitted on the claim is expected to be in the patient's medical record and be available for review. VSP audits patient medical records according to the Clinical Practice Guidelines of the American Optometric Association (AOA) and the Preferred Practice Pattern® Guidelines of the American Academy of Ophthalmology (AAO).

Reminders:

- Essential Medical Eye Care services must be submitted on a separate authorization from routine vision claims.
- Report only those services appropriate for your licensure and your state's current regulations.
- Code to the highest degree of specificity when indicating diagnosis.
- Standard timely filing guidelines apply.

Note:

VSP recognizes but does not currently support Place of Service (POS) code 02 for reporting telehealth services rendered from a distant site except when submitted on paper as a secondary for coordination of benefits. Additionally, VSP recognizes but does not currently support POS code 10 for reporting telehealth services provided in patient's home.
Modifiers GQ or 95 are used to identify telemedicine services, as appropriate. Modifiers are used for information purposes only.

For information about the Interpretation and Report requirement for medical procedures, refer to Guidelines for the Interpretation and Report of Diagnostic Procedures.

Essential Medical Eye Care Reimbursement

- Medical eye exams (CPT codes 920XX and 99202-99215) are reimbursed according to VSP Signature Plan payables, as reported on your practice's Assigned Fee Report.
- To access the Assigned Fee Report for your practice, visit **VSPOnline** at **eyefinity.com** and click the **View Fees** link under **Practice/Doctor Updates** in the **Administration** area.
- Additional covered services are reimbursed at 80% of your usual and customary (U&C) fee, up to the Essential Medical Eye Care maximum allowable.
- VSP's non-exam Essential Medical Eye Care services approximate the Centers for Medicare and Medicaid Services (CMS) Medicare Physician Fee Schedule amounts.

Medicaid Essential Medical Eye Care Reimbursement

- Reimbursement for approved Medicaid procedures will be 80% of your U&C fee or your state's VSP Medicaid fee schedule, whichever is lower.
- VSP's non-exam Essential Medical Eye Care services approximate your state's Medicaid fee schedule amounts.

Pricing Rules for Surgical Procedures (see Surgical Services section below)

- When two or more covered surgical procedures are performed during the same operative session, multiple surgery reductions apply.
- 100% of the allowance for the most expensive surgical procedure or 80% of the billed; whichever is less.
- 50% of the allowance for the remaining surgical procedures or 80% of the billed; whichever is less.

Only one exam or office visit is payable per date of service, including any combination of VSP plans or benefits. Reimbursements aren't available when multiple exams or office visits are submitted for the same dates of service, including the following in any combination:

- Intermediate or comprehensive routine exam
- Ophthalmological exam for medical related eye care
- Evaluation and management office visit
- Exam or evaluation and management service performed via telemedicine

Coordination of benefits (COB) applies to the payment of medical eye care benefits when a member is covered under two or more benefit plans. If a member has medical benefits under a medical health insurance plan that you're contracted with, that plan is primary and VSP is secondary. In the event VSP is the secondary payer, VSP may be billed for the member's out-of-pocket expenses. Examples are copayments, deductibles, charges for noncovered services, or charges for services not covered in full by the primary carrier. Providers are responsible for verifying coverage, as well as billing the other carrier(s).

See Coordination of Benefits section for more information about how to coordinate benefits.

If your patient needs more treatment than you're licensed for, or if your patient needs treatment for services not covered under Essential Medical Eye Care, refer the patient to their primary care physician or a specialist in their medical insurance plan's network.

When making referrals, use the following guidelines and those listed under Patient Referrals in **Levels of Service** section of **Eye Exams**:

- Follow all referral protocols set by your patient's health plan. Typically, an HMO requires that patient referrals be coordinated by the primary care physician (PCP). However, a PPO allows patients to receive care from any medical provider without a PCP referral.
- Provide your findings, in writing, to the doctor you're referring the patient to.
- Forward your diagnostic findings, treatment plan, and follow-up results to your patient's primary care physician. To help you coordinate care for patients with diabetes, we provide the optional Primary Care Physician Communication Form, available in the **Forms** section of the **Administration** menu on VSPOnline at eyefinity.com and in eClaim. This easy-to-use form is a convenient way to help manage eye health for patients with diabetes and underscores the importance of regular eye exams.

Instructions for the administration of specific-client plans are outlined in **Client Details.** Please check client details before providing services to covered patients.

Exams and Office Visits

Comprehensive eye exams are covered once per 12-month period. Additional comprehensive eye exams are reimbursed at the intermediate level.

Code	Description
92002	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
92004	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits
92012	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient
92014	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits.

Modifier 95 or GQ is used to designate telemedicine for eligible E/M services (99202 - 99215)

Code	Description
99202	Office or other outpatient for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.
99203	Office or other outpatient for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.
99242	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
99243	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99244	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
99245	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.

For additional information on billing evaluation and management services, please use the following AMA resource guides:

CPT® Evaluation and Management (E/M) Code and Guideline Changes

CPT® Evaluation and Management (E/M) Office Revisions Level of Medical Decision Making (MDM)

Code	Description
76510	Ophthalmic ultrasound, diagnostic; B-scan and quantitative A-scan performed during the same patient encounter Provide location modifier RT or LT.
76511	Ophthalmic ultrasound, diagnostic; quantitative A-scan only Provide location modifier RT or LT.
76512	Ophthalmic ultrasound, diagnostic; B-scan (with or without superimposed non-quantitative A-scan) Provide location modifier RT or LT.
76513	Ophthalmic ultrasound, diagnostic; anterior segment ultrasound, immersion (water bath) B-scan or high resolution biomicroscopy, unilateral or bilateralProvide location modifier RT or LT.
76514	Corneal pachymetry Allowable once per lifetime per patient. Allowable twice per lifetime with the following diagnoses: Z98.83 Filtering (vitreous) bleb after glaucoma surgery status Allowable once per 12-month period for the following diagnoses: H18.601- H18.603 Keratoconus, unspecified H18.611- H18.613 Keratoconus, stable H18.621 – H18.623 Keratoconus, unstable
76516	Ophthalmic biometry by ultrasound echography, A-scan
76519	Ophthalmic biometry by ultrasound echography, A-scan, with intraocular lens power calculation Provide location modifier RT or LT.
76529	Ophthalmic ultrasonic foreign body localization Provide location modifier RT or LT.
92020	Gonioscopy (separate procedure) Allowable once per 12-month period when visual necessity is established. Allowable twice per 12-month period for patients with the following diagnoses: E08.311 - E13.3599 Diabetes mellitus with diabetic retinopathy H34.00 - H34.9 Retinal Vascular Occlusion H40.001 - H40.063 Glaucoma Suspect H40.10X0 - H40.1194 Primary open-angle glaucoma H40.20X0 - H40.243 Primary Angle-closure Glaucoma H40.61X0 - H40.63X4 Glaucoma Secondary to Drugs Q15.0 Congenital Glaucoma

Code	Description
92025	Computerized corneal topography with interpretation and report Allowable once per 12-month period for the following diagnoses: H11.001 - H11.063 Pterygium H52.211 - H52.213 Irregular astigmatism Q13.4 Congenital anomalies of corneal size and shape Allowable twice per 12-month period for the following diagnoses: H16.001 - H16.073 Corneal ulcer H17.00 - H17.9 Corneal scars and opacities H18.11 - H18.13 Bullous keratopathy H18.20 Unspecified corneal edema H18.221 - H18.223 Other corneal edema H18.40 Corneal degeneration, unspecified H18.451 - H18.453 Nodular degeneration of cornea H18.461 - H18.463 Peripheral degenerations of cornea H18.49 Other corneal degenerations H18.501 - H18.599 Corneal dystrophies H18.601 - H18.623 Keratoconus H18.70 - H18.793 Other corneal deformities H18.831 - H18.833 Recurrent erosion of cornea T26.11XA - T26.12XS Burn of cornea and conjunctival sac T26.61XA - T26.62XS Corrosion of cornea and conjunctival sac Z94.7 Corneal transplant status
92060	Sensorimotor examination with multiple measurements of ocular deviation (e.g., restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure)
92071	Fitting of contact lens for treatment of ocular surface disease Allowable diagnosis codes: H16.101 - H16.103 Unspecified superficial keratitis H16.141 - H16.143 Punctate keratitis H16.9 Unspecified keratitis H18.11 - H18.13 Bullous keratopathy H18.511 - H18.519 Endothelial corneal dystrophy H18.541 - H18.549 Lattice corneal dystrophy H18.591 - H18.599 Other hereditary corneal dystrophies H18.831 - H18.833 Recurrent erosion cornea H18.821 - H18.823 Corneal disorder due to contact lens H18.451 - H18.453 Nodular corneal degeneration S05.00XA - S05.02XS Injury of conjunctiva and corneal abrasion without foreign body T15.00XA - T15.02XS Foreign body in cornea T85.318A - T85.318S Breakdown (mechanical) of other ocular prosthetic devices, implants and grafts T85.328A - T85.328S Displacement of other ocular prosthetic devices, implants and grafts T85.398A - T85.398S Other mechanical complication of other ocular prosthetic devices, implants and grafts T86.8401 – T86.8409 Corneal transplant rejection T86.8411 – T86.8419 Corneal transplant failure Z94.7 Corneal transplant status Provide location modifier RT or LT.
99070	Supplies are materials (except spectacles). Use for bandage contact lens only. Bill with 92071 only. Provide location modifier RT or LT.
92081-92083	Visual field exam, unilateral or bilateral, with interpretation and report Allowable twice per 12-month period when visual necessity is established. Bill with an appropriate medical diagnosis code.

Code	Description
92100	Serial tonometry with multiple measurements of intraocular pressure over an extended interval of time with interpretation and report, same day. See Special Handling Procedures for more information.
92132	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, bilateral Allowable up to two times per 12-month period for the following diagnoses: H17.01 - H17.03 Adherent leukoma H17.11 - H17.13 Central corneal opacity H17.811 - H17.813 Minor opacity of cornea H17.821 - H17.823 Peripheral opacity of cornea H17.89 Other corneal scars and opacities H17.9 Unspecified corneal scar and opacity H18.11 - H18.13 Bullous keratopathy H18.20 Unspecified corneal edema H18.211 - H18.213 Corneal edema secondary to contact lens H18.221 - H18.223 Idiopathic corneal edema H18.231 - H18.233 Secondary corneal edema H21.89 Other specified disorders of iris and ciliary body H22 Disorders of iris and ciliary body in diseases classified elsewhere H40.1210 - H40.1294 Low-tension glaucoma H40.1310 - H40.1394 Pigmentary glaucoma H40.1410 - H40.1494 Capsular glaucoma with pseudoexfoliation of lens H40.20X0 - H40.20X4 Unspecified primary angle-closure glaucoma H40.211 - H40.213 Acute angle-closure glaucoma H40.2210 - H40.2294 Chronic angle-closure glaucoma H40.231 - H40.233 Intermittent angle-closure glaucoma H40.241 - H40.243 Residual stage of angle-closure glaucoma H40.30X0 - H40.33X4 Glaucoma secondary to eye trauma H40.40X0 - H40.43X4 Glaucoma secondary to eye inflammation H40.50X0 - H40.53X4 Glaucoma secondary to other eye disorders H40.60X0 - H40.63X4 Glaucoma secondary to drugs H40.811 - H40.813 Glaucoma with increased episcleral venous pressure H40.821 - H40.823 Hypersecretion glaucoma H40.831 - H40.833 Aqueous misdirection H40.89 Other specified glaucoma H42 Glaucoma in diseases classified elsewhere

Code	Description
92133	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, bilateral; optic nerve Allowable once per 12-month period for the following diagnoses: E08.311 Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy with macular edema E08.319 Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy without macular edema E08.3211 – E08.3399 Diabetes mellitus due to underlying condition with diabetic retinopathy E09.3211 – E09.3399 Drug or chemical induced diabetes mellitus with diabetic retinopathy E10.311 Type 1 diabetes mellitus with unspecified diabetic retinopathy with macular edema E10.319 Type 1 diabetes mellitus with unspecified diabetic retinopathy without macular edema E10.3211 - E10.3219 Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema E10.3291 - E10.3299 Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema E10.3311 - E10.3319 Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema E10.3391 - E10.3399 Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema E11.311 Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema E11.319 Type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema E11.3211 - E11.3219 Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema E11.3291 - E11.3299 Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema E11.3311 - E11.3319 Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema E11.3391 - E11.3399 Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema E13.311 Other specified diabetes mellitus with unspecified diabetic retinopathy with macular edema E13.319 Other specified diabetes mellitus with unspecified diabetic retinopathy without macular edema E13.3211 - E13.3219 Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema E13.3291 - E13.3299 Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema E13.3311 - E13.3319 Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema E13.3391 - E13.3399 Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema H31.101 - H31.103 Choroidal degeneration H31.111 - H31.113 Age-related choroidal atrophy H31.121 - H31.123 Diffuse secondary atrophy of choroid H33.331 - H33.333 Multiple defects of retina without detachment H35.00 Unspecified background retinopathy H35.40 - H35.469 Peripheral retinal degeneration H35.50 Unspecified hereditary retinal dystrophy H35.51 Vitreoretinal dystrophy H35.52 Pigmentary retinal dystrophy H35.53 Other dystrophies primarily involving the sensory retina H35.54 Dystrophies primarily involving the retinal pigment epithelium H35.361 - H35.363 Drusen (degenerative) of macula H36 Retinal disorders in diseases classified elsewhere H46.01 - H46.03 Optic papillitis H46.11 - H46.13 Retrobulbar neuritis H46.2 Nutritional optic neuropathy H46.3 Toxic optic neuropathy H46.8 Other optic neuritis H46.9 Unspecified optic neuritis H47.011 - H47.013 Ischemic optic neuropathy H47.021 - H47.023 Hemorrhage in optic nerve sheath H47.031 - H47.033 Optic nerve hypoplasia H47.091 - H47.093 Other disorders of optic nerve, not elsewhere classified H47.10 - H47.13 Papilledema H47.141 - H47.143 Foster-Kennedy syndrome H47.20 - H47.299 Optic atrophy H47.311 - H47.313 Coloboma of optic disc H47.321 - H47.323 Drusen of optic disc H47.331 - H47.333 Pseudopapilledema of optic disc H47.391 - H47.393 Other disorders of optic disc H47.41 - H47.49 Disorders of optic chiasm

Code	Description
	H47.511 - H47.539 Disorders of visual pathways H47.611 - H47.619 Cortical blindness H47.621 - H47.649 Disorders of visual cortex H47.9 Unspecified disorder of visual pathways H53.40 - H53.489 Visual field defects Q15.0 Congenital glaucoma Allowable twice per 12-month period for the following diagnoses: D31.30 Benign neoplasm of unspecified choroid E08.3411 - E08.3599 Diabetes mellitus due to underlying condition with diabetic retinopathy E09.3411 - E09.3599 Drug or chemical induced diabetes mellitus with diabetic retinopathy E10.3411 - E10.3419 Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema E10.3491 - E10.3499 Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema E10.3511 - E10.3519 Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema E10.3521 - E10.3529 Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula E10.3531 - E10.3539 Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula E10.3541 - E10.3549 Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment E10.3551 - E10.3559 Type 1 diabetes mellitus with stable proliferative diabetic retinopathy E10.3591 - E10.3599 Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema E11.3411 - E11.3419 Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema E11.3491 - E11.3499 Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema E11.3511 - E11.3519 Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, unspecified eye E11.3521 - E11.3529 Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula E11.3531 - E11.3539 Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula E11.3541 - E11.3549 Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment E11.3551 - E11.3559 Type 2 diabetes mellitus with stable proliferative diabetic retinopathy E11.3591 - E11.3599 Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema E13.3411 - E13.3419 Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema E13.3491 - E13.3499 Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema E13.3511 - E13.3519 Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema E13.3521 - E13.3529 Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula E13.3531 - E13.3539 Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula E13.3541 - E13.3549 Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment E13.3551 - E13.3559 Other specified diabetes mellitus with stable proliferative diabetic retinopathy E13.3591 - E13.3599 Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema H33.001 - H33.059 Retinal detachment with retinal break H33.101 - H33.103 Unspecified retinoschisis H33.111 - H33.113 Cyst of ora serrate H33.191 - H33.193 Other retinoschisis and retinal cysts H33.21 - H33.23 Serous retinal detachment H33.301 - H33.303 Unspecified retinal break H33.311 - H33.313 Horseshoe tear of retina without detachment H33.321 - H33.323 Round hole H33.41 - H33.43 Traction detachment of retina H33.8 Other retinal detachments H34.00 - H34.9 Retinal vascular occlusion H35.011 - H35.079 Background retinopathy and retinal vascular changes H35.171 - H35.173 Retrolental fibroplasia H35.21 - H35.22 Other non-diabetic proliferative retinopathy H35.30 - H35.389 Degeneration of macula and posterior pole H35.61 - H35.63 Retinal hemorrhage H35.70 - H35.739 Separation of retinal layers

Code	Description
	H35.81 Retinal edema
	H35.82 Retinal ischemia
	H35.89 Other specified retinal disorders
	H35.9 Unspecified retinal disorder
	H40.001 - H40.9 Glaucoma
	H42 Glaucoma in diseases classified elsewhere
	H44.21 - H44.23 Degenerative myopia
	H44.2A - H44.2A9 Degenerative myopia with choroidal neovascularization
	H44.2B - H44.2B9 Degenerative myopia with macular hole
	H44.2C - H44.2C9 Degenerative myopia with retinal detachment
	H44.2D - H44.2D9 Degenerative myopia with foveoschisis
	H44.2E - H44.2E9 Degenerative myopia with other maculopathy
	Q14.2 Congenital malformation of optic disc
	Q14.3 Congenital malformation of choroid
	Q14.8 Other congenital malformations of posterior segment of eye
	Q15.0 Congenital glaucoma
	S05.10XA - S05.12XS Contusion of eyeball and orbital tissues
	Cannot be billed with extended ophthalmoscopy (initial or subsequent) or fundus photography.

Code	Description
92134	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, bilateral; retina Allowable once per 12-month period for the following diagnoses: E08.311 Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy with macular edema E08.319 Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy without macular edema E08.3211 – E08.3399 Diabetes mellitus due to underlying condition with diabetic retinopathy E09.3211 – E09.3399 Drug or chemical induced diabetes mellitus with diabetic retinopathy E10.311 Type 1 diabetes mellitus with unspecified diabetic retinopathy with macular edema E10.319 Type 1 diabetes mellitus with unspecified diabetic retinopathy without macular edema E10.3211 - E10.3219 Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema E10.3291 - E10.3299 Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema E10.3311 - E10.3319 Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema E10.3391 - E10.3399 Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema E11.311 Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema E11.319 Type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema E11.3211 - E11.3219 Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema E11.3291 - E11.3299 Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema E11.3311 - E11.3319 Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema E11.3391 - E11.3399 Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema E13.311 Other specified diabetes mellitus with unspecified diabetic retinopathy with macular edema E13.319 Other specified diabetes mellitus with unspecified diabetic retinopathy without macular edema E13.3211 - E13.3219 Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema E13.3291 - E13.3299 Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema E13.3311 - E13.3319 Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema E13.3391 - E13.3399 Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema H31.101 - H31.103 Choroidal degeneration H31.111 - H31.113 Age-related choroidal atrophy H31.121 - H31.123 Diffuse secondary atrophy of choroid H33.331 - H33.333 Multiple defects of retina without detachment H35.00 Unspecified background retinopathy H35.40 - H35.469 Peripheral retinal degeneration H35.50 Unspecified hereditary retinal dystrophy H35.51 Vitreoretinal dystrophy H35.52 Pigmentary retinal dystrophy H35.53 Other dystrophies primarily involving the sensory retina H35.54 Dystrophies primarily involving the retinal pigment epithelium H35.361 - H35.363 Drusen (degenerative) of macula H36 Retinal disorders in diseases classified elsewhere H46.01 - H46.03 Optic papillitis H46.11 - H46.13 Retrobulbar neuritis H46.2 Nutritional optic neuropathy H46.3 Toxic optic neuropathy H46.8 Other optic neuritis H46.9 Unspecified optic neuritis H47.011 - H47.013 Ischemic optic neuropathy H47.021 - H47.023 Hemorrhage in optic nerve sheath H47.031 - H47.033 Optic nerve hypoplasia H47.091 - H47.093 Other disorders of optic nerve, not elsewhere classified H47.10 - H47.13 Papilledema H47.141 - H47.143 Foster-Kennedy syndrome H47.20 - H47.299 Optic atrophy H47.311 - H47.313 Coloboma of optic disc H47.321 - H47.323 Drusen of optic disc H47.331 - H47.333 Pseudopapilledema of optic disc H47.391 - H47.393 Other disorders of optic disc H47.41 - H47.49 Disorders of optic chiasm

Code	Description
	H47.511 - H47.539 Disorders of visual pathways
	H47.611 - H47.619 Cortical blindness
	H47.621 - H47.649 Disorders of visual cortex
	H47.9 Unspecified disorder of visual pathways
	H53.40 - H53.489 Visual field defects
	L93.0 Discoid lupus erythematosus
	L93.2 Other local lupus erythematosus
	M05.40 or M05.49 Rheumatoid myopathy with rheumatoid arthritis
	M05.50 or M05.59 Rheumatoid polyneuropathy with rheumatoid arthritis
	M05.70 or M05.79 Rheumatoid arthritis with rheumatoid factor
	M05.80 or M05.89 Other rheumatoid arthritis with rheumatoid factor
	M05.9 Rheumatoid arthritis with rheumatoid factor, unspecified
	M06.00 or M06.09 Rheumatoid arthritis without rheumatoid factor
	M06.80 or M06.89 Other specified rheumatoid arthritis
	M06.9 Rheumatoid arthritis, unspecified
	Q15.0 Congenital glaucoma
	T37.2X1A - T37.2X4S Poisoning by antimalarials and drugs
	Z09 Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm
	Z79.84 Long term (current) use of oral hypoglycemic drugs
	Allowable twice per 12-month period for the following diagnoses:
	D31.30 Benign neoplasm of unspecified choroid
	E08.3411 - E08.3599 Diabetes mellitus due to underlying condition with diabetic retinopathy
	E09.3411 - E09.3599 Drug or chemical induced diabetes mellitus with diabetic retinopathy
	E10.3411 - E10.3419 Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
	E10.3491 - E10.3499 Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema
	E10.3511 - E10.3519 Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema
	E10.3521 - E10.3529 Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula
	E10.3531 - E10.3539 Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula
	E10.3541 - E10.3549 Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment
	E10.3551 - E10.3559 Type 1 diabetes mellitus with stable proliferative diabetic retinopathy
	E10.3591 - E10.3599 Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema
	E11.3411 - E11.3419 Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
	E11.3491 - E11.3499 Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema
	E11.3511 - E11.3519 Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, unspecified eye
	E11.3521 - E11.3529 Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula
	E11.3531 - E11.3539 Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula
	E11.3541 - E11.3549 Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment
	E11.3551 - E11.3559 Type 2 diabetes mellitus with stable proliferative diabetic retinopathy
	E11.3591 - E11.3599 Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema
	E13.3411 - E13.3419 Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
	E13.3491 - E13.3499 Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema
	E13.3511 - E13.3519 Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema
	E13.3521 - E13.3529 Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula
	E13.3531 - E13.3539 Other specified diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula
	E13.3541 - E13.3549 Other specified diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment
	E13.3551 - E13.3559 Other specified diabetes mellitus with stable proliferative diabetic retinopathy
	E13.3591 - E13.3599 Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema
	H33.001 - H33.059 Retinal detachment with retinal break
	H33.101 - H33.103 Unspecified retinoschisis
	H33.111 - H33.113 Cyst of ora serrate
	H33.191 - H33.193 Other retinoschisis and retinal cysts

Code	Description
	H33.21 - H33.23 Serous retinal detachment H33.301 - H33.303 Unspecified retinal break H33.311 - H33.313 Horseshoe tear of retina without detachment H33.321 - H33.323 Round hole H33.41 - H33.43 Traction detachment of retina H33.8 Other retinal detachments H34.00 - H34.9 Retinal vascular occlusion H35.011 - H35.079 Background retinopathy and retinal vascular changes H35.171 - H35.173 Retrolental fibroplasia H35.21 - H35.23 Other non-diabetic proliferative retinopathy H35.30 - H35.389 Degeneration of macula and posterior pole H35.61 - H35.63 Retinal hemorrhage H35.70 - H35.739 Separation of retinal layers H35.81 Retinal edema H35.82 Retinal ischemia H35.89 Other specified retinal disorders H35.9 Unspecified retinal disorder H40.001 - H40.9 Glaucoma H42 Glaucoma in diseases classified elsewhere H44.21 - H44.23 Degenerative myopia H44.2A - H44.2A9 Degenerative myopia with choroidal neovascularization H44.2B - H44.2B9 Degenerative myopia with macular hole H44.2C - H44.2C9 Degenerative myopia with retinal detachment H44.2D - H44.2D9 Degenerative myopia with foveoschisis H44.2E - H44.2E9 Degenerative myopia with other maculopathy Q14.2 Congenital malformation of optic disc Q14.3 Congenital malformation of choroid Q14.8 Other congenital malformations of posterior segment of eye Q15.0 Congenital glaucoma S05.10XA - S05.12XS Contusion of eyeball and orbital tissues Cannot be billed with extended ophthalmoscopy (initial or subsequent) or fundus photography.
92136	Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation

Code	Description
92201	Ophthalmoscopy, extended; with retinal drawing and scleral depression of peripheral retinal disease (e.g., for retinal tear, retinal detachment, retinal tumor) with interpretation and report, unilateral or bilateral • Allowable once per 12-month period for the below diagnoses.
92202	Ophthalmoscopy, extended, with drawing of optic nerve or macula (e.g., for glaucoma, macular pathology, tumor) with interpretation and report, unilateral or bilateral Allowable once per 12-month period for the following diagnoses: A39.82 Meningococcal retrobulbar neuritis A51.43 Secondary syphilitic oculopathy A52.19 Other symptomatic neurosyphilis B39.4 - B39.9 Histoplasmosis B58.01 Toxoplasma chorioretinitis C69.00 - C69.92 Malignant neoplasm of eye and adnexa D09.21 - D09.22 Carcinoma in situ D31.21 - D31.22 Benign neoplasm of retina D31.31 - D31.32 Benign neoplasm of choroid E08.311 - E08.3599 Diabetes mellitus due to underlying condition with diabetic retinopathy E09.311 - E09.3599 Drug or chemical induced diabetes mellitus with diabetic retinopathy E10.311 - E10.3599 Type 1 diabetes mellitus with diabetic retinopathy E10.36 Type 1 diabetes mellitus with diabetic cataract E10.39 Type 1 diabetes mellitus with other diabetic ophthalmic complication E10.65 Type 1 diabetes mellitus with hyperglycemia E11.311 - E11.3599 Type 2 diabetes mellitus with diabetic retinopathy E11.36 Type 2 diabetes mellitus with diabetic cataract E11.39 Type 2 diabetes mellitus with other diabetic ophthalmic complication E11.65 Type 2 diabetes mellitus with hyperglycemia E13.311 - E13.3599 Other specified diabetes mellitus with diabetic retinopathy E13.36 Other specified diabetes mellitus with diabetic cataract E13.39 Other specified diabetes mellitus with other diabetic ophthalmic complication H05.30 - H05.359 Deformity of the orbit H05.401 - H05.429 Enophthalmos H05.50 - H05.53 Retained (old) foreign body following penetrating wound H05.89 Other disorders of orbit H15.811 - H15.9 Other disorders of sclera H16.241 - H16.243 Ophthalmia nodosa H20.00 - H20.9 Iridocyclitis H21.00 - H21.9 Degeneration of iris and ciliary body H21.331 - H21.333 Parasitic cyst of iris, ciliary body or anterior chamber H22 Disorders of iris and ciliary body in diseases classified elsewhere H30.001 - H30.93 Chorioretinal inflammations H31.101 - H31.129 Choroidal degeneration H33.001 - H33.8 Retinal detachments and breaks H34.00 - H34.9 Retinal vascular occlusion H35.00 - H36 Other retinal disorders H40.001 - H40.9 Glaucoma H42 Glaucoma in diseases classified elsewhere H43.00 - H43.9 Disorders of vitreous body H44.001 - H44.029 Purulent endophthalmitis H44.111 - H44.9 Disorders of the globe H46.00 - H46.9 Optic neuritis H47.011 - H47.099 Disorders of optic nerve, not elsewhere classified H47.10 - H47.149 Papilledema H47.20 - H47.299 Optic atrophy H47.311 - H47.399 Other disorders of optic disc H47.41 - H47.49 Disorders of optic chiasm M05.40 Rheumatoid myopathy with rheumatoid arthritis of unspecified site

Code	Description
	M05.49 Rheumatoid myopathy with rheumatoid arthritis of multiple sites M05.50 Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified site M05.59 Rheumatoid polyneuropathy with rheumatoid arthritis of multiple sites M05.70 Rheumatoid arthritis with rheumatoid factor of unspecified site without organ or systems involvement M05.79 Rheumatoid arthritis with rheumatoid factor of multiple sites without organ or systems involvement M05.80 Other rheumatoid arthritis with rheumatoid factor of unspecified site M05.89 Other rheumatoid arthritis with rheumatoid factor of multiple sites M05.9 Rheumatoid arthritis with rheumatoid factor, unspecified M06.00 Rheumatoid arthritis without rheumatoid factor, unspecified site M06.09 Rheumatoid arthritis without rheumatoid factor, multiple sites M06.80 Other specified rheumatoid arthritis, unspecified site M06.89 Other specified rheumatoid arthritis, multiple sites M06.9 Rheumatoid arthritis, unspecified M08.00 Unspecified juvenile rheumatoid arthritis of unspecified site M08.09 Unspecified juvenile rheumatoid arthritis, multiple sites M08.20 Juvenile rheumatoid arthritis with systemic onset, unspecified site M08.29 Juvenile rheumatoid arthritis with systemic onset, multiple sites M08.3 Juvenile rheumatoid polyarthritis (seronegative) M08.40 Pauciarticular juvenile rheumatoid arthritis, unspecified site M08.89 Other juvenile arthritis, multiple sites M35.2 Behcet's disease Q14.0 - Q14.9 Congenital malformation Q15.0 Congenital glaucoma Q85.00 - Q85.02 Neurofibromatosis S05.10XA - S05.12XS Contusion of eye and adnexa S05.50XA - S05.52XS Penetrating wound with foreign body S05.60XA - S05.62XS Penetrating wound without foreign body S05.8X1A - S05.92XS Other injuries of eye and orbit Do not report 92201, 92202 in conjunction with 92250 (fundus photography)
92227	Imaging of retina for detection or monitoring of disease; with remote clinical staff review and report, unilateral or bilateral Allowable once per 12-month period. Do not report 92227 in conjunction with 92002-92014, 92133, 92134, 92250, 92228 or with the evaluation and management of the single organ system, the eye, 99202-99350.
92228	Imaging of retina for detection or monitoring of disease; with remote physician or other qualified health care professional interpretation and report, unilateral or bilateral Do not report 92228 in conjunction with 92002-92014, 92133, 92134, 92250, 92227 or with the evaluation and management of the single organ system, the eye, 99202-99350.
92250	Fundus photography with interpretation and report Allowable once per 12-month period. Allowable twice per 12-month period for the following diagnoses: E08.311 - E08.3599 Diabetes mellitus due to underlying condition with diabetic retinopathy E09.311 - E09.3599 Drug or chemical induced diabetes mellitus with diabetic retinopathy E10.311 - E10.3599 Type 1 diabetes mellitus with diabetic retinopathy E11.311 - E11.3599 Type 2 diabetes mellitus with diabetic retinopathy E13.311 - E13.3599 Other specified diabetes mellitus with diabetic retinopathy H30.001 - H30.93 Chorioretinal inflammations H31.001 - H31.9 Other disorders of the choroid H32 Chorioretinal disorders in diseases classified elsewhere H33.001 - H33.8 Retinal detachments and breaks H34.00 - H34.9 Retinal vascular occlusion H35.00 - H36 Other retinal disorders Cannot be billed with extended ophthalmoscopy (initial or subsequent) or scanning computerized ophthalmic diagnostic imaging (of optic nerve or retina).

Code	Description
92250/52	Diabetic retinal screening (baseline imaging to confirm the absence of diabetic eye disease) Allowable once per 12-month period for Signature, Choice, and Advantage Plan patients who have diabetes without diabetic eye disease. Use CPT code 92250 with modifier 52 Bill diagnosis code Z13.5 in the primary position and diagnosis code E10.9, E11.9 or E13.9 in the secondary position. Z13.5 Encounter for screening for eye and ear disorders E10.9 - Type 1 diabetes mellitus without complications E11.9 - Type 2 diabetes mellitus without complications E13.9 - Other specified diabetes mellitus without complications Diabetic retinal screening is reimbursed $39 (or your U&C fee when less than $39). Medicaid members are not eligible for diabetic retinal screening. Medicaid covers fundus photography with interpretation and report with medical necessity.
92260	Ophthalmodynamometry Service Allowance: Allowable once per 12-month period
92270	Electro-oculography with interpretation and report Service Allowance: Allowable once per 12-month period.
92273	Electroretinography (ERG), with interpretation and report; full field (i.e., ffERG, flash ERG, Ganzfeld ERG) Allowable once per 12-month period, as medically necessary. Provide location modifier RT or LT.
92274	Electroretinography (ERG), with interpretation and report; multifocal (mfERG) Allowable once per 12-month period, as medically necessary. Provide location modifier RT or LT.
92283	Color vision exam, extended Service Allowance: Allowable once per 12-month period as medically necessary.
92284	Dark adaptation exam with interpretation and report Service Allowance: Allowable once per 12-month period.
92285	External ocular photography with interpretation and report for documentation medical progress. Not allowed for pre-cataract diagnoses. Provide location modifier RT or LT.
92286	Anterior segment imaging with interpretation and report; with specular microscopy and endothelial cell analysis Only covered for the following diagnoses: H18.11 - H18.13 Bullous keratopathy H18.51 Fuch's Dystrophy H18.511 - H18.519 Endothelial corneal dystrophy Provide location modifier RT or LT.
92287	Anterior segment imaging with interpretation and report; with fluorescein angiography Provide location modifier RT or LT.

Code	Description
92499	Exam with refraction for diabetic patients only who experience vision shifts of ± 1.00 diopters or greater in at least one eye due to diabetes medications (must be documented in the patient's file). Cannot be billed with another exam service on the same day. Refraction not reimbursed separately; payment is bundled with exam. If applicable, bill the diagnosis code with the correct eye location: left, right or bilateral. Allowable once per 12-month period for the following diagnoses: E10.311 Type 1 diabetes mellitus with unspecified diabetic retinopathy with macular edema E10.319 Type 1 diabetes mellitus with unspecified diabetic retinopathy without macular edema E10.3211 - E10.3219 Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema E10.3291 - E10.3299 Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema E10.3311 - E10.3319 Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema E10.3391 - E10.3399 Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema E10.3411 - E10.3419 Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema E10.3491 - E10.3499 Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema E10.3511 - E10.3519 Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema E10.3521 - 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Code	Description
	H21.1X3 Other vascular disorders of iris and ciliary body (rubeosis iridis), bilateral
95930	Visual evoked potential (VEP) checkerboard or flash testing, central nervous system except glaucoma, with interpretation and report. Service Allowance: Allowable once per 12-month period. VSP will not reimburse fundus photography, extended ophthalmoscopy (initial or subsequent) or scanning computerized ophthalmic diagnostic imaging (of optic nerve or retina) on the same day as VEP testing.

Multiple surgical procedure payment reduction rules apply to the following:

Code	Description
65205	Removal of foreign body, external eye; conjunctival superficial Provide location modifier RT or LT.
65210	Removal of foreign body, external eye; conjunctival embedded, subconjunctival or scleral nonperforating Provide location modifier RT or LT.
65220	Removal of foreign body, external eye; corneal, without slit lamp Provide location modifier RT or LT.
65222	Removal of foreign body, external eye; corneal, with slit lamp Provide location modifier RT or LT.
65430	Scraping of cornea, diagnostic, for smear and/or culture Provide location modifier RT or LT.
65435	Removal of corneal epithelium; with or without chemocauterization (abrasion, curettage) Provide location modifier RT or LT.
67820	Correction of trichiasis; epilation, by forceps only Provide location modifier E1, E2, E3 or E4.
67938	Removal of embedded foreign body, eyelid Provide location modifier RT or LT.
68020	Incision of conjunctiva, drainage of cyst Provide location modifier E1, E2, E3 or E4.
68040	Expression of conjunctival follicles (eg, for trachoma) Provide location modifier E1, E2, E3 or E4
68761	Closure of lacrimal punctum; by plug, each Allowable diagnosis codes: H04.11 - H04.9 Disorders of lacrimal system H16.141 - H16.143 Punctate keratitis H16.221 - H16.223, H11.821 – H11.823, H04.829 Keratoconjunctivitis sicca, not specified as Sjogren's M35.00 – M35.03 Sjogren syndrome Temporary plugs are limited to one, per eyelid, in a 24-month period. Maximum of four (4) per lifetime. Permanent plugs are limited to one, per eyelid, in a 24-month period. Two additional plugs may be authorized if medically necessary; however, VSP will not reimburse more than two plugs per eyelid. Maximum of six (6) per lifetime. Bill the appropriate modifiers E1 (upper lid, left); E2 (lower lid, left); E3 (upper lid, right); or E4 (lower lid, right). Use modifier SC to report temporary plugs. Reimbursement Standard rules for coding a minor surgical procedure apply. Punctal occlusion by plug carries a 10-day global period. All services necessary to complete the procedure, are included in the payment for the procedure. Reimbursement for a minor surgical procedure includes the preoperative visit on the day of surgery, postoperative visits related to recovery, and supplies. Exam services (920XX or 992XX) and local anesthesia is also included in the procedure and should not be reported separately. Punctal occlusion is a unilateral procedure and reimbursement is per punctum. When two puncta are occluded at the same session, multiple surgery rules apply. Use modifier 51 (multiple procedures) when more than one punctum is occluded during the same session
68801	Dilation of lacrimal punctum, with or without irrigation Provide location modifier RT or LT.
68810	Probing of nasolacrimal duct, with or without irrigation Provide location modifier RT or LT.

Code	Description
68815	Probing of nasolacrimal duct, with or without irrigation; with insertion of tube or stent Provide location modifier RT or LT.

Code	Description
83516	Immunoassay for analyte other than infectious agent antibody or infectious agent antigen; qualitative or semiquantitative, multiple step method If applicable, bill the diagnosis code with the correct eye location: left, right or bilateral. Allowable diagnosis codes include, but are not limited to, the following: H00.021 - H00.029 Hordeolum internum H01.011 - H01.019 Ulcerative blepharitis H01.01A - Ulcerative blepharitis right eye, upper and lower eyelids H01.01B - Ulcerative blepharitis left eye, upper and lower eyelids H02.031 - H02.039 Senile entropion H02.101 - H02.109 Unspecified ectropion H04.121 - H04.129 Dry eye syndrome H04.211 - H04.229 Epiphora H04.421 - H04.429 Chronic lacrimal canaliculitis H04.521 - H04.529 Eversion H04.561 - H04.569 Stenosis H10.521 - H10.539 Blepharoconjunctivitis H16.121 - H16.123 Filamentary keratitis H16.221 - H16.223 Keratoconjunctivitis sicca, not specified as Sjogren's H18.831 - H18.833 Recurrent erosion of cornea H40.10X0 - H40.1194 Primary open-angle glaucoma M35.00 - M35.03 Sjogren syndrome Use modifier QW - Clinical Laboratory Improvement Amendment (CLIA) waived test. Provide location modifier RT and/or LT. When billing for both eyes, code 83516 twice, on two lines, for 1-unit of service each, as follows: 83516-QW-RT 83516-QW-LT
83861	Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolarity If applicable, bill the diagnosis code with the correct eye location: left, right or bilateral. Allowable diagnosis codes include, but are not limited to, the following: H00.021 - H00.029 Hordeolum internum H01.011 - H01.019 Ulcerative blepharitis H01.01A - Ulcerative blepharitis right eye, upper and lower eyelids H01.01B - Ulcerative blepharitis left eye, upper and lower eyelids H02.031 - H02.039 Senile entropion H02.101 - H02.109 Unspecified ectropion H04.121 - H04.129 Dry eye syndrome H04.211 - H04.229 Epiphora H04.421 - H04.429 Chronic lacrimal canaliculitis H04.521 - H04.529 Eversion H04.561 - H04.569 Stenosis H10.521 - H10.539 Blepharoconjunctivitis H16.121 - H16.123 Filamentary keratitis H16.221 - H16.223 Keratoconjunctivitis sicca, not specified as Sjogren's H18.831 - H18.833 Recurrent erosion of cornea H40.10X0 - H40.1194 Primary open-angle glaucoma M35.00 - M35.03 Sjogren syndrome Use modifier QW - Clinical Laboratory Improvement Amendment (CLIA) waived test. Provide location modifier RT and/or LT. When billing for both eyes, code 83861 twice, on two lines, for 1-unit of service each, as follows: 83861-QW-RT 83861-QW-LT

Code	Description
87809	Infectious agent antigen detection by immunoassay with direct optical observation; Adenovirus Allowable diagnosis codes: H10.011 - H10.029 Mucopurulent conjunctivitis H10.11 - H10.13 Acute atopic conjunctivitis H10.221 - H10.223 Pseudomembranous conjunctivitis H10.231 - H10.233 Serous conjunctivitis H10.31 - H10.33 Unspecified acute conjunctivitis H10.401 - H10.403 Unspecified chronic conjunctivitis H10.411 - H10.413 Chronic giant papillary conjunctivitis H10.421 - H10.423 Simple chronic conjunctivitis H10.431 - H10.433 Chronic follicular conjunctivitis H10.44 Vernal conjunctivitis H10.45 Other chronic allergic conjunctivitis H10.89 Other conjunctivitis H16.261 - H16.263 Vernal keratoconjunctivitis Use modifier QW - Clinical Laboratory Improvement Amendment (CLIA) waived test. Provide location modifier RT and/or LT. When billing for both eyes, code 87809 twice, on two lines, for 1-unit of service each, as follows: 87809-QW-RT 87809-QW-LT

Services received from a VSP network provider when medical eye care services are required for urgent or emergency care. Urgent and/or emergency facility charges are not covered.

Code	Description
99050	Service(s) provided in the office at times other than regularly scheduled office hours, or day when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service
99051	Service(s) provided in the office during regularly scheduled evening, weekend or holiday office hours, in addition to basic service
99058	Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services in addition to basic service

Use the following codes to indicate established patient, patient initiated, online digital evaluation. Limited to one online evaluation and management code per seven-day period, per chief complaint. Cannot lead to another medical visit in the next 24 hours.

Code	Description
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
99422	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes
99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes

Use the following codes to indicate established patient, patient initiated, telephone evaluation. Limited to one telephone evaluation and management code per seven-day period, per chief complaint. Cannot lead to another medical visit in the next 24 hours.

Do not report these services in conjunction with 99202-99205, 99212-99215, 99241-99245, or 99421-99423.

Code	Description
99441	Telephone evaluation and management service, for established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes Do not report 99441 in conjunction with 99202-99205, 99212-99215, 99241-99245, or 99421-99423
99442	Telephone evaluation and management service, for an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes Do not report 99442 in conjunction with 99202-99205, 99212-99215, 99241-99245, or 99421-99423
99443	Telephone evaluation and management service, for an established patient not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes Do not report 99443 in conjunction with 99202-99205, 99212-99215, 99241-99245, or 99421-99423

Use the following codes to report your office's consultation services only when requested by another physician. Allowable once per patient, per seven-day period. Service is not reported if the patient was seen by the consultant physician within the past 14 days.

Code	Description
99446	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review
99447	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 11-20 minutes of medical consultative discussion and review
99448	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 21-30 minutes of medical consultative discussion and review
99449	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 31 minutes or more of medical consultative discussion and review
99451	Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a written report to the patient's treating/requesting physician or other qualified health-care professional, five or more minutes of medical consultative time.
99452	Interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health-care professional, 30 minutes. Reported by the physician who is treating the patient and requesting the non-face-to-face consult for medical advice or opinion (not for a transfer of care or a face-to-face consult).

Procedure	Special Handling Procedures
92201-92202	Extended ophthalmoscopy is included in the global reimbursement for retinal surgery. Extended ophthalmoscopy (direct or binocular indirect) may not be billed separately during an exam except when **all** of the following conditions are met: patient's presenting symptoms and/or diagnosis of retinal or vitreoretinal problems support the need for extended ophthalmoscopy. The medical record indicates that extended ophthalmoscopy was performed. Dilated retinal evaluation with direct or binocular indirect ophthalmoscopy does not constitute extended ophthalmoscopy unless additional procedures (e.g., contact lens or three mirror evaluations) were required. Additional procedures must be clearly indicated in the patient's chart. The medical record should contain a detailed drawing that describes the retina, including defects. The drawing does not have to accompany the claim but should be available for review upon request.
92250 Fundus Photography with Interpretation and Report	Fundus photography is a procedure in which bilateral photographs of the retina are obtained for diagnostic purposes. Coverage is provided when fundus photography is: Performed during initial glaucoma care, if: 1. intraocular pressures are clearly documented in the patient's medical record and are at or above 21 mm Hg; or 2. intraocular pressures are between 15 and 20 mm Hg and there is clear funduscopic evidence of glaucomatous optic nerve damage (such as abnormal cup size, thinning or notching of the disc rim, progressive change, disc hemorrhage or nerve fiber layer defects). In either instance, repeat studies by the same doctor are covered if submitted at greater than one-year intervals, unless there are other clinical indications to justify the study. Preglaucoma, borderline glaucoma and glaucoma are generally slow disease processes that can be followed by modalities other than fundus photography. Used in evaluating rapid, progressive diabetic retinopathy. In this instance, coverage is provided only when there is no prior retinal laser surgery and photography is not performed more than once every six months. Fundus photography is not covered if used to evaluate stable or minimal diabetic retinopathy.
95930 Visually evoked potential (VEP) checkerboard or flash testing, central nervous system except glaucoma, with interpretation and report	Visual evoked potentials (VEPs) are appropriate for 1) detecting optic neuritis at an early, subclinical stage, and 2) evaluating the following diseases of the optic nerve: Ischemic optic neuropathy Pseudotumor cerebri Toxic amblyopias Nutritional amblyopias Neoplasms compressing the anterior visual pathways Optic nerve injury or atrophy Hysterical blindness (to rule out) The patient's medical record must contain documentation that fully supports the visual necessity for VEPs, including, but not limited to, relevant medical history, physical examination and results of pertinent diagnostic tests or procedures. If your technician is certified, a VEP test may be performed under general supervision (the doctor is not immediately available). If your technician is not certified, a VEP test must be performed with direct supervision (doctor is immediately available).

VSP Diabetic Eyecare Plus Program℠

The Diabetic Eyecare Plus Program is designed to provide supplemental medical eye care services for members with diabetes, diabetic eye disease, glaucoma, or age-related macular degeneration (AMD). Diabetic Eyecare Plus coverage is secondary to other medical eye insurance coverage that may reimburse you, if you are a participating provider with the patient's medical plan. Please refer to Coordination of Benefits section for more information.

Covered-in-full retinal screening (use CPT code 92250 and modifier 52) is available to patients who have diabetes but don't show signs of diabetic eye disease. There is no copay for the member and VSP will reimburse $39.00 or your U&C fees, whichever is lower. Retinal screening (photos) can be billed on the same day as the WellVision® exam, under the Diabetic Eyecare Plus authorization. For additional information, refer to **retinal screening** in the detailed list of covered services below.

Members with type 1 and type 2 diabetes need an annual eye exam that includes dilation to allow for the most thorough examination of the retina and optic nerve. If diabetic eye disease (e.g., diabetic retinopathy or rubeosis) is detected during a comprehensive exam and follow-up care is needed, additional medical eye care services are available under VSP's Diabetic Eyecare Plus Program to track and monitor diabetic eye disease progression.

Additional medical eye care services available for patients with diabetes **and** diabetic eye disease include:

- medical follow-up exams
- fundus photography with interpretation and report
- extended ophthalmoscopy
- scanning computerized ophthalmic diagnostic imaging (SCODI) including optical coherence tomography (OCT)
- remote imaging for detection, monitoring and management of retinal disease
- one additional exam with refraction for changes in vision due to diabetes medication(s).

Coverage is also available for VSP members with glaucoma and/or age-related macular degeneration (AMD) including:

- medical follow-up exams
- Scanning computerized ophthalmic diagnostic imaging (SCODI) including optical coherence tomography (OCT)
- visual field and acuity tests
- tonometry (used to monitor and measure intraocular pressure)
- gonioscopy (examines the drainage angle of the eye)
- pachymetry (process of measuring the thickness of the cornea)

Copays, if required, apply to exams only (92002-92014, 99202-99205, 99211-99215, 99421-99423, 99441-99443). Copays do not apply to additional professional services (e.g., retinal screening). A patient's copay amount should never exceed your VSP payable fee for the service provided.

Check the Patient Record Report to confirm Diabetic Eyecare Plus coverage. Patients don't need a primary care physician's referral before their visit. Patients can make appointments or be seen immediately. Refer ineligible patients back to their medical primary care doctors, unless you participate on their medical plan panel. Patients choosing non-covered services should be informed of any out-of-pocket cost and asked to sign the Patient Responsibility Statement prior to receiving services. You can find the form under the **Forms** section of the **Administration** menu on **VSPOnline** on **eyefinity.com**

Enter the specific procedure code and related diagnosis code(s), when completing the claim online or manually on the **CMS-1500 Claim Form**. For full procedure code descriptions, refer to the Current Procedural Terminology (CPT®) maintained by the American Medical Association (AMA).

Reminders:

- Diabetic Eyecare Plus services must be submitted on a separate authorization from routine vision claims.
- Report only those services appropriate for your licensure and your state's current regulations.
- Code to the highest degree of specificity when indicating diagnosis.
- When applicable, bill the diagnosis code with the correct eye location: left, right or bilateral.
- If evaluation and management services are performed remotely, bill the CPT code with a GQ or 95 modifier, as appropriate

Note: VSP recognizes but does not currently support Place of Service (POS) code 02 for reporting telehealth services rendered from a distant site except when submitted on paper as a secondary for coordination of benefits. Additionally, VSP recognizes but does not currently support POS code 10 for reporting telehealth services provided in patient's home.
Modifiers GQ or 95 are used to identify telemedicine services, as appropriate. Modifiers are used for information purposes only.

- Standard timely filing guidelines apply.
- When billing eye exams or other services for patients with diabetes, remember to include code 3072F to indicate no evidence of retinopathy in the prior year, when applicable. Data collection codes, including 3072F, should be billed with a $0.00 amount.

Reimbursement for eye exams will meet your current VSP Signature Plan payable fees. For retinal screening (photos) you'll be reimbursed $39.00 or your U&C fees, whichever is lower. Approved additional services are reimbursed at 80% of your U&C fee, up to the VSP Primary EyeCare maximum allowables.

Note: For more information about the Interpretation and Report requirement for medical procedures, refer to Guidelines for the Interpretation and Report of Diagnostic Procedures.

Coordination of benefits (COB) applies to the payment of medical eyecare benefits when a member is covered under two or more benefit plans. If a member has medical benefits under a medical health insurance plan that you're contracted with, that plan is primary and VSP is secondary. In the event VSP is the secondary payer, VSP may be billed for the member's out-of-pocket expenses. Examples are copayments, deductibles, charges for noncovered services, or charges for services not covered in full by the primary carrier. Providers are responsible for verifying coverage, as well as billing the other carrier(s).

See Coordination of Benefits section for more information about how to coordinate benefits.

Medical Follow-Up Exam	
92002, 92004, 92012, 92014, 99202 - 99205, 99211 - 99215	**Service Allowance:** Allowable once per 12-month period for patients with type 1 or type 2 diabetes and diabetic retinopathy or rubeosis. Use the diagnosis codes below which include both diabetes and diabetic retinopathy. For rubeosis, include a rubeosis and a 1 or type 2 diabetes diagnosis code. If applicable, bill the diagnosis code with the correct eye location: left, right or bilateral. **Type 1 diabetes mellitus with diabetic retinopathy** E10.311 Type 1 diabetes mellitus with unspecified diabetic retinopathy with macular edema E10.319 Type 1 diabetes mellitus with unspecified diabetic retinopathy without macular edema E10.3211 - E10.3219 Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema E10.3291 - E10.3299 Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema E10.3311 - E10.3319 Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema E10.3391 - E10.3399 Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema E10.3411 - E10.3419 Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema E10.3491 - E10.3499 Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema E10.3511 - E10.3519 Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema E10.3521 - E10.3529 Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula E10.3531 - E10.3539 Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula E10.3541 - E10.3549 Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment E10.3551 - E10.3559 Type 1 diabetes mellitus with stable proliferative diabetic retinopathy E10.3591 - E10.3599 Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema **Type 2 diabetes mellitus with diabetic retinopathy** E11.311 Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema E11.319 Type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema E11.3211 - E11.3219 Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema E11.3291 - E11.3299 Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema E11.3311 - E11.3319 Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema E11.3391 - E11.3399 Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema E11.3411 - E11.3419 Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema E11.3491 - E11.3499 Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema E11.3511 - E11.3519 Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, unspecified eye E11.3521 - E11.3529 Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula E11.3531 - E11.3539 Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula E11.3541 - E11.3549 Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment E11.3551 - E11.3559 Type 2 diabetes mellitus with stable proliferative diabetic retinopathy E11.3591 - E11.3599 Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema

Rubeosis iridis

H21.1X1 Other vascular disorders of iris and ciliary body, right eye (rubeosis iridis)

H21.1X2 Other vascular disorders of iris and ciliary body, left eye (rubeosis iridis)

H21.1X3 Other vascular disorders of iris and ciliary body, bilateral (rubeosis iridis)

Type 1 diabetes mellitus

E10.10 Type 1 diabetes mellitus with ketoacidosis without coma*

E10.21 Type 1 diabetes mellitus with diabetic nephropathy*

E10.22 Type 1 diabetes mellitus with diabetic chronic kidney disease*

E10.29 Type 1 diabetes mellitus with other diabetic kidney complication*

E10.36 Type 1 diabetes mellitus with diabetic cataract*

E10.39 Type 1 diabetes mellitus with other diabetic ophthalmic complication*

E10.40 Type 1 diabetes mellitus with diabetic neuropathy, unspecified*

E10.41 Type 1 diabetes mellitus with diabetic mononeuropathy*

E10.42 Type 1 diabetes mellitus with diabetic polyneuropathy*

E10.43 Type 1 diabetes mellitus with diabetic autonomic (poly)neuropathy*

E10.44 Type 1 diabetes mellitus with diabetic amyotrophy*

E10.49 Type 1 diabetes mellitus with other diabetic neurological complication*

E10.51 Type 1 diabetes mellitus with diabetic peripheral angiopathy without gangrene*

E10.59 Type 1 diabetes mellitus with other circulatory complications*

E10.610 Type 1 diabetes mellitus with diabetic neuropathic arthropathy*

E10.618 Type 1 diabetes mellitus with other diabetic arthropathy*

E10.620 Type 1 diabetes mellitus with diabetic dermatitis*

E10.621 Type 1 diabetes mellitus with foot ulcer*

E10.622 Type 1 diabetes mellitus with other skin ulcer*

E10.628 Type 1 diabetes mellitus with other skin complications*

E10.630 Type 1 diabetes mellitus with periodontal disease*

E10.638 Type 1 diabetes mellitus with other oral complications*

E10.649 Type 1 diabetes mellitus with hypoglycemia without coma*

E10.65 Type 1 diabetes mellitus with hyperglycemia*

E10.69 Type 1 diabetes mellitus with other specified complication*

E10.8 Type 1 diabetes mellitus with unspecified complications*

Medical Follow-Up Exam

Type 2 diabetes mellitus

E11.00 Type 2 diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma*

E11.10 Type 2 diabetes mellitus with ketoacidosis without coma*

E11.21 Type 2 diabetes mellitus with diabetic nephropathy*

E11.22 Type 2 diabetes mellitus with diabetic chronic kidney disease*

E11.29 Type 2 diabetes mellitus with other diabetic kidney complication*

E11.36 Type 2 diabetes mellitus with diabetic cataract*

E11.39 Type 2 diabetes mellitus with other diabetic ophthalmic complication*

E11.40 Type 2 diabetes mellitus with diabetic neuropathy, unspecified*

E11.41 Type 2 diabetes mellitus with diabetic mononeuropathy*

E11.42 Type 2 diabetes mellitus with diabetic polyneuropathy*

E11.43 Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy*

E11.44 Type 2 diabetes mellitus with diabetic amyotrophy*

E11.49 Type 2 diabetes mellitus with other diabetic neurological complication*

E11.51 Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene*

E11.59 Type 2 diabetes mellitus with other circulatory complications*

E11.610 Type 2 diabetes mellitus with diabetic neuropathic arthropathy*

E11.618 Type 2 diabetes mellitus with other diabetic arthropathy*

E11.620 Type 2 diabetes mellitus with diabetic dermatitis*

E11.621 Type 2 diabetes mellitus with foot ulcer*

E11.622 Type 2 diabetes mellitus with other skin ulcer*

E11.628 Type 2 diabetes mellitus with other skin complications*

E11.630 Type 2 diabetes mellitus with periodontal disease*

E11.638 Type 2 diabetes mellitus with other oral complications*

E11.649 Type 2 diabetes mellitus with hypoglycemia without coma*

E11.65 Type 2 diabetes mellitus with hyperglycemia*

E11.69 Type 2 diabetes mellitus with other specified complication*

E11.8 Type 2 diabetes mellitus with unspecified complications*

*Not billable in primary position

Medical Follow-Up Exam	
92020	**Gonioscopy** **Service Allowance:** Allowable once per 12-month period for patients with type 1 or type 2 diabetes and rubeosis. Use the diagnosis codes below. Include both rubeosis and diabetes diagnosis codes. **Rubeosis iridis** H21.1X1 Other vascular disorders of iris and ciliary body, right eye (rubeosis iridis) H21.1X2 Other vascular disorders of iris and ciliary body, left eye (rubeosis iridis) H21.1X3 Other vascular disorders of iris and ciliary body, bilateral (rubeosis iridis) **Type 1 diabetes mellitus** E10.10 Type 1 diabetes mellitus with ketoacidosis without coma* E10.21 Type 1 diabetes mellitus with diabetic nephropathy* E10.22 Type 1 diabetes mellitus with diabetic chronic kidney disease* E10.29 Type 1 diabetes mellitus with other diabetic kidney complication* E10.36 Type 1 diabetes mellitus with diabetic cataract* E10.39 Type 1 diabetes mellitus with other diabetic ophthalmic complication* E10.40 Type 1 diabetes mellitus with diabetic neuropathy, unspecified* E10.41 Type 1 diabetes mellitus with diabetic mononeuropathy* E10.42 Type 1 diabetes mellitus with diabetic polyneuropathy* E10.43 Type 1 diabetes mellitus with diabetic autonomic (poly)neuropathy* E10.44 Type 1 diabetes mellitus with diabetic amyotrophy* E10.49 Type 1 diabetes mellitus with other diabetic neurological complication* E10.51 Type 1 diabetes mellitus with diabetic peripheral angiopathy without gangrene* E10.59 Type 1 diabetes mellitus with other circulatory complications* E10.610 Type 1 diabetes mellitus with diabetic neuropathic arthropathy* E10.618 Type 1 diabetes mellitus with other diabetic arthropathy* E10.620 Type 1 diabetes mellitus with diabetic dermatitis* E10.621 Type 1 diabetes mellitus with foot ulcer* E10.622 Type 1 diabetes mellitus with other skin ulcer* E10.628 Type 1 diabetes mellitus with other skin complications* E10.630 Type 1 diabetes mellitus with periodontal disease* E10.638 Type 1 diabetes mellitus with other oral complications* E10.649 Type 1 diabetes mellitus with hypoglycemia without coma* E10.65 Type 1 diabetes mellitus with hyperglycemia* E10.69 Type 1 diabetes mellitus with other specified complication* E10.8 Type 1 diabetes mellitus with unspecified complications*

Medical Follow-Up Exam	
	Type 2 diabetes mellitus E11.00 Type 2 diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma * E11.10 Type 2 diabetes mellitus with ketoacidosis without coma* E11.21 Type 2 diabetes mellitus with diabetic nephropathy* E11.22 Type 2 diabetes mellitus with diabetic chronic kidney disease* E11.29 Type 2 diabetes mellitus with other diabetic kidney complication* E11.36 Type 2 diabetes mellitus with diabetic cataract* E11.39 Type 2 diabetes mellitus with other diabetic ophthalmic complication* E11.40 Type 2 diabetes mellitus with diabetic neuropathy, unspecified* E11.41 Type 2 diabetes mellitus with diabetic mononeuropathy* E11.42 Type 2 diabetes mellitus with diabetic polyneuropathy* E11.43 Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy* E11.44 Type 2 diabetes mellitus with diabetic amyotrophy* E11.49 Type 2 diabetes mellitus with other diabetic neurological complication* E11.51 Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene* E11.59 Type 2 diabetes mellitus with other circulatory complications* E11.610 Type 2 diabetes mellitus with diabetic neuropathic arthropathy* E11.618 Type 2 diabetes mellitus with other diabetic arthropathy* E11.620 Type 2 diabetes mellitus with diabetic dermatitis* E11.621 Type 2 diabetes mellitus with foot ulcer* E11.622 Type 2 diabetes mellitus with other skin ulcer* E11.628 Type 2 diabetes mellitus with other skin complications* E11.630 Type 2 diabetes mellitus with periodontal disease* E11.638 Type 2 diabetes mellitus with other oral complications* E11.649 Type 2 diabetes mellitus with hypoglycemia without coma* E11.65 Type 2 diabetes mellitus with hyperglycemia* E11.69 Type 2 diabetes mellitus with other specified complication* E11.8 Type 2 diabetes mellitus with unspecified complications* *Not billable in primary position
92133 (1x per 12-month period)	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, bilateral; optic nerve **Service Allowance:** Allowable once per 12-month period for patients with type 1 or type 2 diabetes and diabetic retinopathy. Use the diagnosis codes below which include diabetes and diabetic retinopathy. **Type 1 diabetes mellitus with diabetic retinopathy** E10.319 Type 1 diabetes mellitus with unspecified diabetic retinopathy without macular edema E10.3211 - E10.3219 Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema E10.3291 - E10.3299 Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema E10.3311 - E10.3319 Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema E10.3391 - E10.3399 Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema **Type 2 diabetes mellitus with diabetic retinopathy** E11.319 Type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema E11.3211 - E11.3219 Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema E11.3291 - E11.3299 Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema E11.3311 - E11.3319 Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema E11.3391 - E11.3399 Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema Not billable with either extended ophthalmoscopy (initial or subsequent) or fundus photography.

Medical Follow-Up Exam	
92133 (2x per 12-month period)	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, bilateral; optic nerve **Service Allowance:** Allowable twice per 12-month period for patients with type 1or type 2 diabetes and diabetic retinopathy. Use the diagnosis codes below which include diabetes and diabetic retinopathy. **Type 1 diabetes mellitus with diabetic retinopathy** E10.311 Type 1 diabetes mellitus with unspecified diabetic retinopathy with macular edema E10.3411 - E10.3419 Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema E10.3491 - E10.3499 Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema E10.3511 - E10.3519 Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema E10.3521 - E10.3529 Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula E10.3531 - E10.3539 Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula E10.3541 - E10.3549 Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment E10.3551 - E10.3559 Type 1 diabetes mellitus with stable proliferative diabetic retinopathy E10.3591 - E10.3599 Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema **Type 2 diabetes mellitus with diabetic retinopathy** E11.311 Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema E11.3411 - E11.3419 Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema E11.3491 - E11.3499 Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema E11.3511 - E11.3519 Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, unspecified eye E11.3521 - E11.3529 Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula E11.3531 - E11.3539 Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula E11.3541 - E11.3549 Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment E11.3551 - E11.3559 Type 2 diabetes mellitus with stable proliferative diabetic retinopathy E11.3591 - E11.3599 Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema Not billable with either extended ophthalmoscopy (initial or subsequent) or fundus photography.
92134 (1x per 12-month period)	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, bilateral; retina **Service Allowance:** Allowable once per 12-month period for patients with type 1 or type 2 diabetes and diabetic retinopathy. Use the diagnosis codes below which include diabetes and diabetic retinopathy. **Type 1 diabetes mellitus with diabetic retinopathy** E10.319 Type 1 diabetes mellitus with unspecified diabetic retinopathy without macular edema E10.3211 - E10.3219 Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema E10.3291 - E10.3299 Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema E10.3311 - E10.3319 Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema E10.3391 - E10.3399 Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema Type 2 diabetes mellitus with diabetic retinopathy E11.319 Type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema E11.3211 - E11.3219 Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema E11.3291 - E11.3299 Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema E11.3311 - E11.3319 Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema E11.3391 - E11.3399 Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema Not billable with either extended ophthalmoscopy (initial or subsequent) or fundus photography.

Medical Follow-Up Exam	
92134 (2x per 12-month period)	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, bilateral; retina **Service Allowance:** Allowable twice per 12-month period for patients with type 1 or type 2 diabetes and diabetic retinopathy. Use the diagnosis codes below which include diabetes and diabetic retinopathy. **Type 1 diabetes mellitus with diabetic retinopathy** E10.311 Type 1 diabetes mellitus with unspecified diabetic retinopathy with macular edema E10.3411 - E10.3419 Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema E10.3491 - E10.3499 Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema E10.3511 - E10.3519 Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema E10.3521 - E10.3529 Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula E10.3531 - E10.3539 Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula E10.3541 - E10.3549 Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment E10.3551 - E10.3559 Type 1 diabetes mellitus with stable proliferative diabetic retinopathy E10.3591 - E10.3599 Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema Type 2 diabetes mellitus with diabetic retinopathy E11.311 Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema E11.3411 - E11.3419 Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema E11.3491 - E11.3499 Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema E11.3511 - E11.3519 Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, unspecified eye E11.3521 - E11.3529 Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula E11.3531 - E11.3539 Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula E11.3541 - E11.3549 Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment E11.3551 - E11.3559 Type 2 diabetes mellitus with stable proliferative diabetic retinopathy E11.3591 - E11.3599 Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema Not billable with either extended ophthalmoscopy (initial or subsequent) or fundus photography.

Medical Follow-Up Exam	
92201 92202	Ophthalmoscopy, extended; with retinal drawing and scleral depression of peripheral retinal disease (e.g., for retinal tear, retinal detachment, retinal tumor) with interpretation and report, unilateral or bilateral Ophthalmoscopy, extended, with drawing of optic nerve or macula (e.g., for glaucoma, macular pathology, tumor) with interpretation and report, unilateral or bilateral **Service Allowance** Allowable once per 6-month period for patients with type 1 or type 2 diabetes and diabetic retinopathy Use the diagnosis codes below which include diabetes and diabetic retinopathy. **Type 1 diabetes mellitus with diabetic retinopathy** E10.311 Type 1 diabetes mellitus with unspecified diabetic retinopathy with macular edema E10.319 Type 1 diabetes mellitus with unspecified diabetic retinopathy without macular edema E10.3211 - E10.3219 Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema E10.3291 - E10.3299 Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema E10.3311 - E10.3319 Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema E10.3391 - E10.3399 Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema E10.3411 - E10.3419 Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema E10.3491 - E10.3499 Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema E10.3511 - E10.3519 Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema E10.3521 - E10.3529 Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula E10.3531 - E10.3539 Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula E10.3541 - E10.3549 Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment E10.3551 - E10.3559 Type 1 diabetes mellitus with stable proliferative diabetic retinopathy E10.3591 - E10.3599 Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema Type 2 diabetes mellitus with diabetic retinopathy E11.311 Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema E11.319 Type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema E11.3211 - E11.3219 Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema E11.3291 - E11.3299 Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema E11.3311 - E11.3319 Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema E11.3391 - E11.3399 Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema E11.3411 - E11.3419 Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema E11.3491 - E11.3499 Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema E11.3511 - E11.3519 Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, unspecified eye E11.3521 - E11.3529 Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula E11.3531 - E11.3539 Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula E11.3541 - E11.3549 Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment E11.3551 - E11.3559 Type 2 diabetes mellitus with stable proliferative diabetic retinopathy E11.3591 - E11.3599 Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema Cannot be billed with fundus photography or scanning computerized ophthalmic diagnostic imaging (of optic nerve or retina).
92227	Remote imaging for detection of retinal disease (e.g., retinopathy in a patient with diabetes) with analysis and report under physician supervision, unilateral or bilateral Allowable once per 12-month period Do not report 92227 in conjunction with 92002-92014, 92133, 92134, 92250, 92228 or with the evaluation and management of the single organ system, the eye, 99202-99350

Medical Follow-Up Exam	
92228	Remote imaging for monitoring and management of active retinal disease (e.g., diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral Allowable once per 12-month period. Do not report 92228 in conjunction with 92002-92014, 92133, 92134, 922250, 92227 or with the evaluation and management of the single organ system, the eye, 99202-99350
92250	Fundus photography with interpretation and report **Service Allowance:** Allowable once per 6-month period for patients with type 1 or type 2 diabetes and diabetic retinopathy. Use the diagnosis codes below which include diabetes and diabetic retinopathy. If applicable, bill the diagnosis code with the correct eye location: left, right or bilateral. **Type 1 diabetes mellitus with diabetic retinopathy** E10.311 Type 1 diabetes mellitus with unspecified diabetic retinopathy with macular edema E10.319 Type 1 diabetes mellitus with unspecified diabetic retinopathy without macular edema E10.3211 - E10.3219 Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema E10.3291 - E10.3299 Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema E10.3311 - E10.3319 Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema E10.3391 - E10.3399 Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema E10.3411 - E10.3419 Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema E10.3491 - E10.3499 Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema E10.3511 - E10.3519 Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema E10.3521 - E10.3529 Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula E10.3531 - E10.3539 Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula E10.3541 - E10.3549 Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment E10.3551 - E10.3559 Type 1 diabetes mellitus with stable proliferative diabetic retinopathy E10.3591 - E10.3599 Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema **Type 2 diabetes mellitus with diabetic retinopathy** E11.311 Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema E11.319 Type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema E11.3211 - E11.3219 Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema E11.3291 - E11.3299 Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema E11.3311 - E11.3319 Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema E11.3391 - E11.3399 Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema E11.3411 - E11.3419 Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema E11.3491 - E11.3499 Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema E11.3511 - E11.3519 Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, unspecified eye E11.3521 - E11.3529 Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula E11.3531 - E11.3539 Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula E11.3541 - E11.3549 Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment E11.3551 - E11.3559 Type 2 diabetes mellitus with stable proliferative diabetic retinopathy E11.3591 - E11.3599 Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema Not covered if extended ophthalmoscopy is provided within six months.

Medical Follow-Up Exam	
92250/52	Retinal Screening Covered-in-full retinal screening is available to Signature, Choice and Advantage patients who have diabetes but don't show signs of diabetic eye disease. There is no copay for the member and VSP will reimburse $39.00 or your U&C fees, whichever is lower. Retinal screening can be billed on the same day as the WellVision® eye exam, under the Diabetic Eyecare Plus authorization **Service Allowance:** Allowable once per 12-month period. Use CPT code 92250 with modifier 52 Bill diagnosis code Z13.5 in the primary position and diagnosis code E10.9, E11.9 or E13.9 in the secondary position. Z13.5 Encounter for screening for eye and ear disorders E10.9 - Type 1 diabetes mellitus without complications E11.9 - Type 2 diabetes mellitus without complications E13.9 - Other specified diabetes mellitus without complications

Medical Follow-Up Exam	
92499	Exam with refraction for diabetic patients only who experience vision shifts of ± 1.00 diopters or greater in at least one eye due to diabetes medications (must be documented in the patient's file). Cannot be billed with another exam service on the same day. Refraction not reimbursed separately; payment is bundled with exam. **Service Allowance:** Allowable once per 12-month period for patients with type 1 or type 2 diabetes and diabetic retinopathy or rubeosis. Use the diagnosis codes below which include both diabetes and diabetic retinopathy. For rubeosis, include a rubeosis and a type 1 or type 2 diabetes diagnosis code. If applicable, bill the diagnosis code with the correct eye location: left, right or bilateral. **Type 1 or type 2 diabetes with diabetic retinopathy** E10.311 Type 1 diabetes mellitus with unspecified diabetic retinopathy with macular edema E10.319 Type 1 diabetes mellitus with unspecified diabetic retinopathy without macular edema E10.3211 - E10.3219 Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema E10.3291 - E10.3299 Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema E10.3311 - E10.3319 Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema E10.3391 - E10.3399 Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema E10.3411 - E10.3419 Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema E10.3491 - E10.3499 Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema E10.3511 - E10.3519 Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema E10.3521 - E10.3529 Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula E10.3531 - E10.3539 Type 1 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula E10.3541 - E10.3549 Type 1 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment E10.3551 - E10.3559 Type 1 diabetes mellitus with stable proliferative diabetic retinopathy E10.3591 - E10.3599 Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema E11.311 Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema E11.319 Type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema E11.3211 - E11.3219 Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema E11.3291 - E11.3299 Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema E11.3311 - E11.3319 Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema E11.3391 - E11.3399 Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema E11.3411 - E11.3419 Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema E11.3491 - E11.3499 Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema E11.3511 - E11.3519 Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema, unspecified eye E11.3521 - E11.3529 Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment involving the macula E11.3531 - E11.3539 Type 2 diabetes mellitus with proliferative diabetic retinopathy with traction retinal detachment not involving the macula E11.3541 - E11.3549 Type 2 diabetes mellitus with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment E11.3551 - E11.3559 Type 2 diabetes mellitus with stable proliferative diabetic retinopathy E11.3591 - E11.3599 Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular
99421, 99422, 99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days. Allowed for patients with type 1 or type 2 diabetes and diabetic retinopathy or rubeosis, bill appropriate diagnosis code. For rubeosis, include a rubeosis and a 1 or type 2 diabetes diagnosis code
99441, 99442, 99443	Telephone evaluation and management service, for established patient, patient initiated, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment. Allowed for patients with type 1 or type 2 diabetes and diabetic retinopathy or rubeosis, bill appropriate diagnosis code. For rubeosis, include a rubeosis and a 1 or type 2 diabetes diagnosis code. Do not report these services in conjunction with 99202-99205, 99212-99215, 99241-99245, or 99421-99423

Medical Follow-Up Exam	
99446, 99447, 99448, 99449, 99451, 99452	Interprofessional telephone/internet assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional. Allowed for patients with type 1 or type 2 diabetes and diabetic retinopathy or rubeosis, bill appropriate diagnosis code. For rubeosis, include a rubeosis and a 1 or type 2 diabetes diagnosis code.

Members with AMD and coverage under the Diabetic Eyecare Plus Program are eligible for the services listed below. All services must be billed with appropriate diagnosis codes (see VSP AMD Approved Diagnosis Codes chart below).

VSP AMD Covered Services

Service Allowance: Allowable once per 12-month period for patients with AMD.	
92002, 92004, 92012, 92014, 99202 - 99205, 99211 - 99215	Medical follow-up exam
92081-92083*	Visual Field Exams
92133	SCODI-P (optic nerve)
92134	SCODI-P (retina)
92250	Fundus photography
99421, 99422, 99423**	Digital evaluation and management
99441, 99442, 99443	Telephone evaluation and management service, established patient, patient initiated
99446, 99447, 99448, 99449, 99451, 99452**	Interprofessional internet consultation

*Allowable twice per 12-month period when visual necessity is established.

** Allowable once per 7-day period when visual necessity is established, bill with modifier GQ or 95, as appropriate. If applicable, bill the diagnosis code with the correct eye location: left, right or bilateral.

VSP AMD Approved Diagnosis Codes

Always code to the highest degree of specificity when indicating diagnosis.

If applicable, bill the diagnosis code with the correct eye location: left, right or bilateral.

Provide location modifier when required.

AMD services must be billed with one of the following diagnosis codes.	
H35.30	Unspecified macular degeneration
H35.3110	Nonexudative age-related macular degeneration, right eye, stage unspecified
H35.3111	Nonexudative age-related macular degeneration, right eye, early dry stage
H35.3112	Nonexudative age-related macular degeneration, right eye, intermediate dry stage
H35.3113	Nonexudative age-related macular degeneration, right eye, advanced atrophic without subfoveal involvement
H35.3114	Nonexudative age-related macular degeneration, right eye, advanced atrophic with subfoveal involvement
H35.3120	Nonexudative age-related macular degeneration, left eye, stage unspecified
H35.3121	Nonexudative age-related macular degeneration, left eye, early dry stage
H35.3122	Nonexudative age-related macular degeneration, left eye, intermediate dry stage
H35.3123	Nonexudative age-related macular degeneration, left eye, advanced atrophic without subfoveal involvement
H35.3124	Nonexudative age-related macular degeneration, left eye, advanced atrophic with subfoveal involvement
H35.3130	Nonexudative age-related macular degeneration, bilateral, stage unspecified
H35.3131	Nonexudative age-related macular degeneration, bilateral, early dry stage
H35.3132	Nonexudative age-related macular degeneration, bilateral, intermediate dry stage
H35.3133	Nonexudative age-related macular degeneration, bilateral, advanced atrophic without subfoveal involvement
H35.3134	Nonexudative age-related macular degeneration, bilateral, advanced atrophic with subfoveal involvement
H35.3190	Nonexudative age-related macular degeneration, unspecified eye, stage unspecified
H35.3191	Nonexudative age-related macular degeneration, unspecified eye, early dry stage
H35.3192	Nonexudative age-related macular degeneration, unspecified eye, intermediate dry stage
H35.3193	Nonexudative age-related macular degeneration, unspecified eye, advanced atrophic without subfoveal involvement
H35.3194	Nonexudative age-related macular degeneration, unspecified eye, advanced atrophic with subfoveal involvement
H35.3210	Exudative age-related macular degeneration, right eye, stage unspecified
H35.3211	Exudative age-related macular degeneration, right eye, with active choroidal neovascularization
H35.3212	Exudative age-related macular degeneration, right eye, with inactive choroidal neovascularization
H35.3213	Exudative age-related macular degeneration, right eye, with inactive scar
H35.3220	Exudative age-related macular degeneration, left eye, stage unspecified
H35.3221	Exudative age-related macular degeneration, left eye, with active choroidal neovascularization
H35.3222	Exudative age-related macular degeneration, left eye, with inactive choroidal neovascularization
H35.3223	Exudative age-related macular degeneration, left eye, with inactive scar
H35.3230	Exudative age-related macular degeneration, bilateral, stage unspecified
H35.3231	Exudative age-related macular degeneration, bilateral, with active choroidal neovascularization
H35.3232	Exudative age-related macular degeneration, bilateral, with inactive choroidal neovascularization

AMD services must be billed with one of the following diagnosis codes.	
H35.3233	Exudative age-related macular degeneration, bilateral, with inactive scar
H35.3290	Exudative age-related macular degeneration, unspecified eye, stage unspecified
H35.3291	Exudative age-related macular degeneration, unspecified eye, with active choroidal neovascularization
H35.3292	Exudative age-related macular degeneration, unspecified eye, with inactive choroidal neovascularization
H35.3293	Exudative age-related macular degeneration, unspecified eye, with inactive scar
H35.341	Macular cyst, hole, or pseudohole, right eye
H35.342	Macular cyst, hole, or pseudohole, left eye
H35.343	Macular cyst, hole, or pseudohole, bilateral
H35.351	Cystoid macular degeneration, right eye
H35.352	Cystoid macular degeneration, left eye
H35.353	Cystoid macular degeneration, bilateral
H35.361	Drusen (degenerative) of macula, right eye
H35.362	Drusen (degenerative) of macula, left eye
H35.363	Drusen (degenerative) of macula, bilateral
H35.371	Puckering of macula, right eye
H35.372	Puckering of macula, left eye
H35.373	Puckering of macula, bilateral
H35.381	Toxic maculopathy, right eye
H35.382	Toxic maculopathy, left eye
H35.383	Toxic maculopathy, bilateral

Members with glaucoma and coverage under the Diabetic Eyecare Plus Program are eligible for the services listed below. All services must be billed with appropriate diagnosis codes (see VSP Glaucoma Approved Diagnosis Codes chart below).

VSP Glaucoma Covered Services

Service Allowance: Allowable once per 12-month period for patients with Glaucoma.	
92002, 92004, 92012, 92014, 99202 - 99205, 99211 - 99215	Medical follow-up exam
76514	Pachymetry
92020	Gonioscopy
92081-92083*	Visual Field Exams
92100	Tonometry
92133	SCODI-P (optic nerve)
92134	SCODI-P (retina)
92201-92202	Extended ophthalmoscopy
92250	Fundus photography
99421, 99422, 99423**	Digital evaluation and management
99441, 99442, 99443	Telephone evaluation and management service, established patient, patient initiated
99446, 99447, 99448, 99449, 99451, 99452**	Interprofessional internet consultation

*Allowable twice per 12-month period when visual necessity is established.

**Allowable only once per 7-day period when visual necessity is established, bill with modifier GQ or 95, as appropriate. If applicable, bill the diagnosis code with the correct eye location: left, right or bilateral.

VSP Glaucoma Approved Diagnosis Codes

Always code to the highest degree of specificity when indicating diagnosis.

If applicable, bill the diagnosis code with the correct eye location: left, right or bilateral.

Provide location modifier when required.

Glaucoma services must be billed with one of the following diagnosis codes	
H40.001	Preglaucoma, unspecified, right eye
H40.002	Preglaucoma, unspecified, left eye
H40.003	Preglaucoma, unspecified, bilateral
H40.011	Open angle with borderline findings, low risk, right eye
H40.012	Open angle with borderline findings, low risk, left eye
H40.013	Open angle with borderline findings, low risk, bilateral
H40.019	Open angle with borderline findings, low risk, unspecified
H40.021	Open angle with borderline findings, high risk, right eye
H40.022	Open angle with borderline findings, high risk, left eye
H40.023	Open angle with borderline findings, high risk, bilateral
H40.031	Anatomical narrow angle, right eye
H40.032	Anatomical narrow angle, left eye
H40.033	Anatomical narrow angle, bilateral
H40.041	Steroid responder, right eye
H40.042	Steroid responder, left eye
H40.043	Steroid responder, bilateral
H40.051	Ocular hypertension, right eye
H40.052	Ocular hypertension, left eye
H40.053	Ocular hypertension, bilateral
H40.061	Primary angle closure without glaucoma damage, right eye
H40.062	Primary angle closure without glaucoma damage, left eye
H40.063	Primary angle closure without glaucoma damage, bilateral
H40.10X0	Unspecified open-angle glaucoma, stage unspecified
H40.10X1	Unspecified open-angle glaucoma, mild stage
H40.10X2	Unspecified open-angle glaucoma, moderate stage
H40.10X3	Unspecified open-angle glaucoma, severe stage
H40.10X4	Unspecified open-angle glaucoma, indeterminate stage
H40.1110	Primary open-angle glaucoma, right eye, stage unspecified
H40.1111	Primary open-angle glaucoma, right eye, mild stage
H40.1112	Primary open-angle glaucoma, right eye, moderate stage
H40.1113	Primary open-angle glaucoma, right eye, severe stage
H40.1114	Primary open-angle glaucoma, right eye, indeterminate stage

Glaucoma services must be billed with one of the following diagnosis codes	
H40.1120	Primary open-angle glaucoma, left eye, stage unspecified
H40.1121	Primary open-angle glaucoma, left eye, mild stage
H40.1122	Primary open-angle glaucoma, left eye, moderate stage
H40.1123	Primary open-angle glaucoma, left eye, severe stage
H40.1124	Primary open-angle glaucoma, left eye, indeterminate stage
H40.1130	Primary open-angle glaucoma, bilateral, stage unspecified
H40.1131	Primary open-angle glaucoma, bilateral, mild stage
H40.1132	Primary open-angle glaucoma, bilateral, moderate stage
H40.1133	Primary open-angle glaucoma, bilateral, severe stage
H40.1134	Primary open-angle glaucoma, bilateral, indeterminate stage
H40.1190	Primary open-angle glaucoma, unspecified eye, stage unspecified
H40.1191	Primary open-angle glaucoma, unspecified eye, mild stage
H40.1192	Primary open-angle glaucoma, unspecified eye, moderate stage
H40.1193	Primary open-angle glaucoma, unspecified eye, severe stage
H40.1194	Primary open-angle glaucoma, unspecified eye, indeterminate stage
H40.1210	Low-tension glaucoma, right eye, stage unspecified
H40.1211	Low-tension glaucoma, right eye, mild stage
H40.1212	Low-tension glaucoma, right eye, moderate stage
H40.1213	Low-tension glaucoma, right eye, severe stage
H40.1214	Low-tension glaucoma, right eye, indeterminate stage
H40.1220	Low-tension glaucoma, left eye, stage unspecified
H40.1221	Low-tension glaucoma, left eye, mild stage
H40.1222	Low-tension glaucoma, left eye, moderate stage
H40.1223	Low-tension glaucoma, left eye, severe stage
H40.1224	Low-tension glaucoma, left eye, indeterminate stage
H40.1230	Low-tension glaucoma, bilateral, stage unspecified
H40.1231	Low-tension glaucoma, bilateral, mild stage
H40.1232	Low-tension glaucoma, bilateral, moderate stage
H40.1233	Low-tension glaucoma, bilateral, severe stage
H40.1234	Low-tension glaucoma, bilateral, indeterminate stage
H40.1310	Pigmentary glaucoma, right eye, stage unspecified
H40.1311	Pigmentary glaucoma, right eye, mild stage

Glaucoma services must be billed with one of the following diagnosis codes	
H40.1312	Pigmentary glaucoma, right eye, moderate stage
H40.1313	Pigmentary glaucoma, right eye, severe stage
H40.1314	Pigmentary glaucoma, right eye, indeterminate stage
H40.1320	Pigmentary glaucoma, left eye, stage unspecified
H40.1321	Pigmentary glaucoma, left eye, mild stage
H40.1322	Pigmentary glaucoma, left eye, moderate stage
H40.1323	Pigmentary glaucoma, left eye, severe stage
H40.1324	Pigmentary glaucoma, left eye, indeterminate stage
H40.1330	Pigmentary glaucoma, bilateral, stage unspecified
H40.1331	Pigmentary glaucoma, bilateral, mild stage
H40.1332	Pigmentary glaucoma, bilateral, moderate stage
H40.1333	Pigmentary glaucoma, bilateral, severe stage
H40.1334	Pigmentary glaucoma, bilateral, indeterminate stage
H40.1410	Capsular glaucoma with pseudoexfoliation of lens, right eye, stage unspecified
H40.1411	Capsular glaucoma with pseudoexfoliation of lens, right eye, mild stage
H40.1412	Capsular glaucoma with pseudoexfoliation of lens, right eye, moderate stage
H40.1413	Capsular glaucoma with pseudoexfoliation of lens, right eye, severe stage
H40.1414	Capsular glaucoma with pseudoexfoliation of lens, right eye, indeterminate stage
H40.1420	Capsular glaucoma with pseudoexfoliation of lens, left eye, stage unspecified
H40.1421	Capsular glaucoma with pseudoexfoliation of lens, left eye, mild stage
H40.1422	Capsular glaucoma with pseudoexfoliation of lens, left eye, moderate stage
H40.1423	Capsular glaucoma with pseudoexfoliation of lens, left eye, severe stage
H40.1424	Capsular glaucoma with pseudoexfoliation of lens, left eye, indeterminate stage
H40.1430	Capsular glaucoma with pseudoexfoliation of lens, bilateral, stage unspecified
H40.1431	Capsular glaucoma with pseudoexfoliation of lens, bilateral, mild stage
H40.1432	Capsular glaucoma with pseudoexfoliation of lens, bilateral, moderate stage
H40.1433	Capsular glaucoma with pseudoexfoliation of lens, bilateral, severe stage
H40.1434	Capsular glaucoma with pseudoexfoliation of lens, bilateral, indeterminate stage
H40.151	Residual stage of open-angle glaucoma, right eye
H40.152	Residual stage of open-angle glaucoma, left eye
H40.153	Residual stage of open-angle glaucoma, bilateral
H40.20X0	Unspecified primary angle-closure glaucoma, stage unspecified

Glaucoma services must be billed with one of the following diagnosis codes	
H40.20X1	Unspecified primary angle-closure glaucoma, mild stage
H40.20X2	Unspecified primary angle-closure glaucoma, moderate stage
H40.20X3	Unspecified primary angle-closure glaucoma, severe stage
H40.20X4	Unspecified primary angle-closure glaucoma, indeterminate stage
H40.211	Acute angle-closure glaucoma, right eye
H40.212	Acute angle-closure glaucoma, left eye
H40.213	Acute angle-closure glaucoma, bilateral
H40.2210	Chronic angle-closure glaucoma, right eye, stage unspecified
H40.2211	Chronic angle-closure glaucoma, right eye, mild stage
H40.2212	Chronic angle-closure glaucoma, right eye, moderate stage
H40.2213	Chronic angle-closure glaucoma, right eye, severe stage
H40.2214	Chronic angle-closure glaucoma, right eye, indeterminate stage
H40.2220	Chronic angle-closure glaucoma, left eye, stage unspecified
H40.2221	Chronic angle-closure glaucoma, left eye, mild stage
H40.2222	Chronic angle-closure glaucoma, left eye, moderate stage
H40.2223	Chronic angle-closure glaucoma, left eye, severe stage
H40.2224	Chronic angle-closure glaucoma, left eye, indeterminate stage
H40.2230	Chronic angle-closure glaucoma, bilateral, stage unspecified
H40.2231	Chronic angle-closure glaucoma, bilateral, mild stage
H40.2232	Chronic angle-closure glaucoma, bilateral, moderate stage
H40.2233	Chronic angle-closure glaucoma, bilateral, severe stage
H40.2234	Chronic angle-closure glaucoma, bilateral, indeterminate stage
H40.231	Intermittent angle-closure glaucoma, right eye
H40.232	Intermittent angle-closure glaucoma, left eye
H40.233	Intermittent angle-closure glaucoma, bilateral
H40.241	Residual stage of angle-closure glaucoma, right eye
H40.242	Residual stage of angle-closure glaucoma, left eye
H40.243	Residual stage of angle-closure glaucoma, bilateral
H40.31X0	Glaucoma secondary to eye trauma, right eye, stage unspecified
H40.31X1	Glaucoma secondary to eye trauma, right eye, mild stage
H40.31X2	Glaucoma secondary to eye trauma, right eye, moderate stage
H40.31X3	Glaucoma secondary to eye trauma, right eye, severe stage

Glaucoma services must be billed with one of the following diagnosis codes	
H40.31X4	Glaucoma secondary to eye trauma, right eye, indeterminate stage
H40.32X0	Glaucoma secondary to eye trauma, left eye, stage unspecified
H40.32X1	Glaucoma secondary to eye trauma, left eye, mild stage
H40.32X2	Glaucoma secondary to eye trauma, left eye, moderate stage
H40.32X3	Glaucoma secondary to eye trauma, left eye, severe stage
H40.32X4	Glaucoma secondary to eye trauma, left eye, indeterminate stage
H40.33X0	Glaucoma secondary to eye trauma, bilateral, stage unspecified
H40.33X1	Glaucoma secondary to eye trauma, bilateral, mild stage
H40.33X2	Glaucoma secondary to eye trauma, bilateral, moderate stage
H40.33X3	Glaucoma secondary to eye trauma, bilateral, severe stage
H40.33X4	Glaucoma secondary to eye trauma, bilateral, indeterminate stage
H40.41X0	Glaucoma secondary to eye inflammation, right eye, stage unspecified
H40.41X1	Glaucoma secondary to eye inflammation, right eye, mild stage
H40.41X2	Glaucoma secondary to eye inflammation, right eye, moderate stage
H40.41X3	Glaucoma secondary to eye inflammation, right eye, severe stage
H40.41X4	Glaucoma secondary to eye inflammation, right eye, indeterminate stage
H40.42X0	Glaucoma secondary to eye inflammation, left eye, stage unspecified
H40.42X1	Glaucoma secondary to eye inflammation, left eye, mild stage
H40.42X2	Glaucoma secondary to eye inflammation, left eye, moderate stage
H40.42X3	Glaucoma secondary to eye inflammation, left eye, severe stage
H40.42X4	Glaucoma secondary to eye inflammation, left eye, indeterminate stage
H40.43X0	Glaucoma secondary to eye inflammation, bilateral, stage unspecified
H40.43X1	Glaucoma secondary to eye inflammation, bilateral, mild stage
H40.43X2	Glaucoma secondary to eye inflammation, bilateral, moderate stage
H40.43X3	Glaucoma secondary to eye inflammation, bilateral, severe stage
H40.43X4	Glaucoma secondary to eye inflammation, bilateral, indeterminate stage
H40.51X0	Glaucoma secondary to other eye disorders, right eye, stage unspecified
H40.51X1	Glaucoma secondary to other eye disorders, right eye, mild stage
H40.51X2	Glaucoma secondary to other eye disorders, right eye, moderate stage
H40.51X3	Glaucoma secondary to other eye disorders, right eye, severe stage
H40.51X4	Glaucoma secondary to other eye disorders, right eye, indeterminate stage
H40.52X0	Glaucoma secondary to other eye disorders, left eye, stage unspecified

Glaucoma services must be billed with one of the following diagnosis codes	
H40.52X1	Glaucoma secondary to other eye disorders, left eye, mild stage
H40.52X2	Glaucoma secondary to other eye disorders, left eye, moderate stage
H40.52X3	Glaucoma secondary to other eye disorders, left eye, severe stage
H40.52X4	Glaucoma secondary to other eye disorders, left eye, indeterminate stage
H40.53X0	Glaucoma secondary to other eye disorders, bilateral, stage unspecified
H40.53X1	Glaucoma secondary to other eye disorders, bilateral, mild stage
H40.53X2	Glaucoma secondary to other eye disorders, bilateral, moderate stage
H40.53X3	Glaucoma secondary to other eye disorders, bilateral, severe stage
H40.53X4	Glaucoma secondary to other eye disorders, bilateral, indeterminate stage
H40.61X0	Glaucoma secondary to drugs, right eye, stage unspecified
H40.61X1	Glaucoma secondary to drugs, right eye, mild stage
H40.61X2	Glaucoma secondary to drugs, right eye, moderate stage
H40.61X3	Glaucoma secondary to drugs, right eye, severe stage
H40.61X4	Glaucoma secondary to drugs, right eye, indeterminate stage
H40.62X0	Glaucoma secondary to drugs, left eye, stage unspecified
H40.62X1	Glaucoma secondary to drugs, left eye, mild stage
H40.62X2	Glaucoma secondary to drugs, left eye, moderate stage
H40.62X3	Glaucoma secondary to drugs, left eye, severe stage
H40.62X4	Glaucoma secondary to drugs, left eye, indeterminate stage
H40.63X0	Glaucoma secondary to drugs, bilateral, stage unspecified
H40.63X1	Glaucoma secondary to drugs, bilateral, mild stage
H40.63X2	Glaucoma secondary to drugs, bilateral, moderate stage
H40.63X3	Glaucoma secondary to drugs, bilateral, severe stage
H40.63X4	Glaucoma secondary to drugs, bilateral, indeterminate stage
H40.811	Glaucoma with increased episcleral venous pressure, right eye
H40.812	Glaucoma with increased episcleral venous pressure, left eye
H40.813	Glaucoma with increased episcleral venous pressure, bilateral
H40.821	Hypersecretion glaucoma, right eye
H40.822	Hypersecretion glaucoma, left eye
H40.823	Hypersecretion glaucoma, bilateral
H40.831	Aqueous misdirection, right eye
H40.832	Aqueous misdirection, left eye

Glaucoma services must be billed with one of the following diagnosis codes	
H40.833	Aqueous misdirection, bilateral
H40.89	Other specified glaucoma
H40.9	Unspecified glaucoma
H42	Glaucoma in diseases classified elsewhere
Q15.0	Congenital glaucoma

Laser VisionCare℠ Program

VSP considers co-management to be an integral part of refractive surgery and encourages a co-management relationship between our VSP Laser VisionCare Doctors and Laser VisionCare Facilities. We understand there may be instances when a Laser VisionCare surgeon may determine that it would be in the patient's best interest to provide preoperative and postoperative care; therefore, VSP allows co-management flexibility.

VSP's Laser VisionCare Program provides discounted access to facilities and surgeons for most VSP members who wish to pursue laser vision correction services. There are two plans: the standard Laser VisionCare Program (discount only) and the Laser VisionCare Preferred Program (discount with allowance towards procedure).

Laser VisionCare Program (discount only)

Members receive a complimentary screening as well as preoperative and postoperative services through participating VSP Network Doctors.

The program includes discounted access to on-label applications of FDA-approved laser refractive procedures. Surgeries that involve implantation of retained medical device(s) (such as refractive lens exchange or corneal inlays) or manipulation of ocular tissue other than what is anticipated during traditional laser vision correction are not included (such as corneal cross-linking or scleral-directed therapies) even if performed in conjunction with an on-label, approved laser vision correction procedure. Likewise, refractive procedures performed in conjunction with a clinical trial are deemed to be experimental and are not part of this program.

Members receive the contracted discount amount. Or, if the laser center is offering a temporary price reduction, VSP members will receive 5% off the advertised price, if it is less than the usual discount price.

After discount, patients should not pay more than the following amounts:

- PRK: $1,500 per eye
- LASIK: $1,800 per eye
- Custom LASIK, Custom PRK or Bladeless LASIK: $2,300 per eye
- All other procedures, including SMILE and Contoura, patients pay the contracted discount amount or 5% off the advertised price, if lower than the usual discount price

Laser VisionCare Preferred Program

In addition to discounted pricing available through the Laser VisionCare Program, the patient receives an allowance that may be applied to the cost of surgery. The allowance is provided through one of the following two options:

Per eye allowance: This option enables the member to receive an allowance toward the cost of surgery for each eye, once per eye per lifetime.

Total allowance: This option enables the member to receive an allowance toward the cost of surgery regardless if it is on one or both eyes, once per lifetime.

Note:

Information about the Laser VisionCare Program is available to members and consumers at vsp.com.

Patient Communication

The Laser VisionCare Program emphasizes the need for a patient to visit a VSP Laser VisionCare doctor to initiate services. If you are not participating in the Laser VisionCare Program and a VSP patient inquiries about receiving services under the program, refer the patient to vsp.com or Member Services. To participate in the Laser VisionCare Program, refer to the Enrollment/Doctor Participation section.

VSP contracts only with facilities and surgeons who meet our stringent quality standards. **Please don't refer members to facilities that are not in VSP's network.** Members of the LVC Preferred Program often have no benefit for out-of-network services, or a reduced allowance amount available. There is no guaranteed discount on services received from an out-of-network provider.

Determining Eligibility

Select **View Plans** in the **Check Patient Eligibility** area on **eyefinity.com.** If eligible, you will see one of the two plans listed:

- Laser VisionCare Program–Discounted Services Only (nearly all VSP patients are eligible)
- Laser VisionCare Preferred Program
- LASIK: Allowance amount $XXX (per eye or both eyes)
- PRK: Allowance amount $XXX (per eye or both eyes)
- Custom LASIK, Custom PRK, Contoura, SMILE, or other approved procedures: Allowance amount $XXX (per eye or both eyes)

Note:

Services are available once per eye per member's lifetime unless otherwise indicated

Complimentary Screening

Evaluate the patient's viability for surgery. At a minimum, you are required to determine refractive error and briefly discuss laser vision correction. Laser surgery can't be guaranteed, until a complete preoperative exam has been performed.

Preoperative Exam

If you and the patient agree to proceed, perform a complete preoperative exam to obtain all clinical data required by the facility.

Facility Selection

After completing all preoperative testing, assist the patient in selecting a VSP-contracted facility and surgeon with whom you are affiliated. The facility confirms eligibility and is provided with a tracking number. This number is used for the Laser VisionCare Preferred Program claim submissions or for the collection of encounter data where the patient does not have an allowance.

Surgery

The patient is responsible for paying the facility the discounted surgery fee (less the allowance if covered by the Preferred Program). The surgery is performed at the facility by a VSP Laser VisionCare surgeon. Patient out-of-pocket expenses are not to exceed the stated maximums for PRK, LASIK, Custom PRK, Custom LASIK and Bladeless LASIK.

Postoperative Care

VSP Laser VisionCare patients should return to you for postoperative care as soon as you and the surgeon, along with the patient, agree it is appropriate.

Inform the patient about the importance of regular exams after their surgery. And don't forget—most VSP Signature Plan® patients can use their frame benefit for plano sunglasses (off the board or office stocked) after their surgery.

Note:

For frame-only claim submissions, bill with diagnosis code Z46.0 (Encounter for fitting and adjustment of spectacles and contact lenses) to ensure correct claims processing.

Claim Submission/Encounter Data

The facility is required to submit CMS-1500 form data to VSP electronically.

Compensation

The facility is responsible for paying you and the surgeon.

Billing

Services provided as part of the Laser VisionCare process can't be billed against the members' routine benefits.

There is no charge to the patient for complimentary screening and no doctor compensation is offered, even if the patient chooses not to proceed with the surgery after the screening.

Compensation for preoperative and postoperative services is disbursed to you by the facility as part of the global fee. Do not submit a claim to VSP for services.

If the patient receives a preoperative exam and chooses not to proceed with the surgery, or if you determine that the patient is not a viable candidate then:

- If the patient has Preferred Program coverage, coordinate with the facility to submit a claim to VSP for this exam.
- If the patient does not have Preferred Program coverage, you may bill the patient for the exam at 75% of your U&C fee up to $100. There should be no charge to the patient if you would not customarily charge a private patient for this exam.

To participate in VSP's Laser VisionCare Program, you should:

- Maintain current TPA certification, as applicable for your state.
- Find a participating facility on VSPOnline.
- Contact facility directly to become affiliated. It is the facility's responsibility to offer laser vision correction training at no cost and to inform VSP of all changes in affiliation.

It is your responsibility to learn the facility's reimbursement policies, including compensatory fees for preoperative and postoperative services, prior to the affiliation process. All Laser VisionCare compensation is disbursed directly to you by the facility.

Once you become affiliated with a Laser VisionCare facility, the facility will explain their process for coordinating patient care. Like reimbursement, this process will vary from facility to facility.

After you are affiliated with a Laser VisionCare facility, you should contact providernetworkdevelopment@vsp.com to update your profile on vsp.com.

Low Vision

VSP's Low Vision plan offers members low vision exams and low vision aids, up to a specified maximum, every two service years. Pre-service verification is required. Submit a Low Vision Verification Form.

A low vision evaluation is covered for members who present with moderate, severe, or profound visual impairment. A low vision evaluation includes, but is not limited to, a detailed case history, effectiveness of any low vision aids in use, visual acuity in each eye with best spectacle correction, steadiness of fixation, assessment of aids required for distance vision and near vision, evaluation of any supplemental aids, evaluation of therapeutic filters, development of treatment, counseling of patient, and advice to patient's family (if appropriate).

Note:

The diagnosis code describes the level of visual impairment in each eye. The AMA defines the level of visual impairment using best corrected visual acuity (BCVA) and/or visual field limitation. For example, ***severe*** visual impairment ranges are BCVA from 20/200 to 20/400, *or* visual field of 20 degrees or less, whichever is worse. ***Profound*** visual impairment ranges are BCVA 20/500 to 20/1000, *or* visual field of 10 degrees or less. VSP follows these guidelines for low vision coverage.

We'll cover Low Vision Evaluation and Aids if your patient's best corrected visual acuity is 20/70 or worse in at least one eye, or if there is a visual field of 20 degrees or less, or a hemianopsia. The request and claim should contain the correct low vision diagnosis code(s).

Low Vision Diagnosis Codes

ICD-10	Description	ICD-10	Description
H53.461	Homonymous bilateral field defects, right side (homonymous altitudinal hemianopia)	H54.2X12	Low vision right eye category 1, low vision left eye category 2
H53.462	Homonymous bilateral field defects, left side (homonymous altitudinal hemianopia)	H54.2X21	Low vision right eye category 2, low vision left eye category 1
H53.47	Heteronymous bilateral field defects (hemianopsia)	H54.2X22	Low vision right eye category 2, low vision left eye category 2
H54.10	Blindness, one eye, low vision other eye, unspecified eyes	H54.3	Unqualified visual loss, both eyes
H54.1131	Blindness right eye category 3, low vision left eye category 1	H54.40	Blindness, one eye, unspecified eye
H54.1132	Blindness right eye category 3, low vision left eye category 2	H54.413A	Blindness right eye category 3, normal vision left eye
H54.1141	Blindness right eye category 4, low vision left eye category 1	H54.414A	Blindness right eye category 4, normal vision left eye
H54.1142	Blindness right eye category 4, low vision left eye category 2	H54.415A	Blindness right eye category 5, normal vision left eye
H54.1151	Blindness right eye category 5, low vision left eye category 1	H54.42A3	Blindness left eye category 3, normal vision right eye
H54.1152	Blindness right eye category 5, low vision left eye category 2	H54.42A4	Blindness left eye category 4, normal vision right eye
H54.1213	Low vision right eye category 1, blindness left eye category 3	H54.42A5	Blindness left eye category 5, normal vision right eye
H54.1214	Low vision right eye category 1, blindness left eye category 4	H54.50	Low vision, one eye, unspecified eye
H54.1215	Low vision right eye category 1, blindness left eye category 5	H54.511A	Low vision right eye category 1, normal vision left eye
H54.1223	Low vision right eye category 2, blindness left eye category 3	H54.512A	Low vision right eye category 2, normal vision left eye
H54.1224	Low vision right eye category 2, blindness left eye category 4	H54.52A1	Low vision left eye category 1, normal vision right eye
H54.1225	Low vision right eye category 2, blindness left eye category 5	H54.52A2	Low vision left eye category 2, normal vision right eye
H54.2X11	Low vision right eye category 1, low vision left eye category 1	H54.8	Legal blindness, as defined in USA

Don't use the Low Vision benefit to provide conventional glasses or additional contact lenses. Lenses covered under the Low Vision plan must be either specialty low vision lenses, or glasses specifically designed for use in conjunction with low vision aids. VSP's minimum prescription requirements apply. Please include a manufacturer's invoice when submitting a Low Vision Verification Form.

NOTE:

Patients with a diagnosis of **photophobia** (visual discomfort) are eligible for sun filters. Lenses do not have to meet VSP's minimum prescription requirements.

Note:

H53.141 Visual discomfort, right eye; H53.142 Visual discomfort, left eye; H53.143 Visual discomfort, bilateral

If your patient meets the benefit criteria above and is eligible for low vision benefits, obtain a case number. To get one, complete aLow Vision Verification Form. A copy of the invoice or catalog page is needed for each low vision aid requested. Fax the form to 916.851.4733. Or mail this form to: VSP, PO Box 997100, Sacramento, CA 95899. You can find this form under the **Forms** section of the **Administration** menu on VSPOnline on eyefinity.com, or in the Tools and Forms section of this manual.

Signature Plan and VSP Choice Service Allowance: $1,000 maximum benefit every two service years.

The maximum benefit includes coverage for two supplemental exams*. The remaining allowance is for materials.

*VSP covers additional exams if benefit dollars are available.

Coverage includes two low vision supplemental exams every two service years. We'll pay up to $125 for each exam. Don't balance bill for this service. There's no copay.

Coverage includes an allowance for low vision aids every two years, including prescription services and optical aids. Your patient must pay any overages.

Non-covered low vision aids include, but are not limited to, the following items:

- Plano lenses (excepting lenses for patients with photophobia, as noted above)
- Fitovers/cocoons/clip-ons
- Electronic books
- Computers with voice-enhanced software
- Watches with large dials
- Lamps

Signature Plan and VSP Choice Plan: We'll pay 75% of the covered amount up to $1,000 (minus any amount paid for supplemental exams) for each person every two service years. Bill your patient for the remaining 25% of the covered amount, plus any amount over the maximum benefit.

Patients with Sight for Students Gift Certificates: We'll pay 100% of the allowed amount up to $1,000 for each person every two service years.

Elements: VSP pays 100% of the billed amount. No maximum. No copay.

Medicaid: VSP pays 100% of the billed amount up to fee schedule. No copay or charge to the member for covered services. Based on state guidelines, refer to Medicaid Fee Schedule.

Submit Low Vision claims using our electronic claims submission system. You'll need an authorization number, which can be found on the Benefit Authorization notice. Indicate the case number in Box 23 located on the Diagnosis and Services screen.

For proper payment, bill all covered services with the appropriate CPT or HCPCS codes from this list.

Low Vision Evaluation	
92499	Unlisted ophthalmological service or procedure
Fitting of Low Vision Aids (not reimbursed separately; payment is bundled with aids)	
92354	Fitting of spectacle mounted low vision aid; single element system
92355	Fitting of spectacle mounted low vision aid; telescopic or other compound lens system
Low Vision Aids	
V2600	Hand held low vision aids and other nonspectacle mounted aids
V2610	Single lens spectacle mounted low vision aids
V2615	Telescopic and other compound lens system, including distance vision telescopic, near vision telescopes and compound microscopic lens system

Note:

Low vision claims must be submitted on a separate claim from routine vision. CPT and HCPCS codes are not selectable from the drop-down box and must be manually entered.

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

Vision Therapy

Evaluations for qualified conditions are to be submitted directly through **eClaim** with the appropriate diagnosis codes indicated.

Sessions for a patient who meets the benefit criteria and is eligible for Vision Therapy are authorized when you obtain a case number. To get one, complete a Vision Therapy Verification Form. Fax it to **916.851.4733**, or mail the form to: VSP, PO Box 997100, Sacramento, CA 95899. You can find this form under **Benefit Administration** in the **Forms** section of the **Administration** menu on **VSPOnline** at **eyefinity.com** or in the Tools and Forms section of this manual.

Evaluations

We'll pay a maximum of $85 for one approved sensorimotor exam per service year. You may not balance bill the patient for any amount over the approved amount. The $85 maximum per year for the exam is not included in the $750 yearly vision therapy allowance described below.

Sessions

The number of vision therapy sessions is dependent upon pre-established benefit criteria, indicated on the Benefit Authorization Notice along with the case number. This information is available after we receive your completed Vision Therapy Verification Form.

For orthoptic and/or pleoptic training (therapy sessions) the maximum allowed is $750 annually. VSP pays 75% of allowed amount, patient's responsibility is 25%. Additional sessions beyond those covered by us are a private transaction between you and your patient.

- Max allowable per session up to $50, VSP pays 75%, patient is responsible for 25%.

Note:

VSP pays 100% of the allowable amount for vision therapy sessions provided to patients with an Eyes of Hope gift certificate.

Patients with Eyes of Hope Gift Certificates: In addition to the sensorimotor exam, we'll pay 100% of the allowed amount for vision therapy sessions up to $750 for each person per service year. The patient does not have to pay the 25% patient fee.

Medicaid: VSP pays 100% of the billed amount up to fee schedule. No copay or charge to the member for covered services. Based on state guidelines, refer to Medicaid Fee Schedule.

For Vision Therapy sessions, include the authorization number from the Benefit Authorization notice in Box 23 located on the **Diagnosis and Services** screen on **eClaim**. Also include one of the CPT procedure codes and an appropriate diagnosis code from the tables below:

Note:

Vision therapy claims must be submitted on a separate claim from routine vision. CPT and HCPCS codes are not selectable from the drop-down box and must be manually entered.

Sensorimotor Exam

92060	Sensorimotor examination with multiple measurements of ocular deviation, with interpretation and report.

Vision therapy evaluation (to report use CPT code 92060) is allowable for the following diagnoses

CD-10-CM	Description
H50.06	Alternating esotropia with A pattern
H50.07	Alternating esotropia with V pattern
H50.111	Monocular exotropia, right eye
H50.112	Monocular exotropia, left eye
H50.141	Monocular exotropia with other noncomitancies, right eye
H50.142	Monocular exotropia with other noncomitancies, left eye
H50.15	Alternating exotropia
H50.18	Alternating exotropia with other noncomitancies
H50.30	Unspecified intermittent heterotropia
H50.311	Intermittent monocular esotropia, right eye
H50.312	Intermittent monocular esotropia, left eye
H50.32	Intermittent alternating esotropia
H50.331	Intermittent monocular exotropia, right eye
H50.332	Intermittent monocular exotropia, left eye
H50.34	Intermittent alternating exotropia
H50.51	Esophoria
H50.52	Exophoria
H51.11	Convergence insufficiency
H51.12	Convergence excess
H51.8	Other specified disorders of binocular movement
H53.32	Fusion with defective stereopsis
H55.81	Saccadic eye movements
H55.82	Deficient smooth pursuit eye movements
H55.89	Other irregular eye movements

Vision Therapy Sessions

92065	Orthoptic training

Vision therapy sessions (to report use CPT code 92065) are allowable for the following diagnoses:

ICD-10-CM Code	Description
H50.041	Monocular esotropia with other noncomitancies, right eye
H50.042	Monocular esotropia with other noncomitancies, left eye
H50.05	Alternating esotropia
H50.06	Alternating esotropia with A pattern
H50.07	Alternating esotropia with V pattern
H50.10	Unspecified exotropia
H50.111	Monocular exotropia, right eye
H50.112	Monocular exotropia, left eye
H50.141	Monocular exotropia with other noncomitancies, right eye
H50.142	Monocular exotropia with other noncomitancies, left eye
H50.15	Alternating exotropia
H50.18	Alternating exotropia with other noncomitancies
H50.21	Vertical strabismus, right eye
H50.22	Vertical strabismus, left eye
H50.30	Unspecified intermittent heterotropia
H50.311	Intermittent monocular esotropia, right eye
H50.312	Intermittent monocular esotropia, left eye
H50.32	Intermittent alternating esotropia
H50.331	Intermittent monocular exotropia, right eye
H50.332	Intermittent monocular exotropia, left eye
H50.34	Intermittent alternating exotropia
H50.40	Unspecified heterotropia
H50.411	Cyclotropia, right eye
H50.412	Cyclotropia, left eye
H50.42	Monofixation syndrome
H50.43	Accommodative component in esotropia
H50.51	Esophoria
H50.52	Exophoria
H50.53	Vertical heterophoria
H50.54	Cyclophoria
H50.55	Alternating heterophoria
H51.0	Palsy (spasm) of conjugate gaze

ICD-10-CM Code	Description
H51.11	Convergence insufficiency
H51.12	Convergence excess
H51.8	Other specified disorders of binocular movement
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
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
H53.30	Unspecified disorder of binocular vision
H53.32	Fusion with defective stereopsis
H53.33	Simultaneous visual perception without fusion
H53.34	Suppression of binocular vision
H55.01	Congenital nystagmus
H55.02	Latent nystagmus
H55.03	Visual deprivation nystagmus
H55.81	Saccadic eye movements
H55.82	Deficient smooth pursuit eye movements
H55.89	Other irregular eye movements

Interim Benefits

Interim Benefits covers services or materials for your patients when they're not eligible for services or materials under the core plan, and there's a significant prescription change. Interim benefits criteria may vary from client to client. Check your patient's interim benefits by calling VSP at **800.615.1883** before providing services or materials. Interim Benefits may be covered for exam, frame, and additional pairs of lenses, including elective contact lenses.

Exam	Lenses	Frames
Exams are approved only if your patient has interim benefits for exams and the change in prescription meets the criteria outlined under "**Lenses**."	New lenses are allowed if: • your patient has interim benefits; • your patient meets the criteria for interim lens coverage; • you've received authorization for interim lenses.	A new frame is allowed only if your patient has interim benefits for frames and interim lenses have been approved. Depending on your patient's coverage, frame benefits may be limited to lost or broken frames, or to prescription changes requiring a frame of a different shape or size. If a frame is approved, the benefit is limited to your patient's core plan wholesale/retail frame allowanc

Inform your patients that they must pay for services and/or materials provided if they:

- Don't qualify for the services or materials requested;
- Don't have interim benefits for the services or materials requested;
- Have interim benefits but don't meet the interim services/materials criteria;
- Have recently received laser vision correction surgery, as they are not entitled to use Interim Benefits.

Contact VSP at **800.615.1883** to obtain an authorization for interim benefits. You may need your patient's previous and new prescription, plus the current visual acuity achieved with each prescription. If approved, you'll get an authorization number.

Telemedicine

Telemedicine is the delivery of health care services using telecommunication technology to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a patient's health care. This can include real-time (synchronous) interactions between patient and provider, asynchronous (capture, store, and forward) review of patient health information and/or remote patient monitoring.

As telecommunications, information and medical technologies advance, opportunities for patients to access health care services via non-traditional settings continue to develop, particularly allowing patients in underserved or remote locations to access medical expertise quickly, efficiently and without travel. Additionally, telemedicine has the potential to enhance doctor-patient relationships, support ongoing care and monitoring of eye health conditions, encourage office visits when needed, improve patient engagement in treatment plans for better health outcomes and reduce costs.

VSP® supports delivery of appropriate medical eye care services via telehealth channels to supplement access to quality vision care, including evaluating opportunities to further connect members and doctors and enable providers to practice to the full scope of their licensure, utilizing telehealth channels, when appropriate.

Prior to rendering telemedicine service, inform the beneficiary, obtain consent (verbal or written based individual state requirements), and maintain appropriate documentation. Best practice is written consent.

Only offer telemedicine services in states where you are licensed and practice only when permissible by federal, state and local laws within your scope of licensure – you do not have to sign up with VSP for telemedicine for **Billable Services** outlined below. If you choose, you can designate your practice as offering telemedicine services using the Office Special Interest form on **VSPOnline** on **eyefinity.com**, which will display these services are available to members on the Find a Doctor Directory on vsp.com.

VSP reimburses providers for medical eye care services delivered via telehealth channels, including specific CPT codes covered under the Essential Medical Eye Care and Diabetic Eyecare Plus Program℠ (only for appropriate conditions covered under the corresponding plan). Use your professional judgement to determine if a benefit or service is clinically appropriate to be provided via telehealth, subject to consent by the patient; allow or recommend alternate delivery options, when appropriate. Check with your liability insurance to verify if it covers telemedicine services, for your protection.

Billable Services

Please reference the VSP CPT codes and information in the following chart to continue providing appropriate medical eye care services to your patients via telemedicine channels. Complete CPT code details are available under the Essential Medical Eye Care and Diabetic Eyecare Plus Program detail pages.

Remember:

- All telemedicine services must have patient verbal or written consent (based on state) and documentation of their consent prior to rendering remote services.
- All images and/or videos used to make a diagnosis are required to be saved for future reference.
- Standard billing and documentation requirements must be followed for both remote and in-office services.
- Use the most appropriate CPT code that supports the service completed and appropriate modifier, when billing.
- The following services may be billed under Essential Medical Eye Care Plan and Diabetic Eyecare Plus Program when delivered remotely:

CPT Code Range	Brief Summary Description
92002, 92004	Ophthalmological services: medical examination and evaluation, new patient bill the CPT code with a GQ or 95 modifier, as appropriate
92012, 92014	Ophthalmological services: medical examination and evaluation, established patient bill the CPT code with a GQ or 95 modifier, as appropriate.
99202-99205	Office/outpatient visit, new patient evaluation and management service bill the CPT code with a GQ or 95 modifier, as appropriate.
99211-99215	Office/outpatient visit, established patient evaluation and management service bill the CPT code with a GQ or 95 modifier, as appropriate.
99421-99423	On-line digital evaluation and management service, for up to 7 days established patient, patient initiated only billable once per patient per seven-day period per chief complaint, cannot result in another evaluation and management service within 24 hours.
99441-99443	Telephone evaluation and management service, for established patient, patient initiated, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.
99446-99449, 99451	Interprofessional telephone/internet assessment, including health record assessment, by consulting provider or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional. only billable once per patient per seven-day period, not allowed if you have seen the patient directly within past 14 days.
99452	Interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting physician only billable once per patient per seven-day period.

Copays

Copays, if required, apply to exams only (92002-92014, 99202-99205, 99211-99215, 99421-99423, 99441-99443). You will receive your VSP payable fee for the service provided, less the copay.

Other Approved Services

For patients with Vision Therapy coverage, vision therapy sessions (CPT code 92065) can be billed when performed remotely. Be sure to refer to the Patient Record Report for coverage details.

CPT Code Range	Brief Summary Description
92065	Orthoptic and/or pleoptic training, with continuing medical direction and evaluation bill the CPT code with a GQ or 95 modifier, as appropriate.

Eligibility & Submitting Claims

Telemedicine services may be billed under the Essential Medical Eyecare and Diabetic Eyecare Plus Program (only for appropriate conditions covered under the corresponding plan). Check the Patient Record Report to confirm if the patient has one of these plans.

- Enter the specific procedure code and related diagnosis code(s), when completing the claim online or manually on the CMS-1500 Claim Form.
- When applicable, bill the diagnosis code with the correct eye location: left, right or bilateral.
- Bill the CPT code with a modifier to indicate the modality it was rendered, 95 synchronous or GQ asynchronous, as appropriate.

Note:

VSP recognizes but does not currently support Place of Service (POS) code 02 for reporting telehealth services rendered from a distant site except when submitted on paper as a secondary for coordination of benefits. Additionally, VSP recognizes but does not currently support POS code 10 for reporting telehealth services provided in a patient's home.

Note:

Modifiers GQ or 95 are used instead to identify telehealth services, as appropriate. Modifiers are used for information purposes only.

- Standard timely filing guidelines apply
- Patients choosing non-covered services should be informed of any out-of-pocket cost and asked to sign the Patient Responsibility Statement prior to receiving services. You can find the form under the Forms section of the Administration menu on **VSPOnline** on **eyefinity.com**.

Coordination of Benefits

Essential Medical Eye Care and Diabetic Eyecare Plus Program provide supplemental medical eye care coverage to VSP patients. These plans are secondary to other medical eye insurance coverage that may reimburse you, if you are a participating provider with the patient's medical plan. Standard coordination of benefit guidelines apply. Please refer to Coordination of Benefits in this section for more information.

Reimbursement

Telemedicine services follow the appropriate payment guidelines of the benefit being billed, which include Essential Medical Eye Care, Diabetic Eyecare Plus Program and Vision Therapy.

Technology

Use your professional judgement when selecting the appropriate telemedicine equipment, platform and technology used, adhering to federal, state and local laws to ensure patient health, safety and privacy are protected.

- Be sure to document the technology used when performing remote care.
- Providers must use equipment and data collection techniques consistent with or exceeding the accepted standards of care for in-person eye care services. (Equipment, platforms, and technology vendors used is up to provider's discretion, same as today for in-person equipment),
- Systems/processes must meet regulatory compliance for confidentiality, protecting patient's right to medical information and privacy using HIPAA/HITECH-secure channels.

Eye Exams

Eye Exams

In compliance with the clinical standards of the American Optometric Association and the American Academy of Ophthalmology, an eye exam should include, and is not limited to, the following components:

Components of a VSP WellVision Exam	
Case History	• Chief complaint or reason for the visit • Medical history and review of systems • Ocular history including family ocular and systemic history • Prescription and over the counter medications and supplements • Allergies and reactions • Social history including visual demands for work and school
Entrance Exams	• External ocular examination • Visual acuity with and without habitual correction • Extra ocular motility and vergences • Screening visual fields • Pupillary evaluations assessment of afferent and efferent neurological pathways • Tonometry
Refractive Status Evaluation	• Routine distance and near objective and subjective refraction • Lensometry, as applicable • Keratometry • Additional accommodative and vergence testing is at the discretion of the provider.
Ocular Health Assessment	• Biomicroscopy including fundus evaluation • Direct ophthalmoscopy or binocular indirect ophthalmoscopy • Dilated fundus examination
Assessment and Plan	• Document all clinical findings, not limited to chief complaint, and recommendation(s) for treatment plan in patient's chart notes

In some cases, to support the best possible health outcomes for your patient, you may need to refer your patient to their primary care provider or other eye care specialist. If you determine your VSP patient needs care coordination, please refer the patient to their medical insurance plan with a copy of your referral, including a relevant summary of your examination findings. Retain a copy of any referral correspondence in your patient's records or file. To assist with this communication, we provide the optional Primary Care Physician Communication Form which may be accessed in the **Forms Library** section of the **Administration** area on **VSPOnline**.

VSP covers evaluation and management services for patients who have Essential Medical Eye Care as part of their VSP plan. Please refer to Current Procedural Terminology (CPT) guidelines maintained by the American Medical Association (AMA) for additional information related to evaluation and management services.

The American Diabetes Association, American Optometric Association, and American Academy of Ophthalmology recommend that patients with diabetes receive an annual dilated eye exam. A dilated retinal eye exam is also a measure of clinical quality designated by the National Committee for Quality Assurance (NCQA).

In support of this standard of care, VSP highly recommends patients with diabetes receive a dilated retinal eye exam.

We recognize that at times there are good reasons for not providing a dilated exam. In those cases, medical record documentation of the rationale for not performing dilation is required. Examples include:

- Patient refused
- Dilated exam was performed within the last 12 months
- Patient scheduled dilation for a later date
- Patient is under the care of another practitioner
- Patient has a history of adverse or allergic reaction to mydriatic eye drops

VSP requires network doctors to share dilated or retinal eye exam results with the patient's primary care provider (PCP) or the physician managing diabetes care. This communication not only ensures continuity of care but also highlights your role in the healthcare continuum and your involvement in the treatment of patients with diabetes and other health conditions. To assist you with this communication, we provide the optional Primary Care Provider Communication Form which may be accessed in the **Forms Library** section of the **Administration** area on **VSPOnline**.

Please refer to the HEDIS for Quality Measures section for additional information on VSP's standards of care in diabetes.

Note:

Retinal imaging does not replace a dilated eye exam as the standard of care for a patient with diabetes.

Pediatric Eye Exams

You can perform independent diagnostic and treatment procedures if a child's history indicates a development lag or learning problem. Please refer to the Supplemental Testing section.

Note:

You can bill the following services at the comprehensive exam level if all parts of the age-related exam are completed and documented.

The medical record should be complete and legible, and each encounter should include the date of service and legible identity of the provider performing the service and their signature or electronic identifier. The patient's medical record is considered incomplete without the doctor's authentication that the information is a true and accurate representation of the service provided.

Case History and Visual System Health

Case History	Visual System Health Status Evaluation
• Visual and ocular history • Prenatal, perinatal, and postnatal general health history • Current medications and medication allergies • Family eye and medical histories • Child's developmental history • Time spent outdoors, on near work and screen viewing • Names of, contact information for, patient's other health care providers	• External exam • Biomicroscopy (anterior segment photos are separate procedures. They're not acceptable in place of biomicroscopy without separate documentation of anterior segment findings) • Internal/Fundus exam including direct and/or indirect ophthalmoscopy with or without pupillary dilation and at minimum, a numerical notation of cup-to-disc ratio documented for each eye* • Pupillary reflexes • Binocularity – ocular alignment (cover test, Hirschberg, Krimsky, Bruckner, Stereopsis, near point of convergence) Any of test is sufficient • Ocular motility/Versions (must be recorded separately from binocular function testing) • Tonometry (Tactile) – If child is cooperative • Screening visual fields/confrontations at doctor's discretion ***Note:** Fundus photos and **opto**map® retinal exams are separate procedures. They're not acceptable in place of performing direct or indirect ophthalmoscopy.

Refractive Status Evaluation

Entering and Best Corrected Visual Acuity Suggested measure of acuity assessment, not limited to the following (recorded monocularly):	Refraction or Autorefraction
• Fixation preference tests • Bruckner's test • Preferential looking visual acuity test • Fix and follow and Visual evoked potential	• Cycloplegic retinoscopy • Static retinoscopy

Case History and Visual System Health

Case History	Visual System Health Status Evaluation
• Identification and description of the chief complaint • Visual and ocular history • Prenatal, perinatal, and postnatal general health history and review of systems • Current medications and medication allergies • Family eye and medical histories • Child's developmental history • Time spent outdoors, on sports activities, on near work and screen viewing • Names of, and contact information for, the patient's other health care providers	• External exam • Biomicroscopy (anterior segment photos are separate procedures. They're not acceptable in place of biomicroscopy without separate documentation of anterior segment findings) • Internal/Fundus exam including direct and/or indirect ophthalmoscopy with or without pupillary dilation and at minimum, a numerical notation of cup-to-disc ratio documented for each eye* • Pupillary reflexes • Ocular motility/Versions (must be recorded separately from binocular function testing) • Binocularity – ocular alignment at distance and near (cover test, Hirschberg, Krimsky, Stereopsis,near point of convergence, Positive and Negative Fusional Vergence, Accomodative convergence) Any one test is sufficient • Screening visual fields/confrontations at doctor's discretion • Color Vision Testing – Once in lifetime • Tonometry – if child is cooperative ***Note:** Fundus photos and **opto**map® are separate procedures. They're not acceptable in place of performing direct or indirect ophthalmoscopy.

Refractive Status Evaluation

Entering and Best Corrected Visual Acuity	Refraction or Autorefraction	Accommodation
Suggested measure of quantitative acuity, not limited to the following (recorded monocularly): • Broken wheel acuity cards • Lighthouse cards with matching blocks • HOTV test • Tumbling E chart • Snellen acuity chart • Lea symbols and Sloan letters	At least one, with corrected visual acuity as stated at left: • Static retinoscopy • Cycloplegic retinoscopy	Accomodative Function is a guideline based on the doctor's professional judgment and not an exam requirement. Any near point accommodation testing is performed when clinically indicated.

Case History and Visual System Health

Case History	Visual System Health Status Evaluation
• Identification and description of the chief complaint • Visual and ocular history • Prenatal, perinatal, and postnatal general health history • Current medications and medication allergies • Family eye and medical histories • Child's developmental history • School performance history • Time spent outdoors, on sports activities, on near work and screen viewing • Names of, and contact information for, the patient's other health care providers	• External exam • Biomicroscopy (anterior segment photos are separate procedures. They're not acceptable in place of biomicroscopy without separate documentation of anterior segment findings) • Internal/Fundus exam including direct and/or indirect ophthalmoscopy with or without pupillary dilation and at minimum, a numerical notation of cup-to-disc ratio documented for each eye* • Pupillary reflexes • Ocular motility/Versions (must be recorded separately from binocular function testing) • Binocularity – ocular alignment at distance and near (cover test, Hirschberg, Krimsky, Stereopsis,near point of convergence, Positive and Negative Fusional Vergence, Accomodative convergence) Any one test is sufficient • Screening visual fields/confrontations at doctor's discretion • Color Vision Testing – Once in lifetime • **Tonometry Guideline**: Attempt either applanation or noncontact at the earliest age that a child is cooperative. Tactile estimations acceptable if documentation supports the reason why numerical tonometry wasn't performed. ***Note:** Fundus photos and **opto**map® retinal exams are separate procedures. They're not acceptable in place of performing direct or indirect ophthalmoscopy.

Refractive Status Evaluation

Entering and Best Corrected Visual Acuity	Refraction	Accommodation
Suggested measure of acuity assessment, any one test is sufficient. (Must be recorded monocularly): • Bruckner's test • Snellen acuity chart • ETDRS Visual Acuity	• Static retinoscopy or Auto refractor results- acceptable in non-verbal patients • Determination of refractive state with best corrected visual acuities (recorded monocularly). Testing may be delegated to qualified staff under the supervision of a licensed VSP Network Doctor (as permitted by state regulation) and may be done with or without DPA's (diagnostic pharmaceutical agents) • Cycloplegic retinoscopy	• Accommodative Function is a guideline based on the doctor's professional judgment and not an exam requirement. Any near point accommodation testing is performed when clinically indicated.

Supplemental Testing or Procedures

Additional testing or procedures, beyond those included in a VSP WellVision® Exam, may be needed based on clinical judgment, individual patient symptoms, and exam findings. For example, you may need to perform additional testing or procedures to rule out suspected disease or to provide a more in-depth medical assessment.

Supplemental testing should be associated with a medical eye-related condition, be medically necessary for your patient's care in accordance with accepted ophthalmic standards of care, and include interpretation and report, when required. Please advise your patient of any testing that is not covered by insurance and any associated out-of-pocket cost before the service(s) is rendered.

Exam Documentation

The following exam records must be maintained:

- All exam, diagnostic, and treatment procedures should be filed in your patient's chart.
- Descriptive or quantitative data for all tests. Check marks or slash lines made on your patient's chart are not acceptable as evidence of test results, unless you check specific conditions/structures. We'll accept checking "lens, disc (with numerical cup-to-disc ratio at a minimum for each eye), fovea, and media" if the check indicates the structure has a normal appearance and function, but won't accept checking ophthalmoscopy if no results are provided.
- An itemized record of charges made to your patients for copays, eyewear overages, and contact lens overages. Keep these records in some form (paper copy, CD, electronic health records, etc.). Financial records are kept on your patient's record card, a separate ledger card, or a fee slip.
- Per HIPAA Rules, medical records must be retained and accessible for six years (ten years for Medicare managed care program providers) or as required by federal/state law, from the date of its creation or the date when it last was in effect, whichever is greater.

Actual findings for each patient must be recorded on medical exam records. All records submitted for evaluation must contain true findings. You can't alter, falsify, or add to records in any way.

Doctors using electronic record-keeping systems must record the actual results of tests and procedures done for each patient on the date of service. We won't accept computerized "default" entries. This standard applies to patients of all ages and exams of all levels.

Below, you'll find descriptive recording standards for adult (19 years and older), intermediate and comprehensive eye exams, and pediatric comprehensive exams. For pediatric exams (patients up to 18 years and 11 months), refer to Pediatric Eye Exams.

You can find a sample Patient Exam Form in the **Practice Administration** section under the Administration area on **VSPOnline** on **eyefinity.com**.

Our guidelines for examination procedure and documentation requirements will supersede any specific state minimum requirements for care provided to VSP patients, except to the extent expressly limited by law.

Note:

Reimbursement of a comprehensive service relies on the proper recording of all testing included in the comprehensive exam. Document the reason for any exam components that were attempted but could not be performed or the exam will be considered deficient.

The medical record should be complete and legible, and each encounter should include the date of service and legible identity of the provider performing the service and their signature or electronic identifier. The patient's medical record is considered incomplete without the doctor's authentication that the information is a true and accurate representation of the service provided.

Procedure	Recorded Data
Case History (Hx)	• Patient's chief complaint or reason for exam • Ocular and visual health history (your patient and family, past and present) • General health status (e.g., significant illnesses and medical conditions) • Current medication and medication allergies • Occupational and vocational visual demands
Ophthalmoscopy	At minimum, a nerve head assessment, including a numerical cup-to-disc ratio or hand-drawing of cupping is required to satisfy this requirement. If the C/D ratio is the same for each eye, indicate OU. If different for each eye, document OD and OS accordingly. Ophthalmoscopy may be done with or without diagnostic pharmaceutical agents (DPAs)*. In addition, we advise you record the following: • Vascular assessment, including A/V size ratio or grading of hypertensive or arteriosclerotic retinopathy changes; • Descriptive retinal findings, macula assessment and grading of foveal reflex brightness; • Observations of media. ***Note:** We consider Fundus photos and Optomap retinal exams separate procedures. They're not acceptable in lieu of performing direct or indirect ophthalmoscopy.
Neurological Integrity (pupil reflexes)	Record descriptions of normal pupillary reflexes, such as "equal, round, reactive to light and accommodation (PERRLA)," WNL, pupils R&R (round and reactive), -APD, **Ø** APD, direct and consensual, and/or -Marcus-Gunn. Also, clearly record deviations from normal responses with diagnostic impressions. Measurement and documentation of pupil size in one level of illumination alone is <u>not</u> acceptable.
Versions	Record assessments of extraocular muscle motility, such as "full and smooth," FROM (full range of motion), SAFE, 1-4+, unrestricted, etc., describing any deviations from normal. Must be documented separately from binocularity testing results.
External/Adnexa Exam	Record lids, lacrimal apparatus, sclera and conjunctiva as "clear," describing any deviations from normal in the ocular adnexa.
Biomicroscopy (SLE)	When recording slit lamp exam, include a description of anterior segment, corneal clarity, media clarity or anterior chamber angle quantification. Anterior segment photos are separate procedures. They're not acceptable in lieu of biomicroscopy without separate documentation of anterior segment findings.
Screening Visual Fields	Gross visual fields or confrontation testing is acceptable for the comprehensive level of service. Record any depressions found in the gross visual fields or confrontation testing. Record a normal finding as "negative, WNL, FTFC (full to finger count), full in all quadrants, etc." or taken from automated visual field printouts. At minimum, a tangent screen is an acceptable device used to get gross visual fields. For visual field screening, at minimum, evaluate and record at least two meridians of visual field. Vision screeners that only test or measure single meridian fields won't be accepted.
Tonometry	Record a numerical pressure measurement for each eye, type of instrument, date and time performed. Tactile estimations of intraocular pressure are only acceptable if there's a documented reason for not having done a quantitative measurement. If tonometry is omitted for any reason on an adult, bill a lesser level of service. For pediatric patients, tonometry is a guideline, not a requirement. Attempt tonometry, either applanation or noncontact, at the earliest age the child is cooperative.
Visual Acuity (VA)	Record monocularly as: • Entering visual acuity (at 20 ft) with habitual Rx or unaided. Document monocular distance acuities for each eye for monovision contact lens patients. • Best corrected visual acuity at distance through the subjective refraction. • your patient can't respond properly to testing (e.g., non-verbal or illiterate) please indicate in your documentation.

Procedure	Recorded Data
Subjective Refraction	Determination of refractive state with best corrected visual acuities (recorded monocularly). Testing may be delegated to qualified staff under the supervision of a licensed VSP Network Doctor (as permitted by state regulation) and may be done with or without DPA's (diagnostic pharmaceutical agents) Subjective refraction must be performed without spectacle or contact lenses. The only exceptions to this rule are: • Spectacle overrefractions are acceptable if your patient can't respond properly to subjective testing (e.g., non-verbal, illiterate patients) and are recorded quantitatively. • Contact lens overrefractions are acceptable only in cases of corneal irregularity where the manifest refraction is inconclusive (keratoconus, corneal transplants, dystrophies, etc.). For the above exceptions, indicate why you couldn't perform the subjective Rx.
Accommodative Function	Accommodative Function is a guideline based on the doctor's professional judgment and not an exam requirement. Any near point accommodation testing (pediatric and adult exams) is performed when clinically indicated.
Diagnosis	Document the diagnosis on the exam chart. The diagnosis must be supported by the documented clinical findings. Any charge to your patient for special testing procedures must be supported by a recorded diagnosis. Diagnoses, either written or coded, must have an ICD-9-CM billable code. Always code to the highest degree of specificity when indicating diagnosis. A diagnosis taken from an eClaim printout, CMS-1500 Form, WellVision Savings Statement, or a superbill isn't acceptable unless it's signed, initialed, or has some unique identifer by the doctor. Subjective Rx findings, a written Rx copy, or optical materials order are not acceptable in lieu of the written diagnosis.
Treatment Plan	The treatment plan should be consistent with the diagnosis and/or reflect the clinical findings. The treatment plan/therapies can include specific treatments or documentation that no therapy was needed. Documentation of a treatment plan by the doctor is required in the patient's chart notes. Record the instructions provided to your patient.

Medical-Record Documentation

Providers are responsible for documenting each patient encounter completely, accurately, and timely. Accurate documentation supports compliance with federal and state laws and reduces fraud, waste, and abuse. These medical-record documentation guidelines are provided to help ensure that VSP network doctors meet VSP's documentation requirements. Inadequate documentation may result in the denial of services.

A medical record is a written or electronic health record of a patient's medical history and clinical data associated with a patient's care, including patient demographics, patient medical and family history, examination and evaluation notes, and all data and reports related to point of care assessment, testing, diagnosis, and treatment.

Medical records include and are not limited to:

- Patient history questionnaires or intake forms
- Exam chart notes, progress notes, orders, and prescriptions
- Diagnostic testing and results
- Referral summaries and patient communications
- Correspondences between interprofessional health care providers
- Optical records and lab order forms, including spectacle and contact lens order forms
- CMS-1500 Claim Forms, superbills, and eClaim patient printouts
- Physician orders for services provided in long-term care facilities

Providers are responsible for accurate documentation and claim submission of services performed. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to American Medical Association (AMA), Centers for Medicare and Medicaid Services (CMS), Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), International Classification of Diseases (ICD-10 CM), and National Correct Coding Initiative (NCCI).

All medical record entries must be complete, legible, dated, and include the legible signature of the doctor providing care, consistent with Centers for Medicare & Medicaid Services (CMS) policies and procedures, or as required by federal/state laws. Any encounter between the doctor, clinical staff, and the patient must be documented in the patient's medical record.

In compliance with CMS, VSP network doctors are required to maintain medical records for seven years from the date of service, or as required by federal and state laws. Medicare managed care program providers are required to retain records for ten years from the date of service, or as required by federal and state laws.

Medical Record Requirements	Description
Medical record	Ensure all procedures are documented according to industry standard coding guidelines. Undocumented procedures are considered not performed unless the test was attempted and there is documentation as to why results were not obtained. Examples may include but are not limited: to the patient is non-verbal, non-responsive, uncooperative, refused testing, etc.
Claim date of service	The date of service for the patient encounter must reflect the date of service on the claim.
Past medical history	Document or review the patient's ocular and medical history, which includes but is not limited to diseases and illnesses currently being treated, surgical history, family medical history, social history, allergies, medications, and the date of last eye exam or refractive prescription.
Chief complaint and history of present illness	Document the reason for the visit as stated in the patient's own words. Document the description of the present illness with reference to onset, location, duration, severity, etc. as related to the chief complaint.
Consistent diagnoses, exam findings, and treatment plans	A valid ICD-10-CM diagnosis must be documented for each patient encounter and supported by the documented clinical findings. Documentation should include all recommended treatments, diagnostic testing, and follow-up care instructions. Treatment plans must be appropriate and consistent with the diagnosis.
Follow-up care/visits	Medical record documentation must indicate the patient's follow-up care cadence. Computerized recall documentation alone is insufficient. Electronic records must have recall dates present within the medical record and a doctor identifier must also be present.
Signature requirements	Signatures for each entry must be legible and should include the practitioner's first and last name, and applicable credentials. The practitioner's signature or initials in patients' medical records and chart notes demonstrate that services submitted have been completely and accurately documented, reviewed, and authenticated. Furthermore, it confirms the provider has certified the medical necessity for the service(s) submitted to VSP for payment consideration.
Avoid potential risks for patients	Doctor interventions should be appropriate for the patient history, clinical findings, and diagnosis. There should be no indication that a patient was placed at potential risk due to diagnostic or therapeutic procedures provided or not provided.
Appointment timing	If an appointment is delayed or extended, note in the relevant record that a longer waiting time would not have a detrimental effect on the health of the patient.
Preferred written and spoken language	Document preferred written and spoken language on the patient history form and/or medical record.
Use of interpreter	Document the use of an interpreter in the patient's medical record when a patient receives interpreter services, including who provided the interpretation (trained professional interpreter, office staff, etc.)
Refusal of interpreter	If a patient prefers a language that is not provided in the office and refuses the use of a trained professional interpreter, document the refusal in the patient's medical record. Note: A trained professional interpreter does not include friends or family members, unless the person is professionally trained, including knowledge of medical terminology.

Note:

For California patients, include the following documentation. Refer to the VSP Members Language Assistance Program for more information.

Contact Lens Case Management Procedures

Contact lens services (evaluation/fitting) are in addition to eye exams.

Diagnostic contact lens fittings can be for a first-time contact lens wearer or a refit patient. The diagnostic fitting includes your patient's contact lens history, evaluation/fitting services, assessment, and a treatment plan. We define a contact lens refit for those patients who have worn contact lenses before but must fit into a different parameter (base curve, diameter, etc.) or different lens type (RGP to soft, spherical to toric, extended wear to daily wear, etc.).

If your patient's case is complex and you choose to refer them to another doctor, we'll reimburse you for the eye exam level of service provided. If the referral is to a doctor outside your practice and you've already billed us for a comprehensive level of service, we'll pay that doctor an intermediate exam service fee plus contact lens fees for services and materials. If you provide both services, we'll pay the global fees.

We require evaluation and record-keeping as outlined in each area below. Per HIPAA Rules, medical records must be retained and accessible for six years (ten years for Medicare managed care program providers) or as required by federal/state law, from the date of its creation or the date when it last was in effect, whichever is greater.

Note:

The medical record should be complete and legible, and each encounter should include the date of service and legible identity of the provider performing the service and their signature or electronic identifier. The patient's medical record is considered incomplete without the doctor's authentication that the information is a true and accurate representation of the service provided.

Diagnostic Contact Lens Fitting

Contact lens history	Additional case history impacting the use and care of contact lenses (e.g., work conditions, desired wearing schedule, previous lenses, and solutions).
Contact lens exam services (fitting and evaluation)	• Keratometry • Slit lamp evaluation (SLE):** - With diagnostic contact lenses to assess lens fit (record the diagnostic lenses through which all tests are performed) - Without contact lenses to assess condition of the cornea,sclera, conjunctiva, lids, or tear film • Over-refraction performed with diagnostic contact lenses • Monocular visual acuity measurements with and without new contact lenses • Patient's subjective and/or doctor's objective response to the diagnostic lenses ****Note**: Anterior segment photos are a separate procedure. We won't accept them in place of biomicroscopy without separate documentation of anterior segment findings. ****Note:** Use of diagnostic tools such as ocular wavefront aberrometer, autorefractometer, corneal topographer and keratometer does not replace the requirement to record clinical findings in the patient's records.
Assessment	Record your clinical impressions and diagnosis.
Plan	The treatment plan is related to the assessment above and includes the following: • Ordering information, such as lens material and parameter: base curve, diameter, power, peripheral curves, and thickness, when applicable. • Prior to dispensing the contact lenses, verify the lens parameters, if possible. • At the time of dispensing the contact lenses, provide instructions for lens care, handling, and wearing schedule. Your patient must demonstrate at this time the ability to handle, insert, and remove the contact lenses. • Maintain complete records of financial data relating to contact lens materials, fitting, and management.

Routine Progress Evaluation or Subsequent Visits

Contact lens history	Case history, including lens care and wearing schedule compliance
Contact lens services (evaluation/fitting)	• Monocular visual acuities with new contact lenses • Over-refraction, if appropriate • Slit lamp exam with and without contact lenses** • Keratometry when indicated • Lens movement and centration ****Note:** Anterior segment photos are a separate procedure. We won't accept them in place of biomicroscopy without separate documentation of anterior segment findings.
Assessment	Record your clinical impressions and diagnosis.
Plan	• Recommendations and advice, including the recording of any lens changes or modifications to the lens, wearing schedule, or care • Record of any financial transactions

Ordering and Dispensing Contact Lenses

Manufacturer contact lens order	Contact lens order details to/from the manufacture to include type of contact lens ordered, unit amounts, patient for which the contacts are for and the order date.
Contact lens	• Date contact lens were ordered or indication of stock lenses • Brand and type of contacts ordered • Unit amounts of contacts ordered • Date, brand, type and number units dispensed
Financial records	• Patient name • Date of service • CL brand • Type • Quantity dispensed • U&C cost per box • Amount billed to insurance • Amount paid by the patient • Method of payment

When billing VSP for contact lenses, you must keep a list of your contact lens material U&C fees and costs for services/materials (e.g. Fitting/Evaluation(s)) for reference. **This must be shown to any VSP Representative upon request.**

Quality Measures

Eye exams are an important component of diabetes management and help to close gaps in care.

When submitting retinal or dilated eye exam claims for VSP patients with diabetes, include Current Procedural Terminology (CPT®) Category II codes to provide more complete information and support quality programs such as Medicare's Merit-based Incentive Payment System (MIPS), Healthcare Effectiveness Data and Information Set® (HEDIS), and the Centers for Medicare & Medicaid Services (CMS) Five-Star Quality Rating System.

Including CPT Category II codes 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, using CPT Category II codes reduces the number of medical records requested for quality measure reporting and gap closure attestation.

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. Plans use HEDIS data to measure performance and drive improvement efforts.

HEDIS includes more than 90 measures across multiple domains of care. These measures relate to public health issues, including asthma medication use, blood pressure control, cancer screening, diabetes care, heart disease, and smoking and tobacco use cessation.

Eye Exam for Patients With Diabetes

Eye Exam for Patients With Diabetes (EED) is a HEDIS effectiveness of care measure that evaluates the percentage of members 18 to 75 years of age with diabetes (types 1 and 2) who received a retinal or dilated eye exam.

The measure includes:

- Retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.
- Negative retinal or dilated eye exam by an eye care professional in the year prior to the measurement year.

A slit-lamp examination must have documentation of dilation or evidence that the retina was examined to be considered compliant. Examination of macula, vessels, and periphery without dilation meets the criteria for a "retinal exam."

Diabetic Retinal Exam Codes

Diabetic retinal exam codes valid for the Eye Exam for Patients With Diabetes (EED) measure are:

CPT Codes: 92002, 92004, 92012, 92014, 92134, 92201, 92202, 92227, 92228, 92250, 92260, 99203- 99205, 99213-99215, 99242-99245

HCPCS Codes: S0620, S0621

Patients with Diabetes with Evidence of Retinopathy	
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
Patients with Diabetes 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)

Visit vspeyeondiabetes.com to download a diabetic eye exam CPT Category II codes reference sheet and find additional resources for your practice.

VSP network doctors are eligible for an additional $5 reimbursement on VSP WellVision Exam claims by indicating the patient has diabetes or diabetic retinopathy via the diagnosis code or the checkbox in eClaim on eyefinity.com and including the appropriate CPT Category II code. Refer to the Submitting Patient Conditions Requirement for more information.

CPT® is a registered trademark of the American Medical Association.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

The codes and quality measure tips listed above are informational only, not clinical guidelines or standards of care, and do not guarantee reimbursement.

Clinical Practice Guidelines

Clinical practice guidelines are defined by the Institute of Medicine as, "statements that include recommendations, intended to optimize patient care, that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options." These guidelines are intended to improve the quality of patient care, help reduce inappropriate practice variation, lessen disparities, and empower patients.

VSP network doctors' adherence to these practice patterns supports our continuous quality-improvement program.

VSP Vision Care has adopted the Clinical Practice Guidelines of the American Optometric Association (AOA) and the Preferred Practice Pattern® Guidelines of the American Academy of Ophthalmology (AAO).

Hard copies of these guidelines are available by contacting the above associations directly.

VSP audits patient medical records according to the Clinical Practice Guidelines of the American Optometric Association (AOA) and the Preferred Practice Pattern® Guidelines of the American Academy of Ophthalmology (AAO). Clinical justification must be detailed in the patient's medical record if you choose to deviate from the recommended procedures.

Note:

Clinical reviews are conducted by a licensed optometrist or ophthalmologist.

Using Our Contract Lab System

We contract with optical labs throughout the United States to manufacture prescription orders submitted by VSP network doctors. Claim payment for orders with materials will only be processed after the contract lab completes a prescription and submits the claim to VSP for payment.

Important!

The VSP Signature Plan® doesn't cover lenses made in your office unless they're processed under the VSP In-Office Finishing Program. Covered lenses dispensed to VSP patients must be fabricated entirely by a participating VSP contract lab (unless you're providing an in-office lens enhancement or the lens qualifies for the VSP In-Office Finishing Program).

For additional materials (such as a second pair of eyeglass lenses and frames), you can use any lab you choose, including in-office labs. See VSP Signature Plan in the **Plans & Coverages** section for details.

1. Submit orders to contract labs through eClaim or on paper using the CMS-1500 form and Materials Invoice. Include all prescription information. You can choose any lab on the National Contract Lab List.
2. Charge your patients for lens enhancements unless their plans say otherwise. For these lens enhancements, VSP lab allocations are deducted from your reimbursement to pay the lab (see VSP Signature Lens Enhancements Chart for more information).
3. The lab will ship the completed order to you and forward your claim to VSP for payment.

Using Non-Contract Labs

You can only use non-contract labs in emergencies. VSP monitors the use of non-contract labs and they may only be used in the situations below.

Examples of emergencies include:

- Loss, theft, or breakage of prescription eyewear when your patient doesn't own an alternate pair and can't wear contact lenses
- Situations where your patient can't function at work or school and doesn't have another pair of glasses or contact lenses
- Patients whose safety and well-being will be jeopardized without the immediate delivery of their prescription eyewear

Emergency situations don't include:

- Instances where faster turn-around time is requested to accommodate trips, vacations, or other discretionary events
- Providing faster service when your patient has another functional pair of glasses or contacts

Important!

You must document the emergency that requires the use of Non-Contract Labs. Inappropriate use of Non-Contract Labs will result in the denial of services and materials, including lenses and frames.

To submit a claim when a non-VSP lab is used, select Non-IDC Lab Invoice (Lab 0100) from the pull-down menu in the Lab Selection box on eClaim or write "Non-IDC Lab Invoice (Lab 0100)" in the Special Instructions area of the Materials Invoice. When submitting an emergency claim, please specify the emergency reason. Selecting an emergency reason is for documentation purposes; not selecting a reason does not remove the emergency requirement.

All Lab invoices must be kept for a minimum of seven (7) years. Failure to keep Lab invoices may result in the denial of services and materials.

Lab invoices from an outside private lab must include the following:

- Patient name
- Date ordered/date completed
- Rx
- Lens enhancements
- Style and frame type, including make and model

You'll be responsible for the entire cost of the lab bill and should pay the lab on a private-transaction basis. Don't charge the patient for covered lens enhancements, you won't receive a service fee for covered lens enhancements. For all other lens enhancements, charge the patient according to their plan. You won't receive a VSP lab allocation for these lens enhancements. VSP will pay you an established fee of $10.50 for single vision, $23.50 for bifocal/progressive and $33.50 for trifocal, in addition to your regular dispensing fees. Use your bifocal lens-dispensing fee for progressives. Charge your patient according to the VSP Signature Lens Enhancements Chart or your adjusted U&C fee (whichever is lower). Don't balance-bill the patient.

All emergency orders are subject to review. When a claim is found to be incorrect, payments for material services will be reversed.

Important!

Always verify orders upon receipt by checking all lab lens enhancement codes.

Uncuts

Uncut lenses can only be processed in the case of an emergency. Submit as a private order. The lab will bill their U&C fees. This should only be done on very rare occasions.

You can order the following on a private-transaction basis:

- Proprietary Lens and Frame (see Proprietary Lens and Frame in this section)
- Plano lenses (if not covered by your patient's plan)
- Additional pairs of glasses using the value-added benefit (80% or 70% of U&C unless covered by your patient's plan—refer to **Section 2—Plans and Coverages** for more information about additional pairs of glasses)

Certain single vision stock lenses may be finished in your office through the VSP In-Office Finishing Program. Refer to the VSP In-Office Finishing Program section of the manual for complete details.

A Lab order form and/or invoice are required for in-office jobs as well. These invoices must include the following:

- Patient name
- Date ordered/date completed
- Rx
- Lens enhancements
- Style and frame type, including make and model

Records must also include the date when the glasses were dispensed to the patient.

(AL)

VSP is providing VSP doctors the option to opt-out of the VSP Contract Lab Network in certain approved states. For more information regarding the **VSP Contract Lab Network Opt-Out Policy and Process** click here.

(AR)

VSP is providing VSP doctors the option to opt-out of the VSP Contract Lab Network in certain approved states. For more information regarding the **VSP Contract Lab Network Opt-Out Policy and Process** click here.

(FL)

VSP is providing VSP doctors the option to opt-out of the VSP Contract Lab Network in certain approved states. For more information regarding the **VSP Contract Lab Network Opt-Out Policy and Process** click here.

(GA)

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(KS)

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(ME)

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(MO)

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(NJ)

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(OR)

VSP is providing VSP doctors the option to opt-out of the VSP Contract Lab Network in certain approved states. For more information regarding the **VSP Contract Lab Network Opt-Out Policy and Process** click here.

(OH)

VSP is providing VSP doctors the option to opt-out of the VSP Contract Lab Network in certain approved states. For more information regarding the **VSP Contract Lab Network Opt-Out Policy and Process** click here.

(PA)

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(TX)

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(VA)

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(VT)

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(WV)

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(NV)

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(IL)

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VSP® In-Office Finishing Program

In-office finishing is available for **single vision, stock lenses** purchased from the **Plexus Optix™** Single Vision Stock Lens Catalog on **eBuy** for your VSP Signature Plan®, VSP Choice Plan®, VSP Advantage Plan℠, VSP Enhanced Advantage Plan℠ and CVC and Additional Pair patients.

The program **excludes** the following:

- Orders from other practices—you can only finish lenses from patients seen at your practice; you may not finish work for other VSP Network providers.
- Lenses not purchased from Plexus Optix, Inc. through **eBuy** at **eyefinity.com.**
- Lenses surfaced or altered by any lab (uncuts).
- **Charity care claims** (VSP Eyes of Hope® Gift Certificates, including co-branded VSP Eyes of Hope®/American Red Cross Gift Certificates)—these orders must be submitted to a VSP**One™** Optical Technology Center.
- **Lab-supplied frames**—only frames supplied by the doctor or the patient are eligible for the program.
- **AR coating applied at a lab**—only pre-coated stock lenses are eligible for the program.
- Custom coatings.
- Lab applied coatings (Mirror and Ski Coats).
- Lab applied scratch coatings (VSP lens enhancement code QS: Scratch Resistant Coating B—other Approved Coatings).
- Products not specified in the Plexus Optix Single Vision Stock Lens Catalog.
- Any Rx that doesn't meet the VSP minimum prescription requirements.

Stock lenses dispensed on VSP In-Office Finishing claims should be purchased from the Plexus Distribution Center. Dispensing stock lenses from other vendors on IOF claims may result in penalties or loss of access to the VSP IOF program. Plexus lenses can be ordered through eBuy at eyefinity.com. For assistance call Plexus at **844.753.9870** or email iof@vsp.com.

*Exceptions apply in the following states: Alabama, Arkansas, Florida, Georgia, Illinois, Kansas, Maine, Missouri, Nevada, New Jersey, Ohio, Oregon, South Dakota, Texas, Utah, Vermont, West Virginia.

Online

Claims must be submitted electronically through **eClaim** at **eyefinity.com** or through a practice management system that's integrated with Eyefinity.

1. Select In-Office Stock Lenses in the Lens Finishing section of the Lab Invoice screen.
2. Select Single Vision.
3. Select the appropriate Material.
4. Choose the appropriate lens from the menu.
5. Select VSP IOF Program from the Select Lab dropdown.
6. Choose either Doctor Supplied or Patient Supplied from the Frame Supplier menu.
7. Complete all other required fields and submit the claim.

Paper

Claims for the VSP In-Office Finishing Program must be submitted electronically; paper claim submissions aren't eligible.

Your patient records should accurately document VSP In-Office Finishing Program claims as billed. Patient records must clearly indicate the materials supplied and how and when the order was completed, including the frame manufacturer and model, lens purchase details, prescription, lens materials, lens enhancements, date of lens finishing, date received by patient, and any other relevant data. The VSP Doctor Service Report is not considered adequate documentation.

You must charge patients for all copays and non-covered lens enhancements.

The following redo policies and procedures apply to VSP In-Office Finishing Program single-vision stock lens orders. You're responsible for the cost of all redos. Your patient should not be charged for redos resulting from a prescription change or errors made by office staff or in office labs.

Requirements – A patient is entitled to a redo when one of the following requirement(s) is met:	**Limitations –** You may deny or charge for a redo that falls within the following limitations:
• Power changes (not including changes resulting in plano lenses) • Axis changes • Errors in transcription (not including transcription errors involving tints, photochromics, coatings, or frames) • Change in materials (e.g., glass to plastic, plastic to polycarbonate, plastic to high index plastic, or glass, etc.) • Changes in base curves	• Change made by the patient in the frame size, shape, or style • Addition or change made by the patient in tint or coating • Materials lost, broken, or damaged by the patient

Redos on Lens Enhancements

Important!

Lenses covered by a manufacturer's warranty (e.g., defects and scratch warranties) are not considered a redo. Please refer to the Terms and Conditions in the Plexus Optix Single Vision Stock Lens Catalog.

On qualified first-time doctor redo prescriptions, lens enhancements ordered on the original prescription will be covered on the first-time doctor redo.

Important!

Ordering additional covered lens enhancements not supplied on the original prescription is not a valid reason for a redo, but if there's another reason to remake an order, you may include additional lens enhancements on the new lenses.

Adding a lens enhancement that was not on the original prescription should be administered as follows:

Covered Lens Enhancements	All Other Lens Enhancements
Don't charge the patient.* Submit a copy of the invoice with a First Time Redo Verification form for reimbursement of the added covered enhancement. *There's no charge to you or your patient for adding a covered lens enhancement unless the covered lens enhancement can't be added to the original order (e.g., two options that can't be combined like photochromic and solid tint). Enhancements or materials that can't be added to the original order are a private transaction between you and your patient. Note: Ordering additional covered lens enhancements as the only reason for a redo doesn't meet VSP's requirements. Refer to the First-Time Doctor Redo Requirements and Limitations section to ensure there's a valid reason for the first-time redo.	Charge the patient either the patient copay or 80% of your U&C according to their plan type.

Redos sent to contract labs

If lenses must be remade into a style or with lens enhancements not available through the VSP In-Office Finishing Program, you are responsible for covering all lab costs.

Other Redo Questions

For other questions on IOF redos, call VSP at **800.615.1883**.

Refer to the VSP In-Office Finishing Stock Lens Catalog for a complete list of materials, lens enhancements, and services and their reimbursement amounts. A few important items to note:

- The In-Office Finishing reimbursement per order will be the cumulative total of all associated lens enhancement fees (In-Office Finishing Fees). If there are no associated lens enhancements or the cumulative total of the fees is less than $10, the reimbursement for that order will be $10.
- Reimbursements cover your cost for the lenses. You won't be reimbursed for taxes on In-Office Finishing payments for services or materials.
- You'll receive your In-Office Finishing fee in addition to your base lens dispensing fee and any applicable doctor service fees for lens enhancements provided by your office.

Important!

Lens Enhancements not listed in the VSP In-Office Finishing Stock Lens Catalog are not included in the program and can't be finished in your office. Payment for these services and materials, including frame and lenses will be denied.

Your reimbursements under the VSP In-Office Finishing Program will be included in your VSP Explanation of Payment (EOP). The claims detail will appear as it does today, with a new IOF message code, IF. The In-Office Finishing section outlines your VSP In-Office Finishing Program reimbursements associated with claims submitted under the program. Payments will be included in your VSP check or EFT total.

Maui Jim

Effective September 1, 2023, Maui Jim will discontinue ophthalmic (clear) lenses and ophthalmic frames to focus on Suns. The last day practices can submit Maui Jim clear lens orders to the Maui Jim lab is **August 31, 2023**. If you have questions, please reach out to your Maui Jim Account Executive.

VSP network doctors who are authorized Maui Jim retailers can continue to submit Maui Jim claims and orders through eyefinity.com (or through any of Eyefinity's practice management systems) and VSP patients can use their standard lens and frame coverage towards genuine Maui Jim sunglasses (prescription or plano based on patient's plan). Please refer to the guidelines below when patients select Maui Jim materials.

VSP patients can use their lens and frame coverage towards genuine Maui Jim Lenses, including Maui Jim sunglass lenses.

- Standard benefit coverage applies to determine patient out-of-pocket expenses. Please refer to the Patient Record Report to verify the patient's coverage details for lens, lens enhancements and frame.
- Apply the patient's coverage to the Maui Jim lens and frame following coverage details.
- Review the Product Index for lens enhancements codes and

Maui Jim Lab (authentic lenses)

- Maui Jim Lab will appear in the contract lab list as #584, which is located in Peoria, IL.
- Sunglass frame orders should only go to Maui Jim Lab. Sunglass orders fabricated at any other lab will void the frame warranty.
- Non-Maui Jim prescription lenses and frames will not be processed.

VSP contract lab (non-authentic lenses)

- Sunglass orders fabricated at a non-Maui Jim lab will void the frame warranty.

Maui Jim Lens and Frame

1. On the Lab Invoice, select Lab Finishing and enter the lens type and lens enhancements, as needed.
2. Select the Maui Jim Lab (0584)

- All genuine Maui Jim sunglass lens and sunglass frame orders **must** be sent to Maui Jim.

3. Complete the prescription section with the patient's Rx information
4. Search for the Maui Jim frame to order. Be sure you select the appropriate frame SKUs for prescription vs. non-prescription orders:

- **Rx Sunglasses**: Frames for Maui Jim sunglass prescription orders must begin with "**Mjrx**" in the color description. Frame model will typically display the frame name followed by 3 digits.
  - If you have verified with Maui Jim that the frame is Rx-able, you may edit the frame details to include "**Mjrx**" at the beginning.
- **Plano Sunglasses**: Ready-made Maui Jim sunglasses will display the frame name followed by 3 digits. Ready-made sunglasses have a higher wholesale cost due to the Maui Jim plano sunglasses lenses included with the frame.

Important!

Make sure you select the appropriate SKU. Mjrx is a designation that belongs to only sunglass frames that can be processed in the Maui Jim lab. Sunglass frames without **Mjrx** include plano Maui Jim lenses and have a higher wholesale cost.

5. Verify the wholesale cost populates in the search results.

- Wholesale costs may vary between Rx and non-Rx sunglass frames.
- Do not change the wholesale cost that populates in eClaim (or eLab). These have been provided by Maui Jim to ensure accurate billing and claim payment by VSP.

Important!

Changing the value may result in your order being voided by Maui Jim to reenter correctly or an incorrect VSP claim payment.

- If there is no wholesale value listed, check the frame spelling/casing and retry the search.

Example:

Pearl City 214 will return an outdated SKU and no wholesale whereas PEARL CITY 214 populated the correct SKU and wholesale amount.

6. Select one of the following options from the Supplier drop-down menu:

- **Lab Supplied** – new complete order (lens and frame), billed from Maui Jim to VSP.
- **Patient Supplied - To Come –** when shipping a frame that patient purchased privately
- **Doctor Supplied - To Come** – when shipping a frame to the lab that is being billed under patient's insurance benefits; if frame is purchased from Maui Jim at the time of submitting the order, the account will be billed by Maui Jim for the frame.

7. Follow the instructions below regarding special instructions for the lab:

- **Do not** select the Lab Special Instructions check box. Although you can view any special instructions that you record in eClaim on the order reports, they are not sent to the Maui Jim lab

8. Select Calculate and Continue to proceed to filing your VSP claim.

Important!

Do not enter "Proprietary" in the Special Instructions box (CMS1500 box 19). This will cause the claim to revert to private lab during claim processing and you will be responsible for the lab bill.

Lens and Frame payments follow standard VSP payment guidelines.

Maui Jim offers a limited warranty on lenses and frames as a supplement to any applicable VSP warranty. For questions on the Maui Jim warranty, 1-833-MJRXVSP (657-9877).

Includes:

- Complimentary temple and nose pad replacement as long as parts are available
- One-year one-time scratch warranty on sun lenses

Exclusions:

- Void if original lenses or frames are altered
- Does not apply to normal wear
- Does not cover shipping costs

This isn't a complete list of unique situations. Please refer to the additional resources in the Provider Reference Manual and/or User Guides in Eyefinity eLearn Tab for additional billing instructions.

Scenario Description	Billing Tips
Ordering authentic Maui Jim lenses	• Send order to Maui Jim Lab (#584) • Send sunglass orders to Maui Jim lab • In-office finishing not available • Non-Maui Jim lens/frame orders will not be processed
Ordering non-authentic sunglass lenses for Maui Jim frame	Generic lens orders can be sent to any VSP contracted lab: • Order may indicate Doctor supplied or Patient Supplied frame • Non-authentic sunglass lenses fabricated at non-Maui Jim labs will void the frame warranty.
Maui Jim Lens Guide	Refer to the following Maui Jim style guide.
Identifying frames for prescription sunglass orders	Frames for Maui Jim prescription sun orders must begin with **Mjrx** in the color description.
Identifying ophthalmic frames	Maui Jim ophthalmic frames begin with **MJO** in the color description.
Determining the wholesale cost	**Do not change the wholesale cost that populates in eClaim (or eLab**). • Select **Mjrx** for Rx frames. • Wholesale costs may vary between Rx and non-Rx sunglass frames. • These have been provided by Maui Jim to ensure accurate billing and claim payment by VSP. • If wholesale cost is blank, check the search criteria, such as spelling, casing.
Selecting Frame Supplier	**Lab Supplied** – new complete order (lens and frame). • Maui Jim will bill VSP for the frame material payment. • VSP will deduct any wholesale frame overage to cover frame cost. • You will be paid the frame dispensing fee and may collect any frame overage from patient. **Patient Supplied - To Come** – when shipping a frame that patient purchased privately (or if ordering generic lenses to non-Maui Jim lab). **Doctor Supplied - To Come** – when shipping a frame to the lab that is being billed under patient's insurance benefits. • You will be responsible to ship and restock the frame. • Maui Jim will bill you for the frame cost. • You will be paid the frame dispensing fee and frame material payment (based on patient's plan) and may collect any frame overage from patient.

National Contract Lab List

VSP doctors can use any of the contract labs listed below for the VSP Signature Plan®, VSP Choice Plan®, VSP Advantage Plan℠, or VSP Essentials Plan. Some restrictions apply based on plan type or state. For plans with unique lab requirements, eClaim will provide you with the appropriate lab choices for the order you are submitting.

Initials to the left of the lab numbers indicate the lab is approved for other VSP plans.

N: National Medicaid—for use by all doctors; labs will charge the fixed Medicaid lab fees.

Contract Labs:							
Alabama							
	528	Hoya – Mobile	23050 McAuliffe Dr.	Robertsdale	36567	844.736.5765	
Arizona							
N	744	Hoya – Phoenix	1635 W. University Dr. Ste. 123-124	Tempe	85281	844.736.5767	
	814	GSRx	14505 Hayden Rd. Ste. 101	Scottsdale	85260	480.748.4545	800.833.4779
	885	Meridian Optical Laboratory	3711 E. Atlanta Ave.	Phoenix	85040	602.257.8555	800.352.5465
Arkansas							
N	214	Plunkett Optical	1705 North A St	Ft. Smith	72901	479.783.2001	800.272.4730
California							
N	901	Bartley Optical	1300 Optical Dr.	Azusa	91702	626.969.6181	800.347.4733
	967	Capitol Optical Co.**	1235 Indiana Ct, Ste. 113	Redlands	92374	909.285.9585	530.823.3937
N	940	CSC-Ocular Lab	180 Westgate Dr.	Watsonville	95076	831.426.7423	800.288.2721
N	929	Elite Optical Company	9901 Horn Rd. Ste. G	Sacramento	95827	916.368.6650	800.556.5502
N	973	Elite Optical Company	801 N. Burke	Visalia	93292	559.625.5816	800.624.6672
N	994	Elite Optical Company	1450 W. Walnut St.	Rancho Dominguez	90220	310.604.8668	800.468.6788
N	935	Empire Optical**	7633 Varna Ave.	N. Hollywood	91605	818.997.6474	800.767.6784
N	966	Hoya-Modesto	1400 Carpenter Ln.	Modesto	95351	844.736.5774	
N	918	Hoya-San Diego*	3959 Ruffin Rd.	San Diego	92123	844.736.5773	
N	984	I-Coat / Signetek	12020 Mora Dr. Ste. 2	Santa Fe Springs	90670	562.941.9989	562.941.9989
N	903	Meridian/Precision SD	9560 Ridgehaven Ct.	San Diego	92123	858.565.0751	800.532.3840
	420	Paradise Lens Lab LLC	2540 Zanella Way, Ste. 10	Chico	95928	530.413.9627	530.354.5242
N	968	Prestige Lens Lab*	338 N. Canal St. #14	S. San Francisco	94080	650.588.5540	
	562	Professional Optical Lab	4905 Morena Blvd, Ste 1311	San Diego	92117	858.273.0411	
N	960	Simplify Optics	24844 Avenue Rockefeller	Santa Clarita	91355	844.863.8857	
	551	Sportifeye Optics, Inc.	1854 Business Center Dr	Duarte	91010	626.521.5600	877.742.5000

Contract Labs:							
N	999	VSPOne Sacramento	151 Blue Ravine Road	Folsom	95630	916.369.6161	800.952.5518
N	948	X-Tra Lite Optical	15865 Chemical Ln	Huntington Beach	92649	714.897.3525	800.878.9872
Colorado							
N	770	Duffens Optical Company	2929 W. 9th Ave.	Denver	80204	303.623.5301	800.999.5367
N	778	Pasch Optical Lab, Inc.	2700 W. Hampden	Sheridan	80110	303.789.0089	800.888.0036
	769	Walman Optical Company	10515 E. 40th Ave.	Denver	80239	303.777.4484	800.332.8477
Connecticut							
N	499	Encore Optics	140 Commerce Way	S. Windsor	06074	860.282.0082	866.833.2020
N	460	Hoya-Hartford	580 Nutmeg Rd. North	S. Windsor	06074	844.736.5756	
Florida							
N	867	Hoya-Largo	12345 Starkey Rd, Ste. E	Largo	33773	844.736.5760	
N	863	Kosh Ophthalmic, Inc.	2901 W. McNab Rd.	Pompano Beach	33069	954.975.0100	800.327.4118
N	872	Milroy Optical	5067 Savarese Cir.	Tampa	33634	813.889.0858	800.366.2702
N	866	Pelican Optical, Inc.	6850 Whitfield Industrial Ave.	Sarasota	34243	941.751.4437	800.862.0966
N	862	VSPOne Tampa Bay	5600 115th Ave. North	Clearwater	33760	727.528.8873	866.587.6141
Georgia							
	255	Better Optics	3213 Humphries Hill Rd. Bldg. #4	Austell	30106	770.819.8800	800.831.1846
N	228	Hoya-Atlanta	591-F Thornton Rd.	Lithia Springs	30122	844.736.5744	
N	220	Robertson Optical Lab	2309 Highway 81 South	Loganville	30052	770.554.3000	800.929.2765
N	223	Southern-Reid Optical	1856 Corporate Dr. Ste. 150	Norcross	30093	678.380.7425	800.765.7343
Hawaii							
N	953	Optical Suppliers, Inc.	99-1253 Halawa Valley St.	Aiea	96701	808.486.2933	800.448.0477
N	950	VSPOne Hawaii	3375 Koapaka St. Ste. B292	Honolulu	96819	800.897.4457	800.897.4457
Idaho							
N	710	Hoya – Boise	2741 W. Airport Way	Boise	83705	844.736.5747	
Illinois							

Contract Labs:							
N	546	Custom Eyes Rock Island	4470 48th Ct.	Rock Island	61201	800.322.6754	800.336.2114
	650	Expert Optics	305 Earl Rd.	Shorewood	60431	815.741.1414	800.892.0097
N	626	Hoya-Chicago	3531 Martens St.	Franklin Park	60131	844.736.5749	
N	618	Hoya-St. Louis	301 Vision Dr.	Columbia	62236	844.736.5775	
N	751	Identity Optical	2221 West College Ave	Normal	61761	309.807.3160	309.807.3160
	584	Maui Jim	One Aloha Ln.	Peoria	61615	888.666.5602	
	625	Walman Optical Company	1280 11th St. West	Milan	61264	309.787.0000	800.447.1376
	662	Walman Optical Company	3384 North Publisher Dr.	Rockford	61109	815.874.9565	800.237.8806
	672	Walman Optical Company	901 Parkland Ct.	Champaign	61821	217.352.7865	800.634.3501
Indiana							
N	635	G.K. Optical	2902 Mitthoeffer Place	Indianapolis	46229	317.881.2585	800.500.8830
N	687	Interstate Lab Group-Indy	2902 Mitthoeffer Place	Indianapolis	46229	317.882.1249	800.564.5546
	642	Walman Optical Company	4920 Executive Blvd. Ste. A	Fort Wayne	46808	260.471.5077	800.736.7411
	646	Walman Optical Company	2540 Waterbridge Way	Evansville	47711	812.424.7521	800.727.5367
	705	Walman Optical Company	4555 Independence Sq.	Indianapolis	46023	317.780.1677	317.780.1677
Iowa							
N	603	Pech Optical Corp.	2717 Murray St.	Sioux City	51111	712.277.3937	800.831.2352
N	696	Precision Optical Group	701 S. Oak St.	Creston	50801	641.782.6685	800.497.9239
	683	Twin City Optical	1445 C St SW	Cedar Rapids	52403	319.365.8707	800.245.5859
	632	Walman Optical Company	1214 Maple St.	W. Des Moines	50265	515.223.5280	800.733.4641
Kansas							
N	614	Duffens/Langley	8140 Marshall Dr.	Lenexa	66214	913.492.5379	800.397.2020
Kentucky							
N	175	ABB Labs KY	4400 Olympic Blvd., Ste. 4530	Erlanger	41018	513.619.9108	800.636.2456
	132	Carl Zeiss Vision Kentucky	1050 World Wide Blvd.	Hebron	41048	800.403.8997	
N	120	Twin City Optical	4601-B Proximity Dr.	Louisville	40213	502.966.5662	800.647.6970

Contract Labs:							
Louisiana							
N	208	Gulf States Optical Labs	313 Coolidge St	Jefferson	70121	504.834.1646	800.662.7889
N	741	Hoya – New Orleans	5039 Fairfield St.	Metairie	70006	844.736.5766	
Maine							
Maryland							
N	310	Homer Optical Co., Inc.	2401 Linden Ln.	Silver Spring	20910	301.585.9060	800.627.2710
	306	Walman Optical Company	6304 Blair Hill Ln.	Baltimore	21209	410.828.7424	800.638.5098
Massachusetts							
	278	Perferx-Precision	25 Downing Three	Pittsfield	01201	413.358.9020	
Michigan							
N	110	Optical Supply, Inc.	1526 Plainfield NE	Grand Rapids	49505	616.361.6000	800.441.4441
N	119	Twin City Optical	2323 Aero Park Ct.	Traverse City	49686	231.922.0344	800.424.0344
N	125	Walman Optical Company	5533 Ann Arbor Rd.	Jackson	49201	517.764.5100	800.733.3645
	178	Walman Optical Company	1051 Business Park Dr.	Traverse City	49686	231.929.9070	888.251.2040
Minnesota							
	660	Carl Zeiss Vision North Central	4605 Rusan St.	St. Cloud	56303	800.403.8997	
N	621	D.B.L. Labs, Inc.	6650 Saukview Dr.	St. Cloud	56303	320.654.6650	800.888.0222
	533	Eye-Kraft Optical, Inc.	8 McLeland Rd	St. Cloud	56303	320.257.1182	
	534	Hoya – Ramsey	7000 Sunwood Dr. NW	Ramsey	55303	844.736.5764	
	604	Walman Optical Company	9200 Wyoming Ave.	Brooklyn Park	55445	763.515.5590	800.727.9522
	688	Walman Optical Company	510 Beltrami Ave.	Bemidji	56601	218.751.5327	800.891.1019
	689	Walman Optical Company	327 2nd St. Ste.3 Industrial Bldg 146	Duluth	55810	218.722.7034	800.945.3937
Mississippi							
N	735	Hoya – Jackson	289 Commerce Park Dr., Ste. F	Ridgeland	39157	844.736.5758	

Contract Labs:							
N	234	Superior Optical Labs, Inc.	6525 Sunplex Dr.	Ocean Springs	39564	228.875.3796	800.476.2285
Missouri							
N	605	Gateway Optical	18 Kirkham Industrial Dr.	Webster Groves	63119	314.968.1905	800.325.1416
N	609	Midland Optical Co.	1833 Knox Ave.	St. Louis	63139	314.533.2020	800.325.3176
Montana							
	581	Walman Optical Company	2747 Enterprise Ave. Ste. 3	Billings	59102	406.252.2143	800.759.5501
Nebraska							
	628	Walman Optical Company	12240 Emmet St.	Omaha	68164	402.492.8822	800.373.3200
Nevada							
	298	Doctors Optical Labs Nevada	7330 Eastgate Rd. Ste. 130	Las Vegas	89011	702.463.6373	
	583	Sierra Optical Laboratory	1140 Financial Blvd.	Reno	89521	775.432.2332	
N	809	Truckee-Sunstar Optical	5960 Edmond St.	Las Vegas	89118	702.739.8880	
	815	Walman Optical Company	5740 S. Arville St. Ste. 205-206	Las Vegas	89118	800.621.1150	
New Hampshire							
N	726	N. H. Optical Laboratory, LLC	32 Library St.	Allenstown	03275	603.218.1470	800.852.3717
New Jersey							
	296	Carl Zeiss Vision New Jersey	10 Harmon Dr. Glen Oaks Industrial Park	Blackwood	08012	866.596.5467	
N	445	M. H. Optical Supplies	128 Leuning St.	South Hackensack	07606	201.489.1110	800.445.3090
N	438	Sheridan Optical Company Inc.	108 Clinton Ave.	Pitman	08071	856.582.0963	800.704.1375
New Mexico							
New York							
N	433	21st Century Optics, Inc.	47-00 33rd St.	Long Island City	11101	718.392.2310	800.221.4170
	431	ABB Labs NY	4 Skyline Drive	Hawthorne	10532	866.866.8673	

Contract Labs:							
N	403	Advance Optical	37 Goodway Dr. East	Rochester	14623	585.427.0800	800.828.6331
N	407	Optogenics Of Syracuse**	2840 Erie Blvd. East	Syracuse	13224	315.446.7500	800.247.3072
	543	RLab	920 Emerson St	Rochester	14606	585.254.0022	
N	406	Tri-Supreme Optical, LLC	91 Carolyn Blvd	Farmingdale	11735	631.249.2020	800.321.1100
N	402	Winchester Optical	1935 Lake St.	Elmira	14901	607.734.4251	800.847.9357
North Carolina							
N	207	Southern Optical Co.	860 Aviation Pkwy, Ste. 1300	Morrisville	27560	919.469.1623	800.969.8256
N	218	Southern Optical Co.	1909 North Church St.	Greensboro	27405	800.888.8842	
North Dakota							
N	653	Twin City Optical	1213 Continental Ave.	Bismarck	58501	701.223.7640	800.258.4186
	624	Walman Optical Company	1404 33rd St. South, Ste. K	Fargo	58103	701.235.0571	800.678.9755
	670	Walman Optical Company	17 2nd Ave. SE	Minot	58701	701.852.1048	800.735.5954
Ohio							
N	638	Bell Optical Laboratory, Inc.	3671 Interchange Dr.	Columbus	43204	614.274.0840	800.776.8077
N	103	Central One Optical	6981 Southern Blvd.	Boardman	44512	330.783.9660	800.322.6678
	282	Classic Optical	3710 Belmont Ave.	Youngstown	44505	888.522.2020	
N	115	Hoya-Cleveland	94 Pelret Industrial Pkwy.	Berea	44017	844.736.5750	
	104	Interstate Optical Company, Inc.*	680 Lindaire Ln.	Mansfield	44906	419.529.6800	800.472.5790
	300	R and D Optical, LLC	4024 Bach Buxton Rd.	Batavia	45103	513.273.4034	
	124	Walman Optical Company	1851 Ebert Ave.	Dayton	45439	937.298.0223	800.762.4827
	114	Walman Optical Company	1201 Jefferson Ave.	Toledo	43604	419.248.3384	800.472.0107
	199	VSPOne Columbus^	2605 Rohr Rd.	Lockbourne	43137	614.409.8900	800.251.5150
Oklahoma							
N	545	Dunlaw Optical	1313 SW A Ave.	Lawton	75301	800.678.4525	

Contract Labs:							
	216	Rx Optical	2006 N. Yellowood Ave.	Broken Arrow	74012	918.459.3833	800.886.3467
N	204	Team Duffens	713 SW 119th St.	Oklahoma City	73170	405.703.4133	
Oregon							
	718	Carl Zeiss Vision Northwest	14450 SE 98th Ct.	Clackamas	97015	800.403.8997	
N	713	Hoya-Portland	4500 SE Criterion Ct. #220	Milwaukie	97222	844.736.5768	
N	711	Opti-Craft, Inc.	12130 NE Ainsworth Cir. Ste. 260	Portland	97220	503.256.5330	800.288.8078
Pennsylvania							
N	495	Allentown Optical Corp.	525 Business Park Ln.	Allentown	18109	610.433.5269	800.523.1141
N	411	Balester Optical Company	388 North River St.	Wilkes-Barre	18702	570.824.7821	800.233.8373
N	490	K Optical, Inc.	29 West Main St.	Hummelstown	17036	717.566.5681	800.548.7540
N	443	Luzerne Optical Laboratories, Ltd.	180 N. Wilkes-Barre Blvd.	Wilkes-Barre	18702	570.822.3183	800.233.9637
N	408	Three Rivers Optical Co.	260 Bilmar Dr.	Pittsburgh	15205	412.928.2020	800.756.2020
N	436	Walman Optical Company	150 Rose Ct.	York	17402	717.767.5193	800.673.2425
Puerto Rico							
	868	MGM Excellence Processing	Valle Tolima Industrial Park, Bldg 14 A 3	Caguas	00726	787.745.8875	787.782.2727
Rhode Island							
N	480	Crown Optical Company	15 Commerce St.	Greenville	02828	401.949.3400	800.766.2769
N	481	McLeod Optical Co., Inc.	50 Jefferson Park Rd.	Warwick	02888	401.467.3000	800.288.5367
	526	Ocean State Optical	100 Federal Way	Johnston	02919	401.424.9411	
South Carolina							
	212	Robertson Optical Lab	411 Commerce Dr. NE	Columbia	29223	803.254.9381	800.922.5525
South Dakota							
	633	Walman Optical Company	623 S. Lyons Ave.	Sioux Falls	57106	605.336.3650	800.843.7968
Tennessee							
N	286	Hoya-Knoxville	1529 Western Ave. NW	Knoxville	37921	844.736.5759	

Contract Labs:							
	211	Precision Optical Lab	225 Overton Rd.	Gallaway	38036	901.867.2991	800.238.6828
N	265	Southern Optical Co.	501 Merritt Ave.	Nashville	37203	615.256.6631	800.333.8498
N	288	Southern Optical Co.	136B Industrial Park Rd.	Piney Flats	37686	423.538.5544	800.888.2544
Texas							
N	241	Duffens Optical Company	3625 Willowbend Blvd. #110	Houston	77054	713.663.3000	800.392.9774
N	242	Hoya-Dallas	651 E. Corporate Dr.	Lewisville	75057	800.423.2361	
N	246	Omega Optical Company	13675 N. Stemmons Fwy.	Dallas	75234	972.241.4141	800.366.6342
N	201	VSPOne Dallas	440 E. Vista Ridge Mall Dr.	Lewisville	75067	972.956.5400	866.934.0400
N	230	Wilson Optical	8990 Summerford Ln.	El Paso	79907	915.859.3415	800.351.2287
Utah							
Vermont							
Virginia							
	281	Homer Optical-Virginia Beach	5819 A Ward Ct.	Virginia Beach	23455	757.460.2020	
N	318	Southern Optical Co.	10813 Trade Rd.	Richmond	23236	804.747.8700	800.229.5367
Washington							
	515	Central Optical Lab	412 Diagonal St.	Clarkston	99403	509.758.1791	800.366.1790
N	568	Hoya-Seattle	2330 South 78th St.	Tacoma	98409	844.736.5771	
N	519	Jorgenson Optical Supply	1901 S. Union Ave. B1001	Tacoma	98405	253.572.4522	800.426.8918
	573	Vision Craft, Inc.	202 South Front St.	Yakima	98901	509.248.1951	800.733.3937
	539	Walman Optical Company	20417 80th Ave. South	Kent	98032	253.872.7137	800.752.5227
West Virginia							
N	123	Bell Optical Laboratory, Inc.	2182 Route 75, Ste. 2	Kenova	25530	304.429.8470	800.553.3402
Wisconsin							
	225	Fait Optics	35263 West State St.	Burlington	53105	262.763.0100	

Contract Labs:							
	657	Walman Optical Company	3108 Airport Rd.	La Crosse	54603	608.784.5836	800.356.9504
	658	Walman Optical Company	4005 Felland Rd, Ste. 116	Madison	53718	608.249.7364	800.736.6544
	659	Walman Optical Company	7300 South 1st St.	Oak Creek	53154	414.764.8878	800.677.0680
	649	Walman Optical Company	715 14th Ave.	Green Bay	54304	920.498.2928	800.365.2828
N	668	WOS Optical	610 Lombardi	Green Bay	54304	800.888.4454	800.888.4454
Wyoming							

*****Safety Eyewear monogrammed only by request.

******Safety Eyewear not provided at this lab.

^Accepts only Elements, Advantage Elements, Medicaid Elements, and Safety/ProTec Safety orders

Patient Lens Enhancement Fees Instructions

Don’t charge a fee for any lens enhancements covered by your patient’s plan. We’ll pay you a service fee, as shown on the VSP Signature Lens Enhancements Chart. Please note that if your patient is covered for plastic dyes, glass tints, or plastic or glass photochromics, there’s no service fee for these lens enhancements. There’s also no service fee for covered polycarbonate lenses when dispensed to children or handicapped patients.

Polycarbonate lenses for monocular patients

Don’t charge for the polycarbonate lens enhancement used by functionally monocular patients, defined as those having best corrected vision of 20/200 or worse in one eye. Polycarbonate lenses are covered.

We’ll cover the lens enhancement fee, even if it’s not specifically covered by your patient’s plan. We’ll also pay you a service fee. Simply include the most appropriate ICD-10 diagnosis code describing your patient’s level of visual impairment on the claim form.

Monocular Diagnosis Codes:

The claim must be submitted with a polycarbonate lens enhancement and one of the following monocular diagnosis codes: H54.10, H54.40, H54.1131-H54.2X22, H54.413A-H54.415A and H54.42A3-H54.42A5.

Other Lens Enhancements

For lens enhancements that are covered with a copay, charge the patient according to the VSP Signature Lens Enhancements Chart or your U&C fee (whichever is lower). However, if a client has selected to cover a lens enhancement in full with a specific copay, collect the indicated copay.

Important!

If a lens enhancement is listed with an “N” or is **Not Covered**, the patient’s plan doesn’t allow that lens enhancement to be ordered for the patient. If the item is provided, we’ll deny payment for the lenses and frame, and the patient must pay for the entire cost of the lens and frame.

Determining What to Charge the Patient

VSP patient copays are all add-on fees. Your private-pay lens enhancement fees may be an add-on to your lens fee or included in your total lens fee. Example A shown below explains what to charge your patient when your U&C add-on fees are higher than VSP’s Patient Lens Enhancement fees. Example B explains what to charge your patient when your U&C add-on fees are lower than VSP’s Patient Lens Enhancement fees.

Examples

	Example A	Example B
1. Convert your total U&C fees to add-on fees.		
Your U&C fee for Photogray Extra FT28 bifocal lenses is:	$145	$125
Subtract your U&C fee for clear FT28 bifocal lenses:	-$100	-$100
Your U&C add-on fee for multifocal Photogray Extra is:	$45	$25
2. Determine what to charge your patient. Compare your U&C add-on fee to the VSP lens enhancement patient copay and select the lower of the two.		
Your U&C add-on fee for multifocal Photogray Extra:	$45	$25
The Patient Copay for multifocal Photochromic—Glass is:	$37	$37
Patient pays:	**$37**	Go to Step 3 to continue
The purpose of the following step is to adjust your U&C fee based on contract lab fees. This step preserves your service fees as necessary.		
3. (Example B only) Adjust the amount to charge your patient, if needed. If your U&C fee is lower than the Patient Copay, you'll need to adjust the amount.		
Your U&C add-on fee for multifocal Photogray Extra is:		$25
Subtract your private lab's add-on charge to you for multifocal Photogray Extra:		-$15
Your U&C service charge for multifocal Photogray Extra:		$10
Add the VSP Lens Enhancement Lab Allocation for multifocal Photogray Extra (Photochromic—Glass):		+$23
Your adjusted U&C add-on fee for multifocal Photogray Extra is:		$33
4. (Example B only) Compare your adjusted U&C add-on fee to the fee shown on the Patient Lens Enhancement list and charge the lower fee.		
Your adjusted U&C add-on fee for multifocal Photogray Extra is:		$33
The Patient Copay for multifocal Photochromic—Glass is:		$37
Patient pays:		**$33**

To offer more customized coverage to VSP Vision Care clients and members, we've developed several flexible lens enhancements programs that allow partial coverage for the most popular VSP lens enhancements, including anti-reflective (AR) coatings, photochromics, and progressives. Always refer to the online Patient Record Report and Lens Enhancements Charges report for complete information on lens enhancement coverage. Client specific copays will display under the heading **Covered with Additional Copay, see amount** followed by the specific lens enhancement and copay.

Even though your patient can request a single lens instead of a pair of lenses, VSP doctors and labs are reimbursed for a complete pair of lenses. If your patient only orders one lens and then needs a second lens within 12 months, your patient is entitled to a second lens at no additional cost.

If your patient gets a lens enhancement on a single lens order, charge them the full patient-lens enhancement price.

There may be instances where a patient ordering two prescription lenses, might only need a particular lens enhancement on one of the lenses, such as one plastic progressive lens and one single-vision plastic lens.

Patient Charges

If the lens enhancement is covered, don't charge the patient. For other lens enhancements, charge the patient half of the VSP Patient Copay. Only half of the VSP lab allocation will be deducted from your VSP Explanation of Payment.

Claim Submission

When you submit orders electronically, indicate in Box 19 on the CMS-1500 Form "half-pair lens enhancement" and clearly describe half lens enhancement in Lab Special Instruction area, including which lens has the enhancement; left or right. If one lens is progressive and one is single vision, be sure to bill both lenses as progressive. Eyefinity will not accept SVL in one eye and progressive in the other.

When you submit a paper claim, indicate in Box 19 on the CMS-1500 "half-pair lens enhancement", indicate left or right eye and include the lab invoice.

Patient Lens Enhancement Explanations

Below, you'll find details about patient lens enhancements on the VSP Signature Plan® and VSP Choice Plan® Lens Enhancements Charts.

Style	Lens Enhancement Codes
Mid and High Index Plastic Lenses	AB, BB, DB, FB, IB, JB, KB, NB, OB, AH, BH, DH, NH, OH, FH, JH, KH, AJ, BJ, DJ, NJ, OJ, FJ, JJ, KJ, II, IJ
All plastic lenses with an index of refraction between 1.53 and 1.74 in both non-aspheric and aspheric designs, not including polycarbonate, use these codes. The price includes front and backside scratch-resistant coating and inherent UV protection.	
Glass	AE
Use this lens enhancement code for glass spherical lenses. This code is not applicable with progressive lenses.	
High Index Glass—Non-Aspheric	AF
All glass lenses with an index of refraction between 1.60 and 1.80 in non-aspheric designs.	
Polycarbonate	AD, BD, DD, FD, ID, ND, OD, JD, KD
These codes cover polycarbonate lenses. The price includes front and backside scratch-resistant coating and inherent UV protection.	
Trivex	AB, BB, DB, FB, IB, JB, KB, NB, OB
Lenses manufactured in Trivex fall into the Mid-Index category. These products include progressive, aspheric and non-aspheric designs. The lens enhancement price includes front and backside scratch resistant coating and inherent UV protection. Do not charge for factory scratch coating (category A) or UV protection on Trivex lenses.	
Aspheric Lenses	AA, AB, AH, AJ, AD, AF
Aspheric lenses ordered in 1.50 plastic are available using 'AA' code. If Aspheric lenses are ordered in high index plastic 1.53 -1.60/Trivex, high index plastic 1.66/1.67, or high index plastic 1.70 and above, use code AA plus the appropriate fee for the material. **Note:** Cataract lenses aren't categorized under aspheric. For cataract lens orders processed through **eClaim**, choose **Lenticular** from the pull-down menu under Vision Type. For paper orders processed with Material Invoices, choose the **Other** box and write Lenticular in the space provided.	
Digitally Surfaced Aspheric Lenses	BA, BB, BD, BH, BJ
Digital Aspheric lenses ordered in any plastic material are available using these codes. If Digital Aspheric lenses are ordered in high index plastic 1.53 -1.60/Trivex, high index plastic 1.66/1.67, or high index plastic 1.70 and above, or polycarbonate, use code BA plus the appropriate fee for the material. These additional costs are listed on the lens enhancement charts directly below the main lens charge (e.g., charge codes BA and BB, for 1.60 Digital Aspheric lenses).	
Occupational Lenses There is no charge to the patient for occupational lenses (e.g., double seg/double D, CRT trifocal, 10x25, 10x28, 10x35, 12x35, 14x35 and Datalite lenses). Single Vision glass occupational safety lenses are not available for use with VSP benefits. ED and FD trifocals aren't paid under this category.	
Blended Myo-Disc For standard myo-disc orders on **eClaim**, choose "Lenticular" from the pull-down menu under Vision Type. For paper orders on a Materials Invoice, write "Lenticular" in the "Other" box. Blended Myo-Disc lenses are not available for use with VSP benefits.	
Polarized Lenses	DA, DE, NP, OP, FP, JP, KP
Single vision and lined multifocal plastic polarized lenses are included under code DA. Glass polarized lenses are included under code DE. If polarized lenses are ordered in high index plastic 1.53-1.60/Trivex, high index plastic 1.66/1.67, high index plastic 1.70 and above, or polycarbonate, charge additionally for the appropriate material. These additional costs are listed on the lens enhancement charts directly below the main lens charge. (e.g., charge codes DA and DD for polarized lenses in polycarbonate). Premium polarized lenses are not available for use with VSP benefits. Plastic polarized lenses with a progressive design are included under progressive codes NP, OP, FP, JP, and KP and must be used with corresponding progressive codes NA, OA, FA, JA, and KA respectively. Do not use codes DA, DE, DB, DD, DH or DJ, for progressive polarized lenses. **Note:** Don't charge for full UV protection on polarized lenses, since this is already included in the price. For backside only UV protection, charge the patient using lens enhancement BV.	
Near Variable Focus	IA

Style	Lens Enhancement Codes

If near variable focus lenses are ordered in high index plastic 1.53-1.60/Trivex, high index plastic 1.66/1.67, high index plastic 1.70 and above, or polycarbonate, charge code IA plus IB, IA plus II, IA plus ID, or IA plus IJ. These lenses are only available pre-scratch coated; don't charge for scratch resistant coating. In **eClaim**, choose **Near Variable Focus** from the pull-down menu under Vision Type. On paper, mark the **Bifocal** box located in the **Lens Type** section of the Materials Invoice form.

Blended Bifocals GA

Charge the GA code for blended bifocals in plastic.

Doctor In-Office Lens Enhancements

Doctors can provide the following lens enhancements in their office:

Plastic Dyes—Pink I and II (IM)

Plastic Dyes—Gradients (IP)

Plastic Dyes—Solid Other Colors (IN)

UV Protection - plastic lenses only (IV)

Important! Tell the contract lab when your in-office lab will provide any of the above lens enhancements.

Guidelines:

You're responsible for lenses to which you apply in-office lens enhancement. You must completely and carefully inspect lenses before beginning work on them. If the lenses become damaged (scratched, etc.), you're responsible to replace the full cost of the lenses.

You can provide in-office lens enhancements (plastic dyes and UV protection) only if the lens enhancement is the last step in the fabrication process. For example, anti-reflective coating must be applied after a lens has been tinted; so to avoid delay to your patient, the lab will complete the entire job including the tint. If a contract lab must dye or UV-coat the lens, the lab will replace the doctor code(s) with the lab code(s) for payment.

If lab order information isn't completed correctly to show you'll provide the lens enhancement in-office, the lab may perform and receive payment for those services. However, if a lab order form is completed correctly to show lens enhancements supplied in-office and the lab inadvertently provides the lens enhancements, we will pay your office for the dispensed lens enhancements.

When a redo is needed, you'll be required to provide the lens enhancement in-office again, regardless of fault.

You're required to remit the tax on in-office lens enhancement s as appropriate.

Progressive N/O/F/J/K NA, OA, FA, FE, JA, JE, KA, KE

The difference between the progressive categories is determined only by the market price of the lenses. Refer to the Product Index for information on which codes to use with specific progressives.

If progressive lenses are ordered in high index plastic 1.53-1.60/Trivex, high index plastic 1.66/1.67, high index plastic 1.70 and above, glass/high index glass, polycarbonate, or polarized, charge additionally for the appropriate material. These additional costs are listed on the lens enhancement charts directly below the main lens charge (e.g., charge codes JA and JD for Progressive J lenses in polycarbonate).

If a progressive design includes asphericity, don't charge extra. Asphericity is built into the lens enhancement price.

Important! There is no additional charge for factory-applied scratch resistant coating (category A, code QQ) on any progressive lens, as the prices already includes factory scratch-resistant coating. If a progressive is available either uncoated or pre-scratch coated, the lab will always provide the pre-scratch coated version.

Plastic Dyes MM, MN, MP

Patients are covered for all plastic Pink I and II solid dyes, which can be ordered under a variety of names including Cruxite A, Cruxite AX, Softlite A, Softlite B, Rose I, Rose II, Flesh, Blush, Nutratint Pink, and Lite Pearl.

Charge code MN for all other plastic color solid dyes. Code MP includes single, double, and triple gradients.

You may provide plastic dyes in-office (lens enhancement codes IM, IN, and IP). Please refer to Doctor In-Office Lens Enhancements for instructions on specifying in-office lens enhancements on a lab order form.

Glass Tints MQ, MR

Patients are covered for all glass Pink I and II tints. Charge code MR for all other tints. Glass yellow tints are not available for use with VSP benefits.

Glass Color Coatings MS, MT

Charge code MS for solid glass color coatings and MT for gradient glass color coatings.

Photochromics—Glass PM

Charge this code for photochromic glass lenses.

Photochromics—Plastic PR

Charge this code for photochromic plastic lenses. These lenses come with UV protection and scratch resistant coating; do not charge separately.

Anti-Reflective Coatings A QM

All anti-reflective coatings except those specifically listed under Anti-Reflective Coatings C or D, are in this category. Many anti-reflective coatings have scratch-resistant properties. Contract labs must use the same anti-reflective "formula" and coating methods for your VSP patients that they use for private work (e.g., some labs always include scratch-coated base lenses with their anti-reflective coatings). The scratch-resistant coating (codes QQ and QS) can't be used in conjunction with any anti-reflective coating.

Anti-Reflective Coatings C, and D QT, QV

These anti-reflective categories are for reviewed and categorized AR coatings that are more durable than other AR coatings. All AR brands under these categories are guaranteed for two years, covering any scratches (normal wear) on the coating and lenses. Please see the Product Index for brands under these categories. Don't use the scratch-resistant coating (codes QQ and QS) in conjunction with any anti-reflective coating.

Mirror Coatings QP

Silver and gold mirror coatings, including solid and single gradient, are captured in this category. This includes base color (excluding yellow glass tint), if any. For any colored or double gradient mirror coatings, charge Ski Type Coating (code QR).

Scratch-Resistant Coating A, Factory Applied QQ

This applies only to factory applied scratch-resistant coatings on standard plastic (CR-39) lenses.
Note: Dip and spin coatings are effective and required for the backside of polycarbonate, mid-index, and high-index plastic materials and are included in those prices.
Don't charge for Scratch-Resistant Coating A on anti-reflective, progressive, polycarbonate, photochromic, and high-index plastic lenses. The prices for these materials include front and backside coating.
If a lens has a unique design and is only available with a scratch-resistant coating (e.g., plastic photochromic), don't charge for the scratch-resistant coating. If a lens is available with or without a factory scratch-resistant coating, and the coated version is chosen, charge for the coating. It is assumed the particular lens was chosen for the coating.
There is no additional charge for scratch-resistant coating on any progressive lens. The prices for progressive lenses in standard plastic include factory scratch-resistant coating. Most progressive brands are only available pre-scratch-coated. If a progressive brand is available either uncoated or pre-scratch-coated, the pre-scratch-coated version must always be provided by the contract lab.
We require contract labs to guarantee scratch-resistant coatings on prescriptions for VSP orders for at least one year under normal wear or the lab's policy for private orders, whichever is longer.

Ski Type Coating QR

Use this code for duplications of proprietary coatings (e.g., Revo, Vuarnet, Suncloud, Serengeti, Bolle, and Sportlife), double-mirror gradient, color mirror, and dielectric mirror coatings. This price includes the base tint and color coating (excluding yellow glass tint), if any.
For any solid or single-gradient silver and gold mirror coating, charge Mirror Coating (code QP).

Scratch-Resistant Coating B (Other Reviewed Coatings) QS

Charge this code for non-factory-applied scratch-resistant coatings reviewed and categorized by VSP. You can charge these scratch coatings with progressive, polycarbonate, photochromic, as well as mid-index or high-index plastic lenses. Scratch-resistant coatings can't be billed with anti-reflective coatings (codes QM, QT, or QV).

Oversize RM, RN

Charge code RM for any lenses supplied with a 61 mm eyesize or greater in plastic. Charge code RN for any lenses supplied with a 61 mm eyesize or greater in glass. Use the eyesize stated by the frame manufacturer to see if the oversize applies.

Rimless Drill/Notched Mountings - SW
Charge this code for rimless drilled or notched mountings. Slotted lenses that require the use of a non-VSP contract lab are unavailable on VSP orders. Labs with private policies to only drill and mount certain material types (e.g., polycarbonate, Trivex) may also apply these policies to our prescriptions. If you already include the cost of rimless drill/notched amounts in your frame cost, please deduct that cost to ensure patients are not double billed for this enhancement. Follow the contract lab's private redo policy to handle doctor redo requests caused by lens breakage on drilled prescriptions.

Anti-Fog Coatings
Any anti-fog coating, spray-on or otherwise, is not available for use with VSP benefits.

Balance Lens
A spectacle lens of undesignated power serving only to balance the weight and the appearance of its mate in front of the other eye. Do not charge your patient for balanced lens services.

Beveling
Rolled edges or special placement of lenses in the frame (e.g., hide-a-bevel, fifty-fifty) are included in the base lens price. Don't charge your patient separately. Interchangeable lenses for "sport" frames are not available for use with VSP benefits.

Cement Segs (laminating a wafer segment onto the lens)
Cement Segs are not available for use with VSP benefits.

Center Thickness Below 1.5 mm—
Polycarbonate Minus Powers Only

Center thicknesses below 1.5 mm on all applicable plastic materials are covered. Don't charge your patient extra for center thickness below 1.5 mm.

Clip-Ons
If the clip-on is priced with the frame (e.g., a frame's wholesale cost, including a clip-on, is $69.95), and can only be ordered with the frame, write the cost of the frame and clip-on in the frame cost box.
If the clip-on is priced separately from the frame (e.g., the frame's wholesale cost is $45.85 and the clip-on's wholesale cost is $29.95), charge your patient the retail price of the clip-on as a private transaction.

Custom Measurement

Each time you submit a claim for an eligible lens and include the frame wrap, pantoscopic tilt, and vertex distance, the CM code and HCPC v2702 Deluxe Lens Feature will automatically be added to your claim. All three measurements are required to receive the additional reimbursement.
Review the Lens Enhancements Charges Report when authorizing benefits. VSP will reimburse you directly for additional custom measurements when patients are covered for progressive lenses with or without a copay. For other progressives, you'll collect the patient copay and see a VSP lab allocation on your Explanation of Payment.
Refer to the VSP Signature Plan Lens Enhancements Chart, VSP Choice Plan Len Enhancements Chart, or the Product Index for eligible lenses.

Diving Mask
If the lenses have an adapter within the mask, charge the lens enhancement codes that apply. Lenses that are glued directly into the mask are not available for use with VSP benefits.

Edge Coating, Painted Groove SQ

This applies to edge coating or painted groove.
Note: "Painted Groove" refers to cosmetic grooving and painting of the lens edge. It doesn't refer to grooving needed for rimless mountings. There's no additional charge to your patient for rolled edges or grooving of rimless mountings.

Edge Polish SP

Charge lens enhancement code "SP" for a high luster edge polish. Do not charge for "satin" edge polish.

Engravings
Engravings aren't available. Handle engravings as a private transaction between you and the lab and charge the patient your U&C fees.

Facetted Lenses SR

This applies to single and double faceting, and includes polishing.
Specialty sculpturing (e.g., Multi Facet Lenses, Billy Brock Facets, etc.) are a private transaction between you, the lab, and the patient. Charge your patient 80% U&C.

Frosted Lenses
These are included in the base lens price. Don't charge your patient separately.

Half-Pair Orders
Your patient may need a prescription with a half-pair lens enhancement, such as one plastic progressive lens and one single vision plastic lens. Please refer to the section on Half-Pair Orders for ordering and claim submission information.

High Luster Edge Polish SP

Charge code SP for high luster edge polish.
Important! If a high luster edge polish is provided at your request, the contract labs must always code for this even if it's provided privately at no additional charge (e.g., polycarbonate).
When you request a specific lens package that is defined as including high-luster edge polish, the high luster edge polish is to be provided as billed.
Note: Don't charge your patient for rolled edges or for grooving of rimless mountings.

Lenticular
This applies to aphakic lenses (e.g., hyper-aspheric and Welsh 4-drop lenses), and standard myo-disc lenses. For eClaim orders, choose **Lenticular** from the pull-down menu under **Vision Type**. For paper orders on a Materials Invoice, write "Lenticular" in the "Other" box.

Modified Lens Shapes (for any style of frame or mounting)
Modified lens shapes aren't available and should be handled as a private transaction between you and the lab. Charge your U&C fee for modified lens shape.

No-fault Warranties
No-fault warranties aren't available and should be handled as a private transaction between you and the lab. Charge your U&C fee for the no-fault warranty.

Nose Pads
Don't charge your patients for replacement nose pads. The addition of adjustable guard arms and pads and zyl build-ups is a private transaction between you, the lab, and the patient. Charge your patient 80% of U&C.

Prism: Ground-in Prism and Press on Prism
Don't charge your patients for ground-in prism or press on prism.

Satin Edge Polish
VSP does not define Satin Edge polishes. Please consult your lab regarding their definition of Satin Edge polish. Don't charge patients extra for providing any type of edge polish except "High Luster Edge Polish."

Safety Eyewear

Our contract labs must meet ANSI standards for lens production. Certified safety eyewear is defined as lenses and frames that meet the criteria listed below (from *"Are you ready for ANSI Z87.1-2003"* sponsored by OLA, Titmus, Colts Laboratories; Q7M.06.03.WHA; SAL2246 REV.06.03).

Prescription Lenses

There are two categories of lenses in the standard: basic impact and high impact.

- Basic Impact: Must be 3.00 mm thick, except those lenses having a plus power of 3.00D or greater, which must have a minimum thickness of 2.5 mm.
- High Impact: Must not be less than 2.00 mm thick at their thinnest point.

Lens Marking

All marking is permanent.

- Manufacturer's logo—complies with Basic Impact test requirements
- +—Complies with High Impact test requirements
- Applicable shade designation
- V—Photochromic lenses
- S—Special purpose lenses

Impact

Basic Impact Prescription Lenses

- Must be capable of resisting impact from a 25.4 mm (1 in) steel ball dropped from a height of 127 mm (50 in). The lens must not fracture.
- Glass lenses must be tested 100 percent.
- Plastic lenses must be statistically sample tested.

High Impact Prescription Lenses

- Must be tested to the high-velocity impact test. The lenses must be mounted on a test holder and must be capable of resisting impact from a 6.35 mm (0.25 in) diameter steel ball traveling at a velocity of 45.7 m/s (150 ft/s). Three lenses must be tested.
- Failure consists of any posterior displacement of the lens completely through the test holder; any fracture of the lens; any detachment of a portion of the lens from its inner surface; or full thickness penetration of a lens.
- If all test lenses pass, any prescription lens of the same or greater thickness at its thinnest point made by the same manufacturer and from the same material with the same coatings may bear the "+" mark.

Frames

- Made so that if impacted from the front, the lens won't come out of the back of the frame.
- All frames made after August 19, 2003, must be tested with 2.0 mm High Impact lenses.
- Frames meeting the High Impact requirement must bear the mark Z87-2, and may be used for both Basic Impact and High Impact applications.

Important! If the finished product only meets the Basic Impact requirements, the lab must attach a hangtag stating, "This eyewear meets the Basic Impact Requirements of ANSI Z87.1-2003, but should not be relied upon for protection from high-impact exposures." Only the patient may remove this label.

Side Shields

Add the cost of side shields to the wholesale cost of the frame. Indicate the total cost in the Frame Cost box on **eClaim** or the **Materials Invoice Form**.

Slab-Off

Don't charge your patient for slab-off.

Technical Add-On TA

This lens enhancement applies to digital single vision lenses that include an extra fixed ADD power in the lower part of the lens. These are also known as anti-fatigue lenses. VSP's minimum prescription requirements must be met in order to be used with VSP benefits.
Note: Charge this code in conjunction with qualifying digital single vision lenses.

UV Protection SV

This lens enhancement includes UV treatment and UV coating. Don't use this lens enhancement code in conjunction with mid- or high-index plastic, polycarbonate, trivex, plastic photochromic, or polarized lenses. These lenses block 98-100 percent UVA and UVB by nature of the material or color of the lens. You may provide UV protection in-office on plastic lenses only (code IV).See Doctor In-Office Lens Enhancements for instructions.
Per ANSI Z80 standards, "Manufacturers of lenses who claim specific ultraviolet attenuating properties shall state the average percent transmittance between 290 and 315nm (UVB) and between 315 and 380nm (UVA)." Note that blocking wavelengths above 380nm interferes with the visible spectrum and may impact the color of the lens.
Note: This does not include UV Protection-Backside. Please refer to UV Protection-Backside (BV), when ordering an AR Coating that is inherent with backside UV.

UV Protection-Backside BV

Charge this code in conjunction with qualifying anti-reflective coatings that include an additional back surface ultra-violet protection.

Light Filter LF

This lens enhancement will be used for lenses with blue light filtering technology embedded directly into the lens. It will not be applied to blue light filtering Anti-Reflective Coatings.

Sales Tax

VSP doesn't pay sales tax to providers. Charge sales tax to your patients, as you normally would, based on your state's sales tax laws and regulations.

VSP Acquisition Costs

If appropriate, use the amount paid to the lab on your behalf to assist with your sales tax calculations.

Base Lenses: VSP's acquisition costs for base lenses are:

- Single Vision: $12.67
- Bifocal/Progressive: $24.56
- Trifocal/Other: $35.95

Lens Enhancements: Refer to the appropriate Lens Enhancements Charts (VSP Signature Plan®, VSP Choice Plan®, or VSP Advantage Network) depending on the patient's plan type and use the Charge Back amount to determine the amount paid to the lab for each lens enhancements.

Proprietary Lens and Frame

Some proprietary products are available for use with VSP benefits under the Proprietary Lens and Frame Procedure. Please refer to the Guidelines below for information.

This isn’t a complete list of products. Please refer to the Product Index for a complete list.

Description	Sample Products	Guidelines
Proprietary Genuine Brand Lens & Frame: Genuine brand name Rx lenses that must be sent to the frame company's lab or a non-VSP contract lab	Bollé Costa Del Mar Oakley Panoptx Serengeti Suncloud Adlens Focuss (Adlens) Wiley X	For products listed in the Product Index as a proprietary lens and frame, see Proprietary Lens and Frame Orders. Products not listed in the Product Index aren't covered. Call VSP at **800.615.1883** to verify coverage and receive billing instructions.
Reproductions of genuine brand name lenses, that are produced in a contract lab	Bollé Costa Del Mar Maui Jim Oakley Panoptx Serengeti Suncloud	Use a contract lab and applicable lens enhancement code(s).
Proprietary Frame Mounting: Any frame and lens mounting combination that can't be fabricated by a VSP contract lab	Click 12—lenses Eyephorics—lenses Kazuo Kawasaki—lenses Nikon Performance Packages Silhouette/Adidas—sport insert #A741 SwissFlex—lenses w/oval drill holes Wiley X	For products listed in the Product Index as a proprietary lens and frame, see Proprietary Lens and Frame Orders. Products not listed in the Product Index aren't covered. Call VSP at **800.615.1883** to verify coverage and receive billing instructions.
Complicated lens/frame mounts that some contract labs can fabricate	Air Titanium—notched lenses Silhouette—rimless lenses Lindberg Optic Design—lenses Toki—rimless lenses	Use a contract lab and applicable lens enhancement code(s).
Fitovers, or frames made specifically to fit over a pair of prescription eyeglasses	Fitovers	Covered only when glazed with prescription lenses. If your patient has plano benefits, a frame with plano lenses can be used. Otherwise, fitovers aren't covered by VSP and handled privately.
Readers	Scojo Vision, LLC	Readers are only covered if the generic lenses supplied with the frame are replaced with custom prescription lenses at the time of purchase. Otherwise, they're not covered by VSP and should be handled as a private transaction.
Diving masks when Rx-able lenses are glued directly into the mask		This is not available for use with VSP benefits. If dispensed, VSP benefits can't be applied to the lens OR frame. This is a private transaction between you and the patient. Do not submit claims to VSP for payment.
General sports goggles with an adapter or insert in which a lab can fabricate and mount lenses relatively easily Includes diving masks with an adapter.	Rec Specs Silhouette–Adidas	Please use a contract lab and all applicable lens enhancement code(s).
Clip-ons with frame, priced as one unit are considered a single frame.	See Patient Lens Enhancements Explanations.	Handle this frame as you would any other frame. Enter the wholesale single unit price in wholesale frame cost box. If the frame is unlisted, enter the acquisition cost in the wholesale frame cost box.

Description	Sample Products	Guidelines
Clip-ons priced separately from frame.		These are not covered by VSP and constitute a private transaction between the doctor and patient.

The two products available to process as a private order for proprietary lens and frame order are:

- Genuine brand name RX lenses that must be sent to the frame company's lab or a non-VSP contract lab.
- Frame and lens mounting that can't be fabricated at a VSP contract lab.

Check the Product Index to see if a product is available as a proprietary lens and frame.

Important!

This is only available for genuine brand name RX lenses that must be sent to the frame company's lab or a non-VSP contract lab and frame and lens mounting that can't be fabricated at a VSP contract lab.

Charge your patient 80% of your U&C fee, minus the lens allowance and your scheduled lens dispensing fee. Lens Enhancements normally covered for your patient aren't covered under Proprietary Lens and Frame process.

Note:

Collect material, and/or lens copays as you normally would.

Calculating Patient Out-of-pocket Expenses

- Determine your U&C fee for the lens
- Deduct 20%.
- Subtract the RX lens allowance listed below
  - Single Vision: $20
  - Bifocal/Progressive: $35
  - Trifocal: $45
- Subtract your assigned lens-dispensing fee available on your Assigned Fee Report on **VSPOnline** at **eyefinity.com**.
- Add applicable copays

The following table is an example you can use to calculate patient charges:

Calculating Patient Charges on Proprietary Lens and Frame Orders	
U&C fee for lens	$
Deduct 20%	- $
Subtotal	$
Subtract VSP proprietary RX lens allowance	- $
Subtract your assigned lens dispensing fee	- $
Add any applicable copays collected from patient.	$
Patient's out-of-pocket expense	$

Calculate the patient's out-of-pocket expenses for frame as you normally would, according to section Providing Frames.

Electronic Claim Submission

Order proprietary lens and frame through **eClaim** at **eyefinity.com**:

- Choose the vision type (single vision, bifocal, etc.) in the pull-down menu.
- Choose the material type (plastic, glass, etc.) in the pull-down menu.
- Select "Proprietary Genuine Brand Lens & Frame" or "Proprietary Frame Mounting" as the lens choice.
- Choose Non IDC Lab Invoice. (Lab 0100 is allowed when tied to Proprietary Lens and Frame)
- Enter a comment in Box 19 on the CMS-1500 form that includes the lab's private invoice cost and the product name:
- Continue normal claim submission
- EXAMPLE: Frame and Lens Mounting not available through a VSP Contract Lab – Non-VSP mounting Bolle - $500.50
- EXAMPLE: Genuine Brand RX lenses not available through a VSP Contract Lab – Genuine Brand RX Costa Del Mar - $500.50

Note:

Please keep a copy of the lab invoice for your files. We may ask for a copy if there's a question about your submission.

Paper Claim Submission

Submit your patient's claim form and the lab's private invoice to VSP.

Enter a comment in Box 19 on the CMS-1500 form that includes the lab's private invoice cost and the product name:

- EXAMPLE: Frame and Lens Mounting not available through a VSP Contract Lab – Non-VSP mounting Bolle - $500.50
- EXAMPLE: Genuine Brand RX lenses not available through a VSP Contract Lab – Genuine Brand RX Costa Del Mar - $500.50

Provider Reimbursement

We'll reimburse you for the lens allowance, in addition to your scheduled lens dispensing fee and other fees that may apply.

First-Time Redos on Proprietary Lens and Frame Orders

First-time redos are a private transaction between you and the patient.

Doctor In-Office Lens Enhancements

You may provide the following lens enhancements in your office:

- Plastic Dyes—Pink I and II (IM)
- Plastic Dyes—Gradients (IP)
- Plastic Dyes—Solid Other Colors (IN)
- UV Protection (IV)

Please refer to Patient Lens Enhancements Explanations for rules related to each lens enhancement.

Important!

Refer to the VSP In-Office Finishing Program section for information and requirements regarding finishing Signature or Choice single vision stock lenses in your office.

You'll be paid the lab fee, plus the service fee, and any tax that applies. Payment will appear under the CO (covered options) column of your statement. For UV protection provided in-office, please note the following:

- UV protection can't be added to lenses that inherently block UV.
- Applicable ANSI standards must be met.
- Doctor-applied UV protection must block 98-100 percent of UVA/UVB rays.

Charge your patient the correct Patient Copay in the VSP Lens Enhancements Chart. We won't deduct any lab charge backs from your check because you're providing the lab service for these items. When providing in-office lens enhancements, please note:

- Please carefully inspect any lenses before doing any work on them. If you damage a lens, you're responsible for replacing it.
- You may provide in-office lens enhancements (plastic dyes and UV protection) only if the lens enhancement is the last step in the fabrication process. For example, anti-reflective coating must be applied after a lens has been tinted. So the entire job, including the tint, will be done by the lab to avoid delays. If the lab must dye or UV-coat the lens, the lab will replace the doctor code(s) with its lab code(s) for payment.
- When a redo is required, you must provide the in-office lens enhancement again, regardless of fault. We also require labs to provide original lab-supplied lens enhancements on first-time redos.
- If the lab order information isn't completed properly, the lab may do the work and get payment for services. If the lab inadvertently provides services when the order information is completed correctly, you'll be paid.
- You're required to remit tax on in-office services, as appropriate.
- These In-office lens enhancements cannot be billed on IOF lenses.

Important!

You must tell the lab that you're supplying in-office lens enhancements.

On eClaim

- Complete the Invoice Services page.
- If supplying a plastic dye, select the appropriate lens enhancement in the Tint Type field:
- If supplying a UV coating, select **Doctor Supplied UV Coating** in the UV coating field.

The appropriate lab codes will be automatically generated.

- Plastic Dr Supplied—Gradient Color
- Plastic Dr Supplied—Solid (except Pink 1 and 2)
- Plastic Dr Supplied—Solid Pink 1 and 2

On Paper

For appropriate payment, mark the following areas on the Materials Invoice Form:

1. In the **Lens Enhancement Code** boxes of the **Lab Information** section, enter the code(s) in the spaces provided:

Example:

Note:

Only fill in the **Lab Information** section when you provide an approved in-office service. Please don't complete any other fields in this section; this space is designed for lab use.

2. Enter “Dr Sup” (Doctor Supplied) in the **Special Instructions** section to inform the lab you’re providing the specified services. Also specify the lens tint color in the **Plastic Dyes** section or enter “UV” in the **Coatings** section for the record.

Providing Frames

VSP's material benefit is designed to provide corrective eyewear to members with visual needs. The minimum criteria for coverage is below. Unless your patient has plano coverage, plano or demo lenses may not be provided in a frame billed to VSP (exceptions apply; see LightCare Enhancement or Laser VisionCare: postoperative care). Providing frames with plano or demo lenses or providing demo lenses back to a patient for the purpose of placing them in a VSP covered frame is a violation of VSP's policy.

If the patient does not have plano coverage as described above, the patient must pay for the non-covered frame as an out-of-pocket expense if the frame will contain plano lenses.

General guidelines when providing frames for VSP patients:

- Depending on lab policy, you can send the frame from your office to the lab, have the frame shipped directly from the manufacturer, or use a frame supplied by the lab.
- Unless your patient is eligible for plano lenses, only provide frames with prescription lenses in them that meet our minimum prescription criteria.
- Lenses that don't meet our minimum prescription criteria aren't covered by VSP and can't be dispensed to your patient in or with a VSP-covered frame.

VSP's minimum prescription criteria:
The combined power in any meridian is ±0.50 diopters or greater in at least one eye or one of the following exceptions occurs:
—Necessary prism of 0.50 diopters or greater in at least one eye
—Anisometropia is 0.50 diopters or greater in at least one eye
—Cylinder power is ±0.50 diopters or greater in at least one eye

Frame companies listed on the Frame Companies/Lines List have completed our application and meet the following criteria:

- The manufacturer provides us and our doctors with current catalogs and wholesale price lists for their frames, or the manufacturer is listed in the *Frames*® catalog.
- Catalog price or manufacturer's wholesale price doesn't exceed a 25% markup over the typical acquisition price.

When billing us for listed frame companies/lines, please use the frame price indicated on the manufacturer's wholesale price list or the *Frames* catalog list as the wholesale cost. If the manufacturer is not listed on VSP's Frame Companies/Lines List, use your acquisition price when indicating the wholesale cost for in-network frames.

Keep invoices of frame purchases other than those on the Frame Companies/Lines List for at least six years (ten years for Medicare managed care program providers) or as required by federal/state law, from the date of its creation or the date when it last was in effect whichever is greater. We may ask you for these invoices.

We include listed frame companies' entire collections unless otherwise noted.

The purpose of the VSP Frame Companies/Lines List is solely to ease the administration of wholesale frame calculations and provider reimbursement rates. The list does not specify or guarantee that any particular frame manufacturer or frame brand will be covered by VSP at in-network rates. Certain manufacturers and/or brands may be designated by VSP as "out-of-network" and will be reimbursed on an out-of-network basis; this only applies to manufacturers or brands specifically designated as "out-of-network" frames.

No frame manufacturers or brands are currently on this list.

Under the VSP Signature Plan®, your patient's frame allowance is represented by a combination of the wholesale frame amount and corresponding retail amount for which your patient is covered. Although patients will only be informed of their retail allowance, they're covered for any in-network (or covered) frame less than or equal to their wholesale or retail allowance.

Effective January 1, 2014, most patients with a VSP Signature Plan will have an extra $20 on top of their frame allowance when they select Marchon® or Altair® frames. Look for the wholesale and retail allowances for Marchon/Altair and all other frames indicated on the Patient Record Report at authorization. You'll be reimbursed based on the wholesale equivalent of the patient's retail allowance for Marchon and Altair frames.

Your patient can apply the frame allowance to any frame, listed or unlisted, (except for out-of-network frames in which case the patient's out-of-network frame allowance should be applied). If patients choose unlisted frames, use your acquisition cost instead of the *Frames* catalog price when submitting the "wholesale cost" to VSP.

There is no charge to patients for standard frame cases; however, you may charge patients for special orders or for deluxe frame cases.

VSP does not provide a dispensing fee when a patient-supplied frame is used and patients can't be charged any additional fees.

Frame Overages

Charge your patient according to our frame overage procedures. When patients choose frames exceeding both their wholesale and equivalent retail allowances, they're responsible for overages (any amount exceeding their retail frame allowance at 80% of your U&C). Don't charge your patient more than 80% of U&C for frame overage, plus sales tax if it applies.

Don't bill patients for standard costs to ship frames to you. Non-standard shipping costs are a private transaction between you and your patients. Tell patients what the cost will be before ordering frames.

Total charges to patients can't exceed the retail price of frames.

Frame Companies/Lines

Frame companies on the Frame Companies/Lines List have completed our application and meet the following criteria:

- The manufacturer provides us and our doctors with current catalogs and wholesale price lists for their frames, or the manufacturer is listed in the "*Frames"* catalog.
- Catalog price or manufacturer's wholesale price doesn't exceed a 25% markup over your typical acquisition price.

When billing us for listed frame companies/lines, please use the frame price indicated on the manufacturer's wholesale price list, or the "Frames" catalog list as the wholesale cost. If the manufacturer is not listed on VSP's Frame Companies/Lines List, use your acquisition price when indicating the wholesale cost for in-network frames.

If you haven't populated a wholesale frame cost, your Explanation of Payment may show a claim denial message.

Note:

Keep invoices of frame purchases other than those on the Frame Companies/Lines List for at least six years (ten years for Medicare managed care program providers) or as required by federal/state law, from the date of its creation or the date when it last was in effect, whichever is greater. We may ask you for these invoices.

The purpose of the VSP Frame Companies/Lines list is solely to ease the administration of wholesale frame calculations and provider reimbursement rates. The list does not specify or guarantee that any particular frame manufacturer or frame brand will be covered by VSP at in-network rates. Certain manufacturers and/or brands may be designated by VSP as "out-of-network" and will be reimbursed on an out-of-network basis; this only applies to manufacturers or brands specifically designated as "out-of-network" frames as listed in the Providing Frames section of the VSP Manual.

No frame manufacturers or brands are currently on this list.

Entries don't imply endorsement, promotion, contracts, or any other relationship between VSP and listed companies. We'll include listed companies' entire collections unless otherwise noted.

A
Abba Optical, Inc.
Aim Optics
Allure
Altair Eyewear
B
Best Image
Bolle´ America
Boston Eye Designs
C
CAC Optical, Inc.
Capri Optics
Charmant Inc., USA
Clariti Eyewear, Inc.
ClearVision Optical
Colors in Optics, Ltd.
Continental Sales Co.
Costa Del Mar
D
Dan's Optical Supplies
De Rigo USA

E
Eastern States Optical
Eight to Eighty Eyewear
Eyewear Designs Ltd.
F
Fast Metal, LLC
First Look Optic
G
Global Optique, Inc.
H
Hudson Optical Corp.*
I
Imagewear
Inspecs USA (formerly Gone Vision Group)
International Point of View, Inc.
J
Jordan Eyewear, Inc.
JR Vision Group
K
Kala Eyewear/Golden Gate Optical USA
Kenmark Optical/Lancer Int'l
Kering Eyewear USA, Inc.
Kio Yamato
L
L & Y Optical Wholesale
LBI Company
L'Amy, Inc.
LG Eyewear
Luxottica Group
M
Marchon
Marcolin
Masunaga Group, Inc.
Maui Jim
McGee Group, The
Modern Optical Ltd. (except Best B-Eyes & Modern Times)
Modo Eyewear

N

New Millennium Eyewear Group, Inc.

New Trends Eyewear

O

O.G.I. Frames, Inc.

On-Guard Safety Corp.*

Optimate, Inc.

Otego Optical

P

R

Red 88 Eyewear

Revolution Eyewear

Rodenstock

ROI

Royal Vision Int'l. Co.

S

Safilo USA

SAMA Eyewear

Signature Eyewear

Silhouette

Spectacle Eyeworks

Standard Optics

Styl-Rite Optical

Symmetry Eyewear

T

Tura

U

Ultra/Palm Optical Co., Inc.

V

W X Y Z
Warszawski USA (Rimmel)
WestGroup
Wiley X Eyewear*
Windsor Eyes (formerly Windsor Optical/ Ambassador Eyewear)
Zimco Optics, Inc. (except Budget Collection)
Zyloware

* Safety Eyewear frame company.

First-Time Doctor Redos

The following doctor redo policies and procedures apply to all plans requiring the use of a contract lab. Acceptable first-time doctor redos **for lenses only** maybe done at your discretion without pre-certification:

- Your patient cannot be charged for redos required because you or your office staff made errors.
- A frame change alone is not an acceptable first-time redo (see Frame Changes, below).
- Second or subsequent requests for a lens redo are private transactions between you, the lab, and your patient.
- Providers are not paid any additional service fees when an additional **covered** lens enhancement is added to the lens redo.

For Signature and Choice single vision stock lenses finished in your office through the VSP In-Office Finishing Program, refer to the VSP In-Office Finishing Program section for information and requirements regarding first-time doctor redos of these lenses.

The following criteria must be met to qualify as a first-time doctor redo:

- The same doctor and lab must be used for both the original and redo prescriptions.
- The redo must be requested within six months from the date of service.
- The redo is for lenses only.
- One of the following requirements is met:

Requirements	Limitations
• Acceptable first-time doctor redos require at least one of the following: • Power changes (not including changes resulting in plano lenses) • Axis changes • Segment height/segment style changes due to non-adaptation (e.g., FT28 to Executive) • Change in lens style (e.g., bifocal to trifocal, bifocal to single vision, or any other base lens change, except progressive to non-progressive lens style) • Errors in transcription (not including transcription errors involving tints, photochromics, coatings, or frames) • Change in materials (e.g., glass to plastic, plastic to polycarbonate, plastic to high index plastic or glass, etc.) • Changes in base curves	• The lab will deny any doctor redo that falls within the following limitations: • Request for a redo more than six months from the original date of service, unless the patient was physically unable to request the redo (see Redos After Six Months) • Second or subsequent submission of a redo • Change made by the patient in the frame size, shape, or style • Addition or change made by the patient in tint or coating is a private transaction and the patient can be billed for services • Materials lost, broken, or damaged by the patient

- Lenses covered by a manufacturer's non-adapt warranty (e.g., photochromics, aspheric lenses) are not considered a first-time doctor re-do. Resubmit lenses to the original lab for replacement consideration.

Redos on progressive lenses under our first-time doctor redo guidelines are not covered. These lenses must be covered under the lab's private progressive warranty or the manufacturer's progressive warranty, then applied to the same VSP patient in the form of replacement lenses. The same doctor must be used for both the original and redo prescriptions. Any redo on a progressive lens must be handled as a private transaction between the doctor, lab, and patient.

If the progressive lens is covered by a manufacturer's warranty or lab guarantee, submit the lens to the original lab on a private invoice for replacement consideration. Lens enhancements or materials not covered by the manufacturer or lab are a private transaction between you and your patient.

1. First-time doctor redos must be for lenses only and submitted within six months of the original order.
2. Order the redo from the same lab that made the original prescription. Complete the lab's private invoice, clearly indicating a "VSP Doctor Redo" is requested.
3. Submit the invoice to the lab with a copy of the original lab order form or Eyefinity Service Report and the patient's original lenses. If you submit an Eyefinity Service Report, please remove procedure and diagnosis information.
4. The lab will send the new lenses to you and keep the original lenses.
5. Redo transactions are between you and the lab. No paperwork needs to be sent to us except for Covered Lens Enhancements.

On acceptable first-time doctor redo prescriptions, we'll cover lens enhancements ordered on the original prescription. Follow the procedures below in cases where a new lens enhancement is added on a redo:

Covered Lens Enhancements	All Other Lens Enhancements
You'll be charged privately by the lab. Send a First-Time Redo Verification form with the lab's material invoice to us for reimbursement. There's no charge to your patient for adding a covered lens enhancement. **Note:** Ordering additional covered lens enhancements as the only reason for a redo does not meet VSP's requirements. Refer to the First-Time Doctor Redo Requirements and Limitations section to ensure there's a valid reason for the first-time redo.	Charge your patient either the copay shown on the VSP Signature/VSP Choice Lens Enhancement Chart or your U&C fees (or "add-on" fees), whichever is lower. See Patient Lens Enhancements Fees Instructions for more information. The lab will bill you directly for additional lens enhancements.

A frame change alone is not an acceptable condition for a first-time doctor redo. At least one of the requirements listed above must be met in order for a job to qualify as a first-time doctor redo. If such a valid redo reason exists, the patient may select another frame at that time.

Redo of lenses is not covered for frame changes due to your error or your patient's dissatisfaction with the style, shape, size, or fit. Any exchange of materials under these circumstances is a private transaction between you and your patient.

Lens redos may be approved if your patient has an allergic reaction to the material in the original frame. Call the Provider Services Support Line at **800.615.1883** to request redo of lenses in this case. If lenses are approved, the frame exchange is a private transaction between you and your patient.

Doctor redos requested more than six months from the original date of service may be approved for a first-time doctor redo only if your patient was physically unable to visit your office to request the redo earlier (e.g., the patient was ill or out of town for an extended period). Call the Provider Services Support Line at **800.615.1883** to request redo of lenses in this case.

If you need to order a doctor redo from a different contract lab, you must submit the order to your state-routed VSP**One** lab with a First-Time Doctor Redo Verification form indicating that the redo lab has changed. Clearly explain the reason(s) for the lab change on the verification form. We will only honor doctor redos at a VSPOne lab under the following circumstances:

- The original lab is out of business.
- The original lab could not redo the job because of a change in the original order (e.g., could not accommodate a brand or material change, etc.).
- The original lab cannot complete the job to your satisfaction.

Important!

You must try to resolve the issue with the original lab under the first-time doctor redo program before we'll cover new lenses at a different lab.

Product Index

Products listed in the Product Index, plus corresponding descriptions and codes, are for reference only. Entries don't imply endorsement, promotion, contracts, or any other relationship between VSP and listed companies. Please contact the manufacturer for more details on individual products.

Products not listed in Branded Product Index:

Branded Anti-Reflective Coatings
Lab Choice Anti-Reflective Coatings
Lab Choice Lens Products
Branded Photochromics
Lab Choice Photochromics
Photochromics Polarized
Photochromics w/Mirrors
Coatings
Tints/Dyes
Generic Blue Light Filter
Unavailable Products
Proprietary Lens & Frame Products

Category C (QT):

Category C w/ Backside UV (QT + BV):

Category D (QV):

Category D w/ Backside UV (QV + BV):

This product is not branded for VSP orders and is available as an unbranded or lab choice selection through the claim submission process. When these products are ordered, it is the lab's choice as to which product is provided. Do not request a specific brand or product for these orders.

Category A-Lab Choice (QM):

Category C-Lab Choice (QT):

Category C-Lab Choice w/ Backside UV (QT + BV):

None at this time

Category D-Lab Choice (QV):

Category D-Lab Choice w/ Backside UV (QV + BV):

This product is not branded for VSP orders and is available as an unbranded or lab choice selection through the claim submission process. When these products are ordered, it is the lab's choice as to which product is provided. Do not request a specific brand or product for these orders.

Any Single Vision (Lab Choice):

Any Single Vision Digital (Lab Choice):

Digital Bifocal:

Photochromics are available in many lens styles. Please refer to the specific lens brand name for the appropriate lens enhancement code(s).

Photochromics Plastic (PR):

Photochromics Glass (PM):

This product is not branded for VSP orders and is available as an unbranded or lab choice selection through the claim submission process. When these products are ordered, it is the lab's choice as to which product is provided. Do not request a specific brand or product for these orders.

Photochromics Plastic (PR) + Polarized (Use applicable code):

Mirrors are not branded for VSP orders and are available as an unbranded or lab choice selection. Do not request a specific brand or product for these orders.

Photochromics w/Mirrors (PR + QR or QP):

The following applies only to factory applied scratch-resistant coatings on standard plastic (CR-39) lenses. Do not provide or charge for backside scratch coating on any non-plastic lens.

Scratch Resistant Coating A (QQ):

The following applies only to non-factory applied scratch-resistant coatings reviewed and categorized by VSP.

Scratch Resistant Coating B (QS):

The following is used for duplications of proprietary coatings, double-mirror gradient, color mirror and dielectric mirror coatings and includes the base tint and color coating (excluding yellow glass tint), if any.

Ski Type Coating (QR):

Mirrors are not branded for VSP orders and are available as an unbranded or lab choice selection. Do not request a specific brand or product for these orders.

Mirror Coating (QP):

These lens/coatings are not available for use with VSP benefits. If dispensed, VSP benefits can’t be applied to the lens OR frame. This is a private transaction between the doctor and the patient. Do not submit claims to VSP for payment.

Refer to the Billing Procedures for Proprietary Lens and Frame Orders

Client Details

BCBSM-MESSA (Blue Cross Blue Shield of Michigan - MESSA)

Providers will be able to locate MESSA members in the VSP system using their full SSN or by searching by name, date of birth, and the last four digits of their SSN. Should MESSA members present their Blue Cross/MESSA insurance card, staff should use it as identification only. MESSA members' Enrollee ID's are not going to be used as an identifier in the system.

Follow VSP's standard COB process. When paying secondary, please use the below COB secondary allowances.

Maximum COB Secondary Allowances

	VSP-1	VSP-2	VSP-3	VSP-3 Plus	VSP-1 B	VSP-2 S	VSP-3 G	VSP-3 Plus P
Exam	$38	$38	$38	$38	$38	$38	$38	$38
Lenses	$50	$50	$50	$70	$50	$50	$50	$70
Frame	$50	$65	$65	$80	$130	$130	$130	$130
Deductible	$35	$24.50	None	None	$35	$24.50	None	None

Important!

Effective January 1, 2021 MESSA has added 3 new Choice Plan offerings* "MESSA Vision, MESSA Vision Enhanced, and MESSA Vision Preferred" and has retired their Signature Plan "VSP-1". All other plans will stay the same.
*Please refer to the Choice PRM for plan benefit information.

Plan Name	Exam Copay	Materials Copay	Elective Contact Lens Allowance	Frame Allowance	Covered Lens Enhancements	Other Lens Enhancements
VSP-1 Retired 01/01/21	$10	$25	$65 total; see Note #1	$65 retail/ $26 whlsl.	Rimless drilling and grooving, Pink 1 or 2 tints.	Tints other than Pink 1 or 2, photochromics, oversize blanks, blended/progressive lenses, and all items on the VSP Signature Plan Lens Enhancements Chart.
VSP-2	$6.50	$18	$90 total; see Note #1	$65 retail/ $26 whlsl.	**For both:** Rimless drilling and mounting, all tints, photochromics, oversize blanks, blended lenses (not progressive), polarized lenses.	**For all:** Anti-reflective or mirror coating, thin-lite/hi-lite, hi-index lenses, progressives, polycarbonate lenses, scratch-resistant coatings, edge coating/ groove painting, faceting, UV 400 coatings, roll, and polish.
VSP-3	None	None	$115 total; see Note #1	$65 retail/ $26 whlsl.		
VSP-3 Plus	None	None	Non-Disposables: Covered in full. Disposables: The allowance is $200 Total. Deduct 20% from the balance of the U&C fees for routine exam, contact lens services and first three months materials after applying the patient's allowance. See Note #4.	$80 retail/ $35 whlsl.	Rimless drilling and mounting, all tints, photochromics, oversize blanks, blended and progressive lenses including smart-segs, polarized lenses.	
VSP-A Retired 7/1/17	$10	None	$65	N/A; see Note #2.	N/A; see Note #2.	N/A; see Note #2.
VSP-1 B	$10	$25	$85 total; see Note #3.	$130 retail/$50 whlsl.	Rimless drilling and mounting, Pink 1 or 2 tints.	Tints other than Pink 1 or 2, photochromics, oversize blanks, blended/progressive, and polarized lenses.
VSP-2 S	$6.50	$18	$110 total; see Note #3.	$130 retail/$50 whlsl.	**For both:** Rimless drilling and mounting, all tints, photochromics, oversize blanks, blended lenses (not progressives), polarized lenses.	**For all:** Anti-reflective or mirror coating, thin-lite/hi-lite, hi-index lenses, progressives, polycarbonate lenses, scratch-resistant coatings, edge coating/ groove painting, faceting, UV 400 coatings, roll, and polish.
VSP-3 G	None	None	$135 total; see Note #3.	$130 retail		
VSP-3 Plus P	None	None	Non-Disposables Covered in full. Disposables limited to a Total: contact lens plan with $250 allowance, including routine exam, contact lens services, and materials; see Note #3 and Note #4	$130 retail/ $50 whlsl.	Rimless drilling and mounting, all tints, photochromics, oversize blanks, blended and progressive lenses (including smart-segs), polarized lenses.	

Plan Name	Exam Copay	Materials Copay	Elective Contact Lens Allowance	Frame Allowance	Covered Lens Enhancements	Other Lens Enhancements
VSP-1 Retired 01/01/21	$10	$25	$65 total; see Note #1	$65 retail/ $26 whlsl.	Rimless drilling and grooving, Pink 1 or 2 tints.	Tints other than Pink 1 or 2, photochromics, oversize blanks, blended/progressive lenses, and all items on the VSP Signature Plan Lens Enhancements Chart.
VSP-2	$6.50	$18	$90 total; see Note #1	$65 retail/ $26 whlsl.	**For both:** Rimless drilling and mounting, all tints, photochromics, oversize blanks, blended lenses (not progressive), polarized lenses.	**For all:** Anti-reflective or mirror coating, thin-lite/hi-lite, hi-index lenses, progressives, polycarbonate lenses, scratch-resistant coatings, edge coating/ groove painting, faceting, UV 400 coatings, roll, and polish.
VSP-3	None	None	$115 total; see Note #1	$65 retail/ $26 whlsl.		
VSP-3 Plus	None	None	Non-Disposables: Covered in full. Disposables: The allowance is $200 Total. Deduct 20% from the balance of the U&C fees for routine exam, contact lens services and first three months materials after applying the patient's allowance. See Note #4.	$80 retail/ $35 whlsl.	Rimless drilling and mounting, all tints, photochromics, oversize blanks, blended and progressive lenses including smart-segs, polarized lenses.	
VSP-A Retired 7/1/17	$10	None	$65	N/A; see Note #2.	N/A; see Note #2.	N/A; see Note #2.
VSP-1 B	$10	$25	$85 total; see Note #3.	$130 retail/$50 whlsl.	Rimless drilling and mounting, Pink 1 or 2 tints.	Tints other than Pink 1 or 2, photochromics, oversize blanks, blended/progressive, and polarized lenses.
VSP-2 S	$6.50	$18	$110 total; see Note #3.	$130 retail/$50 whlsl.	**For both:** Rimless drilling and mounting, all tints, photochromics, oversize blanks, blended lenses (not progressives), polarized lenses.	**For all:** Anti-reflective or mirror coating, thin-lite/hi-lite, hi-index lenses, progressives, polycarbonate lenses, scratch-resistant coatings, edge coating/ groove painting, faceting, UV 400 coatings, roll, and polish.
VSP-3 G	None	None	$135 total; see Note #3.	$130 retail		
VSP-3 Plus P	None	None	Non-Disposables Covered in full. Disposables limited to a Total: contact lens plan with $250 allowance, including routine exam, contact lens services, and materials; see Note #3 & Note #4.	$130 retail/ $50 whlsl.	Rimless drilling and mounting, all tints, photochromics, oversize blanks, blended and progressive lenses (including smart-segs), polarized lenses.	

Important!

Exam and material copays don't apply to contact lenses. Don't collect these from your patient or deduct them from your patient's contact lens allowance

Client Detail Notes

Note #1: Add your U&C fees for professional services & materials, then apply your patient's allowance. Deduct 20% from any remaining balance. For disposable contacts, only deduct 20% from the first three months' supply. This replaces the standard contact lens benefit of 85% of U&C for exam, fitting, and evaluation.

Note #2: Patients are responsible for lenses and frames, so please give them itemized receipts. They'll submit charges to us for reimbursement. For contact lenses, charge your U&C fee, minus the allowance.

Note #3: Standard contact lens benefit of 85% of U&C for exam, fitting, and evaluation.

Note #4: As defined by MESSA: Disposables are daily and 1-2 week disposables. Non-disposables are conventional and planned replacement (including monthly and quarterly). When billing for 1-24 units of Planned Replacement lenses, enter “Planned Replacement” in Box 19.

Please use HCPCs-specific codes when filing VSP claims through eClaim. The Contact Lens Type drop-down list has HCPCS-specific codes and descriptions consistent with industry standards.

HCPCS Description	**Covered***
V2500—Hard/PMMA, spherical	2 or less
V2501—Hard/PMMA, toric or prism ballast	2 or less
V2502—Hard/PMMA, bifocal	2 or less
V2503—Hard/PMMA, color vision deficiency	2 or less
V2510—Gas permeable, spherical	2 or less
V2511—Gas permeable, toric, prism ballast	2 or less
V2512—Gas permeable, bifocal	2 or less
V2513—Gas permeable, extended wear	2 or less
V2520—Soft/hydrophilic, spherical	24 or less, see Note #4
V2521—Soft/hydrophilic, toric or prism ballast	24 or less, see Note #4
V2522—Soft/hydrophilic, bifocal	24 or less, see Note #4
V2523—Soft/hydrophilic, extended wear	24 or less, see Note #4
V2530—Scleral, gas impermeable per lens	2 or less
V2531—Scleral, gas permeable	2 or less
V2599—Other	2 or less

*Number of units covered, up to the maximum. Don’t balance-bill patients. An allowance applies if units are over this amount.

Patients can use the Elective Contact Lens allowance only to pay for new or replacement contact lenses. The allowance doesn’t cover lost or damaged lenses, except at covered intervals.

If your patient chooses a lens enhancement that is covered with copay, charge your U&C fee for the Starter Plan or the patient copay for all other plans.

If you offer a special promotion or discount, charge whichever is lower: Your “special” fee or 80% of U&C. If you’re charging the patient your “special” fee, explain that in “Special Instructions.”

Note:

Using the Elective Contact Lens allowance makes the patient ineligible for any other service or materials for that eligibility period.

The following items aren’t covered and are a private transaction between you and your patient:

- Contact lens insurance
- Contact lens care kit
- Follow-up visits (except those included in the initial fee)
- Plano sunglasses
- Supplies

Coventry Health Care of Virginia, Coventry Health Care of West Virginia, Coventry Health and Life Insurance Company

Authorizations for all Coventry Health Care and Coventry Health and Life Insurance Company patients are valid for 15 days only.

Coventry Health Care and Coventry Health and Life Insurance Company employees do not use Social Security Numbers (SSN) for patient identification. Member ID cards show the unique 11-digit identification numbers that are issued by Coventry Health Care and Coventry Health and Life Insurance Company.

Sample ID cards:

Coventry Health Care and Coventry Health and Life Insurance Company patients cannot receive the automated VSP Savings Statement.

For NBS Comment Codes: D619, D620, D621, D622, and D624

The patient is eligible to receive a covered in full contact lens exam (fitting and evaluation) after applicable copay. Please bill your U&C fees.

For NBS Comment Code: D623

Important!

The contact lens material code must be billed with the fitting and evaluation code to ensure payment. If materials are not dispensed at the time of the fitting and evaluation, bill the contact lens material HCPCS that the patient is being fitted for with a $0 amount.

Based on the type of contact lenses prescribed:

Specialty Contact Lenses 15% discount off your usual & customary fee up to an allowance of $40, minus applicable copay. Patient is responsible for remaining balance. Please bill your U&C fees.	**Non-Specialty Contact Lenses** Covered-in-full contact lens exam (fitting and evaluation 15% discount off your usual and customary fee) after a $35 copay. Please bill your U&C fees.
V2501—Hard/PMMA, toric or prism ballast	V2500—Hard/PMMA, spherical
V2502—Hard/PMMA, bifocal	V2510—Gas permeable, spherical
V2503—Hard/PMMA, color vision deficiency	V2513—Gas permeable, extended wear
V2511—Gas permeable, toric, prism ballast	V2520—Soft/hydrophilic, spherical
V2512—Gas permeable, bifocal	V2523—Soft/hydrophilic, extended wear
V2521—Soft/hydrophilic, toric or prism ballast	
V2522—Soft/hydrophilic, bifocal	
V2530—Scleral, gas impermeable per lens	
V2531—Scleral, gas permeable	
V2599—Other	

Elective Contact Lens Copayment Exception Clients

This information applies only to clients with Elective Contact Lens (ECL) copay exceptions if the following comment is indicated on the authorization within the contact lens section. These clients require subtracting the copay from the total charged, rather than the allowance.

For complete ECL information, refer to “Contact Lens Plans” in the Plans & Coverages section.

Copay applies to ECL. Subtract copay from total of discounted contact lens exam services and U&C material charge. Apply your patient’s allowance to the remaining balance. See “VSP” Manuals.

Examples

Remaining balance is less than Contact Lens Allowance	
1. Determine the total of your fitting & evaluation and U&C material charge.	
Your U&C fee for contact lens materials:	$50
Add 85% of your U&C fee for fitting and evaluation:	+$30
Total:	$80
2. Subtract the copay from this total to determine the remaining balance.	
Patient’s copay:	-$20
Remaining balance:	$60
3. Subtract the contact lens allowance from this total.	
Contact lens allowance (e.g., $105)	-$60
Remaining balance to charge to patient:	$0
Remaining balance is more than Contact Lens Allowance	
1. Determine the total of your fitting & evaluation and U&C material charge.	
Your U&C fee for contact lens materials:	+$95
Add 85% of your U&C fee for fitting and evaluation:	+$50
Total:	$145
2. Subtract the copay from this total to determine the remaining balance.	
Patient’s copay:	-$20
Remaining balance:	$125
3. Subtract the contact lens allowance from this total.	
Contact lens allowance (e.g., $105)	-$105
Remaining balance:	$20

Note:

Our online Savings Statement won’t automatically calculate copays for these scenarios.

Elective Contact Lens Covered in Full Exception Clients

This information applies only to those clients with Elective Contact Lens (ECL) covered-in-full exceptions. These clients require that an annual supply of ECL contacts be covered in full to your patient.

For complete ECL information, refer to “Contact Lens Plans" in the **Plans & Coverages** section.

Eye Exam
Use your patient’s exam benefit to bill for the routine exam.

CONTACT LENS SERVICES
Bill the right CPT code and your U&C fees for the contact lens services.

Contact Lens Materials
Bill the right HCPCs code(s) for provided materials. Submit your U&C fees for materials and indicate the number of units (contact lenses) dispensed.

Contact Lens Type
Based on the number of units dispensed, indicate the correct type of lenses:

- 1–2 units: Conventional or non-disposable contacts
- 3–52 units: Planned replacement, month/quarter, or 14-day disposables
- 53–106 units: 7-day disposables
- 107–361+ units: 1-day disposables

VSP Payment
We’ll pay you 85% of your contact lens service fees plus your U&C fees for materials up to the maximum amount for the type of contact lenses provided. We’ll pay separately for a routine exam.

Note:

Unless otherwise indicated on the Patient Record Report, there are no benefits for professional services or materials connected with the following:

Corneal Refractive Therapy, Orthokeratology, and myopia management.

Copay
Collect any applicable copays from your patient.

Balance Billing
Don’t bill your patient for the contact lens services or the annual supply of contact lenses. You must accept payment from us as payment in full for services rendered and make no additional charge to the patient for covered services.

Hexcel Corp Clients Details (Utah Employees Only)

The following applies to Hexcel ProTec Safety® Plan coverage, only for employees who reside, or purchase their ProTec materials in the state of Utah, where there is a state sales tax for durable medical equipment (DME).

The standard dispensing fee for ProTec is $25. We have increased the dispensing fee for these Utah employees, to $35. This increase will cover the cost of sales tax on the glasses and covered lens enhancements. Please do not collect sales tax from the employee/member for any covered ProTec materials.

Hometown Health Plan Integrated Primary EyeCare

Members of Hometown Health Plan's HMO and PPO are covered under VSP's Integrated Primary EyeCare Program℠. Refer to the Integrated Primary EyeCare Program in the Plans & Coverages section for more information.

Please contact Hometown Health's Provider Relations department at **775.982.3233** to schedule an in-service to learn more about policies and procedures, obtain information on electronic claims submittal, and check member eligibility status.

Important!

Centers for Medicare & Medicaid Services (CMS) require that Hometown Health (RenownHealth) make available to all providers of healthcare services for their members its Code of Conduct and Compliance Policies. This information can be accessed at https://www.hometownhealth.com/compliance-program/policies-and-procedures/ and should be reviewed annually for the latest updates.

For questions about eligibility, paper claims and benefits, check your patient's ID card for information and the contact phone number. Keep a copy of the ID card in your patient's file.

Sample ID cards

Patients have direct access to any participating VSP Integrated Primary EyeCare provider. Participating providers are listed on the Hometown Health website at www.hometownhealth.com. Services that are approved will be applied to the members' medical benefit.

Note:

Integrated Primary EyeCare patients can only be referred to another doctor or refused service if the service required is beyond the scope of your licensure.

Hometown Health handles reimbursement and pays claims daily following state and federal regulations. Reimbursement is based on your current VSP contracted rates.

Please refer to the patient's ID card from Hometown Health for directions on submitting claims.

Hometown Health Plan Schedule of Covered Services – Effective January 1, 2022

Idaho Power Company Client Details

The following applies to Idaho Power Company members' Safety pair of safety coverage. Employees have first and second pair benefits under the company safety plan. This is coverage for EMPLOYEE ONLY, no dependent coverage.

Authorization

Idaho Power patients may fill out a questionnaire about their work environments and related safety requirements before their exam. A sample Safety Requirements Questionnaire is located in the **Tools and Forms** section of the **Manuals** on **VSPOnline** on **eyefinity.com**. Keep a copy of the questionnaire or the information it contains in your patient's record.

To obtain an authorization, contact our Provider Services Support Line at **800.615.1883**.

Collect a $15 copay from patients for the first pair and $20 for the second pair.

Lenses

Safety lenses are available to the member only. The following lens enhancements are covered for 1st pair Safety:

- Polycarbonate
- Progressive
- Blended
- Photochromic
- Anti-reflective
- Solid and gradient tints
- Ultraviolet (UV) coating (required)

The following lens enhancements are covered for 2st pair Safety:

- Polycarbonate
- Photochromic
- Anti-reflective
- Solid and gradient tints
- Ultraviolet (UV) coating (required)

Frame

Permanent side shields are required for all frames and are covered, up to the frame allowance, including frame and side shields.

The patient has a retail frame allowance of $100 (wholesale allowance of $38) for their first safety pair . If the member chooses a frame with a cost that exceeds both the wholesale and retail allowances, deduct 20% from the retail overage. Determine the patient's cost (if any) as you do today and collect any overages from patient.

Additional Pair Eligibility

An additional pair of Safety lenses and frame up to $100 are also available every calendar year.

Important!

The patient could be eligible for an additional pair of safety glasses, even if they're not showing availability on **eyefinity.com**. Call VSP to confirm eligibility and receive an authorization.

Repair & replacement

Idaho Power members also have an additional interim benefit that includes repair or replacement of lenses and/or frame once every calendar year for any reason (broken, lost, stolen, etc.).

Important!

Call VSP to receive an authorization for repair or replacement.

Copay

First Pair: Collect $15 copay for materials from patients

Second Pair: Collect $20 copay for materials from patients

Lab

Order safety lenses and frames for these clients from a lab capable of producing ANSI certified safety eyewear (see the National Contract Lab List)

Navajo Transitional Energy Company

Cloud Peak Energy was gifted to a new region and changed their name to Navajo Transitional Energy Company. The following applies to Navajo Transitional Energy Company members only.

Navajo Transitional Energy Company members are eligible for safety lenses every twelve months and a frame every 24 months. Refer to the ProTec Safety Plan section for complete Safety Eyecare information and details. Patients may present an ID card with the details of their plan:

Additional Pair Eligibility

An additional pair of ProTec Safety lenses are also available every 12 months and a frame every 24 months through Interim Benefits.

Important!

The patient could be eligible for an additional pair of safety glasses through Interim Benefits, even if they're not showing availability on **eyefinity.com**. Call VSP to confirm eligibility and receive an authorization.

Repair & replacement

Navajo Transitional Energy members also have an additional interim benefit that includes repair or replacement of lenses and/or frame once every 12 months for any reason (broken, lost, stolen, etc.).

Important!

Call VSP to receive an authorization for repair or replacement.

Copays

Don't collect any copays from the patient for ProTec Safety lenses, frames, or covered lens enhancements.

Covered Lens Enhancements

- Progressive lenses
- Polycarbonate lenses
- Photochromic lenses
- Solid and gradient tinting
- Anti-reflective coating

NV Energy Client Details

The following applies to NV Energy, employee only benefit entitles them to two (2) pairs of Safety glasses every 12 months.

NV Energy patients may fill out a questionnaire about their work environments and related safety requirements before their exam. A sample Safety Requirements Questionnaire is located in the **Tools and Forms** section of the **Manuals** on **VSPOnline** on **eyefinity.com**. Keep a copy of the questionnaire or the information it contains in your patient's record.

To obtain an authorization, contact VSP at **800.615.1883**.

$0.

Lenses

Safety glasses are available to the employee only.

Polycarbonate lenses are preferred and covered.

Photochromic and Tinted lenses are covered.

Progressive and Blended Bifocals lenses are covered.

UV and Scratch resistant coated lenses are covered.

Frame

The patient has a retail frame allowance of $130 (wholesale allowance of $50). If the member chooses a frame with a cost that exceeds both the wholesale and retail allowances, deduct 20% from the retail overage. Determine the patient's cost (if any) as you do today and collect any overages from patient. (The patient is NOT limited to ProTec frames).

Order safety lenses and frames for employees of these members from a lab capable of producing ANSI certified safety eyewear (see the National Contract Lab List).

Post-Cataract Enhancement Clients

Coverage for post cataract enhancement services is indicated by the following comment: “Patient is eligible for exam and materials after cataract surgery. Call Customer Service.”

Please call VSP at **800.615.1883** for an authorization. Verify copay and coverage details on the Patient Record Report.

Our post-cataract services are based on national Medicare guidelines. Patients can get post-surgical exams and materials covered up to the plan allowance, minus any copays. Please call VSP for an authorization for post-cataract exams and materials. Pre-certification isn’t required.

This isn’t a medical benefit and doesn’t cover postoperative/ambulatory care. The benefit only covers a comprehensive or intermediate exam and corrective materials needed after cataract removal or the lack of an intraocular lens (IOL).

Eligibility

Aphakic with IOL (pseudophakia): Post-surgical exam and one pair of eyeglasses or contact lenses after each cataract surgery with IOL insertion (diagnosis code Z96.1) once per lifetime per operative eye.

Aphakic without IOL: In addition to the post-surgical exam, aphakic patients who do not have an IOL (aphakia diagnosis codes H27.00 - H27.03 or Q12.3) are covered for the following lenses or combination of lenses after each cataract surgery when visually necessary:

- Bifocal lenses in frames; or
- Lenses in frames for distance vision and lenses in frames for near vision (two pairs of glasses); or
- Conventional contact lenses for distance vision, eyeglasses for near vision to wear with contact lenses, and eyeglasses to wear when the contact lenses have been removed.

Lens Materials

The following lens enhancements may be covered following cataract extraction when visually necessary and documented by the treating doctor:

- Tints (V2744-V2745)
- Anti-reflective coating (V2750)
- UV lenses (V2755)
- Oversize lenses (V2780)
- Follow the instructions on the Patient Record Report for covered and non-covered lens enhancements

Frames

Only standard frames are covered (V2020). Deluxe frames (V2025) aren’t covered, but your patient may pay to upgrade frames. Tell patients about price differences in advance. They must sign an “Advanced Beneficiary Notice” agreeing to pay the extra charge.

Non-Covered Materials

If your patient chooses materials other than those covered, the cost of those materials is a private transaction between you and your patient. We don’t cover replacement frames, eyeglasses, or contact lenses. Presbyopia-correcting intraocular lenses (IOLs) are also not covered.

Principal Financial Group

All Principal plans are on the Choice Network with participating retails chains, VSP Choice Plan®, which includes a fully covered VSP WellVision Exam® and quality prescription eyewear featuring the lowest out-of-pocket costs with our lens enhancements savings and wholesale frame pricing guarantee.

Retirees: Please refer to VSP Vision Savings Pass in the **Client Details** section for further information.

Current employees and dependents: Please refer to VSP Choice Plan and Exam Plus Plan for further information.

Eligibility

Principal identifies members by a unique nine-digit ID number referred to as a member or privacy ID. Members can find this number on principal.com or on the Principal mobile app.

RTX Corporation

The following client details apply to RTX members only. Please refer to the Patient Record Report to confirm coordination or benefits restriction applies.

Important!

RTX employees are covered under the VSP ProTec Safety plan.

The following client details apply to RTX Corporation members only. Please refer to the VSP Safety Eyecare Plan in the Plans and Coverages section for complete Safety Eyecare information for these members.

Before scheduling an appointment, RTX members must get a signed “RTX ProTec Eyewear Authorization Form” from RTX. Although not required, RTX members may also present the VSP Safety Requirements Questionnaire at the time of their exam. Please put all applicable forms in the patient’s file.

Important!

RTX employees must provide a signed RTX ProTec Eyewear Authorization Form before they can receive safety services or materials even if they are eligible for safety benefits online.

There are two ways to get authorization:

- **Online:** Log on to **eyefinity.com**, select **Get Authorization & Check Eligibility**, and then select **Member Search.**
- **By phone:** Call VSP at **800.615.1883**. You’ll need to provide the name of the Raytheon supervisor who approved the benefit to our Customer Service Representative to get an authorization.

Copay

Exam – No co pay.

Materials – No copay.

Under the ProTec Safety Plan, RTX members are eligible for a fully covered safety frame from the ProTec Eyewear® frame kit and single-vision, lined bifocal, or trifocal polycarbonate lenses. Detachable side shields and a frame case are provided with each order through the participating labs.

The following limitations and requirements apply to RTX members:

- Safety glasses are available to the employee only.
- Polycarbonate lenses are preferred and covered.
- Permanent or removable side shields are required for all frames and are covered for ProTec Eyewear frames.
- If permanent side shields are required, it will be noted on the member’s RTX Technologies ProTec Eyewear Authorization form. Note: When billing on eyefinity.com enter “permanent side shields” in Lab Special Instructions on Invoice Services page of eClaim.
- All ProTec Safety and Repair/Replace orders must be sent to participating labs.
- Frames for electricians must be made from non-metallic materials.

Repair/Replace Benefits

RTX employees must provide a signed “RTX Safety Eyewear Authorization Form” before they can receive repair/replacement safety services or materials.

After using their materials benefit under their ProTec Safety plan, RTX members have an additional Repair/Replace benefit for their safety eyewear which covers materials.

- RTX members are eligible for repair/replacement if their spectacle lenses or frames are broken or damaged.
- Eligible RTX members covered under this additional benefit are entitled to safety eyeglass lens and safety frame repair/replacement.
- Frame repair includes temples only, front only, hinge, and miscellaneous repairs.
- The repair benefit may also include replacement of a complete frame and/or basic lens based on your professional judgment.

The following limitations and requirements apply to RTX members:

- For RTX members that supply a non-ProTec Eyewear frame to have lenses replaced, order must be sent to participating labs.
- For RTX members that supply a non-ProTec Eyewear frame for repair/replacement, previous safety frame must be replaced with a selected ProTec Eyewear model.
- For new frames, RTX members must choose one of the 30 ANSI-approved frames from the ProTec Eyewear kit or online catalog which are fully covered.

The Greenbrier Companies Inc

Protect Safety Materials Only: ProTec Safety First and Second Pair Benefit and Eligibility

The Greenbrier Companies Inc members have a materials only benefit lens and frame plan.

Members are eligible for a first pair, safety lenses and frame once every 12 months beginning in January. Visit **eyefinity.com** for eligibility and authorization information. Refer to the ProTec Eyecare section for complete coverage and billing details.

Protec Safety Stand Alone: ProTec Safety First Pair Benefit and Eligibility

The Greenbrier Companies Inc members have exam, lens and frame plan.

Members are eligible for a first pair exam, safety lenses and frame once every 12 months beginning in January. Visit **eyefinity.com** for eligibility and authorization information. Refer to the ProTec Eyecare section for complete coverage and billing details.

FRAME DETAILS:

Fully covered from ProTec Eyewear kit/online catalog.

ProTec Safety Second Pair Benefit and Eligibility

Second pair of prescription safety lenses and frame is available once every 12 months beginning in January. When visiting **eyefinity.com** for eligibility, note that the ProTec Safety second pair benefit has special handling rules. Refer to the Materials Coverage section.

To obtain an authorization, contact VSP at **800.615.1883** or go to **VSPOnline** at **eyefinity.com**.

The Greenbrier Companies Inc. patients may fill out a questionnaire about their work environments and related safety requirements before their exam. A sample Safety Requirements Questionnaire is located in the **Tools and Forms** section of the **Manuals** on **VSPOnline** at **eyefinity.com**. Keep a copy of the questionnaire or the information it contains in your patient's record.

Protec Safety Materials Only: Do not collect copay from patients

Protec Safety Stand Alone: Collect $10 copay for safety exam

Lenses

Safety lenses are available to the member only.

Progressive lenses are covered.

Polycarbonate lenses are preferred and covered.

Ultraviolet (UV) coating is covered.

Scratch-resistant coating is covered.

Anti-reflective coating is covered.

Frame

While all ProTec frames are available for this client, the patient has to choose the selected ProTec Eyewear frame approved by Greenbrier. Please have them check with their employer if the ProTec frame selected is approved for both first and second pair.

The order will automatically route to VSP**One** Columbus or VSP**One** Sacramento. You may select either of these VSP**One** labs.

Tucson Electric Power

The following applies to Tucson Electric Power patients only. This information is intended to explain their unique first and second pair safety glasses benefits. Refer to the ProTec Safety Plan section for complete coverage and billing details.

Tucson Electric Power members have a materials only ProTec Safety Plan. Members are eligible for a first pair of safety lenses and frame, which can either be clear or a tinted set of prescription safety glasses, once every 30 months. Visit **eyefinity.com** for eligibility and authorization information.

Note:

If the member has already obtained their first pair of safety glasses, call VSP at **800.615.1883**, they could be eligible for a second pair of safety glasses.

Second pair of prescription ProTec Safety lenses and frame may be available, once every 30 months, and can also be either clear or tinted.

Note:

The respirator lens inserts benefit doesn’t automatically appear on **eyefinity.com**, call VSP at **800.615.1883** for eligibility and authorization information.

The following is a listing of covered lens enhancements:

- Progressives
- Polycarbonate lenses
- Solid and gradient tints
- Scratch resistant coating

Don’t collect any copays from the patient.

Union Benefits Trust

Interim benefits are available within 12 months of the last exam. Exam and lenses are covered if:

- Diopter changes >= .50 diopters, or
- Axis change >= 15 degrees, or
- Prism change >= .50 diopters

See Interim Benefits in the **Plans and Coverages** section for more information.

United Parcel Service (UPS)

Some UPS members may be eligible for covered in full hard and soft Conventional (aka Annual Replacement) contacts under the Special Conventional Contact Lens Coverage as identified by the following comment on the Patient record Report:

SPECIAL CONVENTIONAL DAILY WEAR CONTACT LENS COVERAGE

Contact Lens Type	Covered	Covered Codes
Soft	Yes	V2520—2 units or less
Hard	Yes	V2500—2 units or less
Other	No—See Other Contact Lenses	N/A

Two units or less of Conventional clear contact lenses should be handled as stated in “Covered Contact Lenses” under Contact Lens Plans in the Plans and Coverages section of the **Manual**.

Please use HCPCS-specific codes when filing VSP claims in eClaim. The Contact Lens Type drop-down list has HCPCS-specific codes and description consistent with industry standards.

All other elective contact lenses, i.e., disposable, planned replacement, extended wear, bifocal, toric, or tinted daily wear, as well as rigid, gas-permeable daily wear, are covered through the "Exam And" plan. Refer to the Contact Lens Plans in the Plans and Coverages section of the **Manual** for more information.

Vulcan Materials Client Details (Alabama employees Only)

The following applies to Vulcan Materials ProTec Safety Plan coverage, only for employees who reside, or purchase their ProTec materials, in the state of **Alabama**, where there is a state sales tax for durable medical equipment (DME).

The standard dispensing fee for ProTec is $25. We have increased the dispensing fee for these Alabama employees only to $45. This increase will cover the cost of sales tax on the glasses and covered lens enhancements. Please do not collect sales tax from the employee/member for any covered ProTec materials.

Business Continuity Plan

We've established emergency recovery plans that'll go into effect immediately in the unlikely event our corporate office experiences a major disaster, such as a flood or earthquake. Follow the guidelines below in the event of a disaster.

Major disasters could impact these authorization support systems:

- Electronic claim submission system
- Interactive Voice Response (IVR) system

Please follow these guidelines if a disaster impacts our corporate office:

- Call VSP at **800.615.1883** and follow the recorded instructions. We'll update them as needed.
- For procedural questions, check the appropriate section in this manual.
- Modified Authorizations—If the greeting instructs you to give "modified authorizations," please follow this procedure:

1. Provide exam services to your patient. Explain that VSP's experiencing a business interruption and you can't obtain an authorization for services. Tell your patient that, unless you receive full authorization, they may have out-of-pocket expenses that you can't confirm until later.
2. Have your patient sign a Patient Responsibility Statement. You can find an electronic copy under the **Patient Education** area in the **Administration** section on **VSPOnline** at **eyefinity.com**. Collect deductibles (if known).
3. Materials should be held until you are able to confirm eligibility and benefit information. Obtain the authorization and notify the patient of any out-of-pocket expenses incurred upon confirmation of coverage and prior to ordering materials.
4. When systems become available for obtaining authorizations, you may submit the exam and materials using the original date of service through eClaim using the backdated authorization process.

Note:

Follow this process to get authorizations during our recovery phase only. Please use the electronic claim submission system when it becomes available for you to get authorizations.

- VSP makes every attempt to resolve complaints and grievances expeditiously and to the member's satisfaction. VSP network doctors are responsible for ensuring office staff is informed of the VSP Member Complaint Process and provide a copy of the VSP Member Complaint/Grievance Form to patients upon request. The VSP Member Complaint/Grievance Form is available in English, Spanish, and Chinese, and can be found in the **Patient Education** area **Administration – Form Library** section on **VSPOnline** at **eyefinity.com**.

Note:

For California residents see Complaints and Grievances under Patients' Rights and Responsibilities.

For California Residents: If a provider or enrollee is unable to obtain a timely referral from a provider, a complaint may be filed with the DMHC at their toll-free telephone number (1-888-466-2219) and/or a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department's internet website www.dmhc.ca.gov has complaint forms, IMR application forms, and instructions online.

- **Complaint/Grievance** – is a written or verbal expression of dissatisfaction regarding the plan and/or provider, including quality of care and quality of service concerns, dispute, request for reconsideration, or appeal made by a member or the member's representative. This includes a written or verbal expression of dissatisfaction by a member or group contract holder who believes their plan contract has been or will be improperly cancelled, rescinded, or not renewed.
- When the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.
- Neither VSP nor its contracted providers may retaliate against a member on the basis of filing a complaint or grievance, in accordance with State and Federal regulations.
- HIPAA privacy-related complaints may be submitted with or without other complaints related to quality and other services.

- **Quality of Care Grievance** – Complaints that allege concerns about the standards of care provided, which may include and are not limited to, misdiagnosis, negligent treatment, and/or incorrect prescription.
- **Quality of Service Grievance** – Complaints that allege concerns about the standards of service provided, which may include and are not limited to, unprofessional behavior, inappropriate disclosure of PHI, discrimination, appointment availability, and/or physical accessibility.
- When a quality of care and/or quality of service grievance is identified, VSP is required to gather medical records, a response from the contracted provider, and any additional information necessary to determine if there is sufficient evidence that deviation from clinical practice guidelines occurred, resulting in an adverse effect on the patient's health, or a violation of applicable laws and regulations occurred.
- If no violation is found, or VSP finds insufficient evidence, the quality of care and/or quality of service complaint is closed.

- VSP regularly sends patient satisfaction surveys by random selection to VSP members who have received services with a VSP network doctor. If a complaint/grievance is identified through a satisfaction survey it will be sent to the appropriate department for review and resolution, following our policies and procedures described above.

SP credentials its Network Providers in accordance with the standards and guidelines of the National Committee for Quality Assurance (NCQA), and other accrediting or regulatory agencies, as appropriate. The doctor network consists of Optometrists, Ophthalmologists and Doctors of Osteopathy and each is required to be an active participant in the Medicare program.

Confidentiality

VSP maintains confidentiality of all information obtained for the purposes of credentialing and recredentialing VSP doctors. Only staff in Network Development, the Credentialing Committee and delegated entity(ies) have access to this confidential doctor information. VSP does not disclose confidential doctor information to any person or entity except with the written permission of the doctor or as otherwise permitted, required by contract or State and/or Federal law.

Delegation of Primary Source Verification

VSP delegates the administrative activities of its credentialing to an NCQA certified Credentialing Verification Organization (CVO).

In accordance with NCQA standards, the CVO verifies the presence and timelines of the following:

- Timeliness of current attestation
- All active state licenses
- Board certification of MDs and DOs
- Education and training
- DEA license as required by applicable State regulation
- CDS, if applicable
- Current individual doctor malpractice insurance coverage
- Malpractice claims history and/or sanctions
- Medicare/Medicaid sanctions via National Practitioner Database, (NPDB), Office of the Inspector General (OIG) and System for Award Management (SAM)
- State Medicaid enrollment including State Agency suspension, exclusions and terminations list, if applicable
- Hospital privileges loss or limitation of privileges
- Work history for initial applications only—application or curriculum vitae
- Medicare opt out
- Query the SSA Master Death
- National Plan and Provider Enumeration System (NPPES) – NPI number
- Office of Foreign Asset Control (OFAC)
- CMS Preclusion List

Medicare participation is required of all VSP network doctors in order to comply with the implementation of the Centers for Medicare and Medicaid Services' (CMS) Medicare Advantage program. VSP doctors are required to provide evidence of participation at initial and re-credentialing.

Application

All applicant and existing doctors must complete and attest to the accuracy of their CAQH information and consent to the inspection of records and documents pertinent to the credentialing and recredentialing processes.

Doctors must complete the CAQH application, or State-mandated application, that includes a current and signed attestation of the following:

- Physical and mental status
- Lack of impairment due to chemical dependency/substance abuse
- History of loss of license and/or felony convictions
- History of loss or limitation of privileges or disciplinary activity
- Current malpractice insurance coverage
- The correctness and completeness of the application

Doctor Rights Regarding Application

Doctors have the right to request the status of their credentialing and recredentialing application. The doctor's rights and VSP contact information is included in the Provider Reference Manual for existing providers and online at **vspglobal.com** for applicant doctors. The doctor can request, in writing, to review and correct information obtained from outside sources for the purposes of initial credentialing and recredentialing. Doctors may submit their request via email to credentialing@vsp.com. VSP will respond within 3-5 business days. Peer review information is confidential and protected. The doctor application for VSP participation includes this provision.

Doctor Notification of Information Discrepancy

If the information submitted by the doctor varies substantially from the primary source verification and/or VSP network requirements, VSP or its CVO will make multiple contacts to inform the doctor via mail, facsimile, or phone call. Failure to correct the information may result in a denial and/or termination from the VSP network.

Doctor Failure to Disclose Adverse Information

VSP applicant and existing doctors must provide complete and accurate information. If the doctor fails to disclose adverse actions, VSP or its CVO will make multiple contacts with the doctor electronically, by facsimile.

Non-Discrimination

The Credentialing Committee members sign a non-discrimination agreement that remains in effect during their term as a Committee member. The statement attests that all decisions made by the committee are based on the doctor's credentials and VSP network participation criteria and not the doctor's age, gender, sexual orientation, race, ethnic/national identity, specialization or special services the doctor may provide.

Credentialing and Recredentialing Timeframes

The credentialing and recredentialing process follows these timeframes:

- All source verification occurs within 180 calendar days of doctor signature date and Credentialing Committee date.
- CVO notifies the applicant doctor electronically, by facsimile or by certified mail, return receipt requested within 30 calendar days of receipt if application is incomplete.
- VSP notifies applicant doctors of Credentialing Committee approval and all doctors of Credentialing Committee denial within 10 business days of Committee decision.
- Recredentialing of doctors occurs with thirty-six (36) months of prior credentialing date in accordance with state and federal requirements and NCQA guidelines.

Note:

Timeframes are adjusted to meet State specific requirements. Verification concludes when the Credentialing Committee reaches the decision to approve or deny.

Additional VSP Network Participation Requirements

- All VSP services must be provided by a network doctor at a qualified office location. Each office location and doctor connected to the applicant doctor must be credentialed by VSP and meet network participation criteria.
- Each practice must have internet access to submit claims electronically and provide a valid e-mail address to receive communications from VSP.
- Each practice must be able to receive claim payment under one Tax Identification Number, electronically, via direct deposit.
- Use VSP contracted laboratories, as required based upon a patient's VSP plan type (except, this shall not apply to doctors who practice in states with laws that specifically prohibit a health plan such as VSP from requiring the provision of such services).
- Maintain and display a minimum inventory of 200 frames from approved frame manufacturers, including a minimum of 100 frames that fall within the average VSP frame allowance of $150.
- Provide contact lens care to VSP patients.
- Provide 24-hour access to VSP patients, as well as have 24-hour access to instrumentation and materials. The 24-hour access to patients must include one or more of the following options:
  - (a) answering service,
  - (b) on-call service,
  - (c) pager/mobile phone or
  - (d) answering machine message providing the patient with instructions on how and where to obtain services from a VSP doctor, and instructions on what to do in case of a medical emergency.

All of these options must allow a patient to leave a message for a returned call back.

- Provide service to patients who have the VSP Choice Plan or the VSP Advantage Plan (except, that this shall not apply to doctors who practice in states with laws that specifically prohibit a health plan such as VSP from requiring the provision of such services).
- VSP's primary method of communication is e-mail. At least one network doctor's valid e-mail address is required for each Qualified Office Location. It is the network doctor's responsibility to maintain an up-to-date e-mail address to ensure receipt of important updates and critical information from VSP.

Insurance, Licensure and Certification

Our network doctors must maintain malpractice insurance coverage, in individual or group coverage, in an amount of not less than $1,000,000 per occurrence and $3,000,000 annual aggregate. However, if a doctor participates in an active state patient compensation fund or excess liability program and meets that particular state's fund/program requirements, that doctor will be exempt from maintaining VSP's malpractice insurance coverage requirements. Doctors must notify us within 10 days of any lapse in professional or general liability insurance coverage and indemnify us against damage or claims stemming from a lack of insurance coverage. Insurance verification is done during the credentialing and recredentialing processes.

Our network doctors must be licensed and in good standing as optometrists or ophthalmologists in the state(s) where they practice. We verify state licenses, state-controlled substance licenses (CDS) and federally controlled substance certificates (DEA) during the credentialing and recredentialing processes.

Therapeutic Pharmaceutical Agents (TPA) Certification: Optometrists

Optometrists must be fully licensed and TPA certified.

Board Certification: Ophthalmologists

All ophthalmologists must be board-certified by either the American Board of Ophthalmology (ABO), or the American Osteopathic Board of Ophthalmology and Otorhinolaryngology Certificate of Specialization (AOBOO).

A certificate from the American Osteopathic Colleges of Ophthalmology and Otolaryngology-Head and Neck Surgery isn't acceptable.

U.S. Drug Enforcement Administration Requirements

Ophthalmologists must maintain current authorization to prescribe medication following federal DEA and state requirements in each state where they see patients. In some states, optometrists must have current DEA licenses to get or maintain TPA certification and prescribe medicine to the fullest extent of that certification.

Locum Tenens

VSP requires its network providers to adhere to the following when utilizing a locum tenens (fill-in) doctor:

1. When using a fill-in doctor, such doctor shall be a VSP credentialed doctor in good standing.
2. If unable to arrange for a VSP credentialed doctor to fill-in the following applies:

   A. If the fill-in doctor(s) is to fill-in for a period of 10 days or less in a calendar year, VSP does not need to be notified and the use of a non-VSP credentialed provider shall be permitted.
   B. If the fill-in doctor(s) is to fill-in for a period of 11 days but not more than 60 days in a calendar year, VSP reserves the right to either approve or deny the fill-in doctor(s). The network provider shall contact VSP at least 10 calendar days in advance of a planned absence with the fill-in doctor's name, degree, license number and NPI number. VSP will verify the following:

- All active states License
- Current individual doctor malpractice insurance coverage
- Malpractice claims history and/or sanctions
- Medicare /Medicaid sanctions via NPDB, OIG and SAM
- State Medicaid enrollment including State Agency suspension, exclusions and terminations list, if applicable
- Query the Master Death and NPPES
- Office of Foreign Assets (OFAC)
- CMS Preclusion List

VSP will notify network doctor of its decision and if approved by VSP, doctor(s) may fill-in for the network provider.

Should an emergency situation arise requiring an immediate and unplanned absence of 11-60 days in total, the network provider, or his or her staff, shall contact VSP as soon as the need for the immediate and unplanned absence arises, to provide the name, degree, license number and NPI number of the fill-in doctor(s). Network provider shall also provide VSP with information related to the emergency situation. The fill-in doctor(s) may be used for up to 10 days in total while the fill-in doctor's verifications are obtained.

In no event shall a doctor or multiple doctors provide services on behalf of the same VSP network provider to VSP patients in the locum tenens capacity for more than 60 days in a calendar year unless otherwise specified by State regulation.

Submitting a Claim for Locum Tenens or Fill-in Providers

If you're away for up to 60 days in a calendar year and use a Locum Tenens or fill in provider, you can submit a claim using eClaim or paper:

Submit the claim under your NPI and Tax ID number

Include the Locum Tenens or fill in provider's NPI or SSN in box 19 "Reserved for Local Use" and a modifier for each line as follows:

Modifier Q5 – The covering physician must be a permanent part of the existing office practice, and is not hired from the outside, or operating under a different tax ID number, or billing for services provided under a 'group practice' tax ID number.

Modifier Q6 – The Locum Tenens provider is brought in or hired from outside the existing office practice.

Medicaid & Medicare Compliance

Your agreement with VSP requires you to comply with all applicable requirements under state and federal laws and regulations. According to the U.S. Department of Health and Human Services, applicable requirements include the following:

You are responsible for ensuring that you do not employ or contract with excluded individuals or entities, whether in a physician practice, a clinic, or in any capacity or setting in which Federal health care programs may reimburse for the items or services furnished by those employees or contractors. This responsibility requires screening all current and prospective employees and contractors against Office of Inspector General (OIG) List of Excluded Individuals and Entities. This online database can be accessed from OIG's Exclusion Web site. If you employ or contract with an excluded individual or entity and Federal health care program payment is made for items or services that person or entity furnishes, whether directly or indirectly, you may be subject to a civil monetary penalty and/or an obligation to repay any amounts attributable to the services of the excluded individual or entity.

For more information, see OIG's exclusion Web site available at http://oig.hhs.gov/fraud/exclusions.asp.

Keep Your Information Current with NPPES

As a provider with an NPI, you are required to keep your information current with the National Plan and Provider Enumeration System (NPPES). To review or update your information, please visit https://nppes.com.hhs.gov/#/.

VSP regularly monitors provider participation for Medicaid/Medicare. If a provider received payment from VSP during a time period when they were ineligible to participate in Medicaid/Medicare, VSP is required to recoup payment under Title XIX of the Social Security Act in accordance with 42, CFR, 438.608(d). This provision does not apply to any amount of recovery to be retained under False Claims Act cases or through other investigations.

MEDICARE ADVANTAGE CONTRACT PROVISIONS TO THE NETWORK DOCTOR AGREEMENT

The Centers for Medicare and Medicaid Services (hereinafter "CMS") requires that specific terms and conditions be incorporated into the Agreement between a Medicare Advantage Organization, a First Tier Downstream or Related Entity to comply with the Medicare laws, regulations, and CMS instructions, including; and

Except as provided herein, all other provisions of the Agreement between Vision Service Plan ("VSP") and Network Doctor not inconsistent herein shall remain in full force and effect.

Definitions:

Centers for Medicare and Medicaid Services ("CMS"): the agency within the Department of Health and Human Services that administers the Medicare program.

Downstream Entity: any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a first-tier entity. These written arrangements continue down to the level of the Network Provider of both health and administrative services.

First Tier Entity: any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.

Medicare Advantage Plan ("MA"): an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

Medicare Advantage Organization ("MA organization"): a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

Provider: (1) any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and (2) any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.

Related entity: any entity that is related to the MA organization by common ownership or control and (1) performs some of the MA organization's management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA organization at a cost of more than $2,500 during a contract period.

VSP and Network Doctor agree to the following:

1. Network Doctor agrees that Health and Human Services ("HHS"), the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the first tier, downstream, and entities related to CMS' contract with a Medicare Advantage Organization, ("MA") through 10 years from the final date of the final contract period of the contract entered into between VSP and the MA organization or from the date of completion of any audit, whichever is later. [42 C.F.R. §§ 422.504(i)(2)(i) and (ii)]

   HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records under paragraph 1 of this contract provision

directly from any first tier, downstream, or related entity. For records subject to review under paragraph 1, except in exceptional circumstances, CMS will provide notification to the MA organization that a direct request for information has been initiated. [42 C.F.R. §§422.504(i)(2)(ii) and (iii)]

2. Network Doctor will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118]
3. Enrollees will not be held liable for payment of any fees that are the legal obligation of VSP or the MA organization. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]
4. Network Doctor will not be eligible for payment and will be prohibited from pursuing payment from VSP enrollees after the expiration of the 60-day period specified in 42 C.F.R. § 422.222. The provider will hold financial liability for services, items, and drugs that are furnished, ordered or prescribed after the expiration of such 60-day expiration period. [42 C.F.R. §§ 422.504(g)(1)(iv), 422.504(i)(2)(v)]
5. For all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for cost sharing when VSP or the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. The Network Doctor may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX, Medicaid, if the individual were not enrolled in such a plan. Providers will: (1) accept VSP payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]
6. Any services or other activity performed in accordance with a contract or written agreement by VSP or the Network Doctor are consistent and comply with the MA organization's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)]
7. Contracts or other written agreements between VSP the MA organization and providers must contain a prompt payment provision, the terms of which are developed and agreed to by the contracting parties. VSP is obligated to pay contracted providers under the terms of the contract between MA Organization/VSP and Network Doctor. [42 C.F.R. §§ 422.520(b)(1) and (2)]
8. Network Doctor and any related entity, contractor or subcontractor will comply with all applicable Medicare laws, regulations, and CMS instructions. [42 C.F.R. §§ 422.504(i)(4)(v)]
9. If any of the MA Organization’s activities or responsibilities under its contract with CMS are delegated to VSP as a first tier, downstream, and related entity:

(i) The MA Organization reserves the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS or the MA Organization determines that such parties have not performed satisfactorily.

(ii) The MA Organization will monitor the performance of the parties on an ongoing basis.

(iii) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA Organization or the credentialing process will be reviewed and approved by the MA Organization and the MA Organization must audit the credentialing process on an ongoing basis.

(iv) If the MA organization delegates the selection of providers, the MA organization retains the right to approve, suspend, or terminate any such arrangement. [42 C.F.R. §§ 422.504(i)(4)(5)]

In the event that VSP, CMS, and/or MA determine that Network Doctor’s performance under this MA Contract provision is not satisfactory, VSP, CMS, and/or MA may revoke Network Doctor’s participation in the MA Program.

Except as provided in this Contract provision, all other provisions of the Agreement between Network Doctor and VSP not inconsistent with this Contract provision shall remain in full force and effect. This Contract provision shall remain in force as a separate but integral addition to the Agreement to ensure compliance with required CMS provisions, and shall continue concurrently with the term of the Agreement.

PERSONS ELIGIBLE FOR MEDICARE AND MEDICAID

Pursuant to the Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS) implemented a national duals demonstration program for people dually eligible for Medicare and Medicaid to test new service delivery and payment models. The program may be called MMP or Duals.

The MMP/Duals are implemented through private health plans contracting with CMS and the applicable state Medicaid agency. Agreements with providers and other third parties who contract with health plans (directly or indirectly) must comply with applicable VSP/MMP contract requirements.

VSP and Network Doctor agree to comply with the following requirements:

To agree that cost sharing for Dual-Eligible Members is limited to the Medicaid cost sharing limits; and that for those dual-eligible Members the Network Doctor will accept VSP, and/or MMP payment as payment-in-full or will separately bill the appropriate state source for any amounts above the Medicaid cost sharing.

Office Location Standards

VSP Vision Care is committed to high-quality, safe, and accessible office settings for our membership. Network doctors are required to meet or exceed all outlined doctor office location standards. To ensure compliance with these standards a site review is initiated upon reaching the established threshold of site quality complaints.

- Facility site must meet city, county, and state building structure and access ordinances for persons with physical disabilities. A facility site includes the building structure, walkways, parking lots, and equipment.
- All facilities designed, constructed; or altered by, on behalf of, or for the use of a public entity must be readily accessible and usable by individuals with disabilities, if the construction or alteration was begun after January 26, 1992 (28 CFR 35.151).
- Any alteration to a place of public accommodation or a commercial facility, after January 26, 1992, must be made to ensure that, to the maximum extent feasible, the altered portions of the facility are readily accessible to and useable by individuals with disabilities, including individuals who use wheelchairs (28 CFR 36.402).
- Reasonable accommodations must be made to allow adequate access for persons with disabilities.
- Provide accessible pedestrian paths of travel (ramps, corridors, walkways, lobbies, elevators, etc.) between elements (seats, tables, displays, equipment, parking spaces, etc.).
- The minimum clear passage needed for a single wheelchair is 36 inches along an accessible route and may be reduced to a minimum of 32 inches at a doorway.
- Restroom and hand washing facilities should be wheelchair-accessible. If wheelchair-accessible handwashing facilities are not available within the site, reasonable alternative accommodations are provided such as alcohol-based hand cleansers, and wheelchair-accessible restrooms are located within the building.

For more information about the ADA, including ADA regulations, visit www.ADA.gov; or, www.access-board.gov.

VSP requires network doctors to use an appointment scheduling process and system that allows appointments to be scheduled according to patients' stated eye care needs within the timeliness standards established for VSP members. The intent is to ensure that patients are handled consistently and scheduled for appointments in a manner that recognizes the urgency of their eye care needs.

- Patents experiencing an eye care emergency should be seen immediately or referred to an appropriate alternative medical facility.
- Make every effort to see the patient at their scheduled appointment time. Patient wait time should not exceed 30 minutes.
- The site must have (or arrange for) a telephone triage, voicemail system, and/or answering service to provide routine, after-hours, and urgent/emergency eye care instructions, whenever office staff is unavailable to answer phone calls. Patients should receive a return call from this system for follow-up within a reasonable timeframe.
- Ensure a process is in place to follow up on missed and canceled appointments. Missed and/or canceled appointments and contact attempts must be documented in the patient medical record.

General Appointment Availability Standards

Routine Preventive Eye Care: Standard routine or preventive eye care scheduled within 30 calendar days.

Medical Eye Care: Medical eye care scheduled within 7 days.

Urgent Eye Care: If call is received during office hours, and the doctor determines the need of the member to be urgent, member should be seen within 24 hours.

Emergency Eye Care: When emergency treatment is necessary the patient should be seen immediately or directed to the most appropriate emergency facility for care.

Unscheduled Appointments: Evaluated (triaged) by a doctor to determine the severity of the condition and disposition of the patient. Patients who need to be seen immediately are to be accommodated.

Specialty Referral: Scheduled within 14 calendar days from the time the primary care provider requests the referral.

Check here **for state exceptions to the above general appointment availability standards.**

If a patient is unable to obtain a timely referral, the patient may call VSP at **800.877.7195** or the Department of Managed Health Care at **888.466.2219** for further assistance.

VSP network doctors are required, at a minimum, to have the following instrumentation necessary to provide eye care services at the comprehensive level, including and not limited to:

- Visual acuity testing charts and/or projector for distance and near
- Phoropter or trial lenses
- Keratometer and/or topographer
- Ophthalmoscope: direct and binocular indirect with appropriate condensing lenses
- Biomicroscopy with appropriate condensing lenses
- Tonometer
- Lensometer
- Stereopsis test
- Color vision test
- Screening visual field
- Penlight
- Cover test paddle
- Blood pressure measuring device
- Appropriate diagnostic pharmaceutical agents

- Equipment used to measure and assess patient health must be in proper working order and adequately maintained according to the manufacturer's guidelines for the routine inspection, calibration, repair, and cleaning/sterilization of the equipment.
- Calibration, cleaning, and maintenance logs should be kept for all instruments and available for review.
- Use proper sterilization and decontamination of instrumentation and testing devices that come into contact with patients before each use. When possible, perform in front of the patient.
- Doctors and office staff are required to wash their hands, use single-use exam gloves, and/or use an alcohol-based hand cleanser before each patient. When possible, perform in front of the patient.
- Maintain diagnostic and/or therapeutic pharmaceutical agents in a secure location, according to the manufacturer's storage guidelines.
- Contact lenses, contact lens solutions, therapeutic products, and pharmacological agents must be properly discarded on or before the manufacturer's expiration date.

- Complaint forms, at least one telephone number for filing grievances, and a copy of the VSP complaint/grievance procedure must be available on-site and can be provided to patients promptly upon request.
- VSP Vision™, VSP Vision Care®, and VSP contracted providers comply with applicable Federal and applicable State civil rights laws and must not discriminate, exclude, deny benefits to, or treat people differently because of race, color, religion, national origin, age, disability, or sex (including sexual orientation and gender identity).

Refer to the Complaints & Grievances section of the VSP Provider Reference Manual for additional information.

- Doctors and their office staff are responsible for ensuring clinical and non-clinical services are provided in a culturally competent manner and accessible to all patients.
- Network doctors must complete cultural competency training annually. Training must be current, documented, and available for review. VSP includes Cultural Competency training in the Training & Support section of VSPOnline.
- Interpreter services are made available in identified threshold languages specified for the site location.
- Provide 24-hour access to interpreter services for all members, including non- or limited-English proficient (LEP) members, either through telephone language services or interpreters onsite.
- Interpreter services for the hearing impaired are made available at no cost to the member.

Refer to the Patients' Rights and Responsibilities section of the VSP Provider Reference Manual for additional information.

- VSP requires network doctors to maintain malpractice insurance coverage with defined coverage limits.
- All required professional licenses and certifications, must be current and issued from the appropriate agency for practice, and available onsite.

Refer to the Insurance, Licensure, and Certification section of the VSP Provider Reference Manual for additional information.

- VSP requires medical records, including electronic health records (EHRs), to be maintained according to applicable state and federal laws and regulations.
- Maintain medical records and member information in a confidential, secured location that denies unauthorized access.
- Medical records should be easily retrieved by appropriate office personnel.
- Ensure storage and transmittal of EHRs preserve confidentiality and security and are compliant with state and federal guidelines.
- Medical records must be retained for a minimum of 10 years (42 CFR 438.3).

Refer to the Medical Record Documentation section of the VSP Provider Reference Manual for additional information.

- VSP requires privacy and confidentiality be maintained for each patient and their health information according to applicable state and federal laws and regulations.
- Office personnel must regularly receive training on patient confidentiality. Training must be current, documented, and available for review.
- Patients have the right to privacy for examination and consultations.
- Protected Health Information (PHI) and Personal Identifiable Information (PII) must be securely maintained.

- Conduct patient interviews and personnel discussions in a manner that safeguards patient privacy and confidentiality.
- Ensure personal patient information is not discussed in front of other patients or visitors, displayed, or left unattended in reception and/or patient flow areas.
- Disclosure of patient PHI for purposes outside of treatment, payment, and healthcare operations requires patient permission.

- VSP requires pharmaceutical dispensing to be compliant with applicable state and federal laws and regulations. Pharmaceutical drugs may only be dispensed only by a physician or other persons lawfully authorized to dispense medications.
- VSP requires appropriate medication and pharmaceutical supplies storage and maintenance.
- For patient safety and risk management, medications should be secured and not left unattended in patient care areas.
- Prescription pads, medications, sample and over-the-counter drugs must be securely stored in a lockable space (cabinet or room) within the office/clinic to prevent unauthorized access.
- As a routine office procedure, with documented frequency and inspection, medications and other pharmaceutical supplies must be regularly checked for expiration.
- Expired medications and pharmaceutical supplies should be properly discarded on or before the manufacturer's expiration date.

- VSP requires network doctors' office and clinic site locations to be maintained in a safe, clean, and sanitary condition.
- Provide a patient waiting area with adequate lighting and office furnishings that are clean and in a good state of repair.
- The physical appearance of waiting and exam rooms, floors, carpets, walls, furniture, and restrooms should be clean and well-maintained.
- Provide a clean, properly working restroom, which includes toilet and hand washing facilities, and appropriate sanitary supplies (toilet paper, hand washing soap, paper towels, etc.) for patient use.
- As required by law, maintain a smoke and pet-free environment.

- Site must meet city, county, and state fire safety and prevention ordinances.
- Site must be adequately equipped with fully charged and operable portable fire extinguishers that are readily accessible to personnel. Annual inspection tags should be affixed to the extinguishers indicating the month and year that the extinguisher was professionally inspected.
- Office personnel must regularly receive safety training for 1) fire safety and prevention and 2) non-medical emergencies procedures (e.g., site evacuation, workplace violence). Training must be current, documented, and available for review.
- Ensure adequate lighting in patient flow working and walking areas such as corridors, walkways, waiting and exam rooms, and restrooms to allow for a safe path of travel.
- Exit doorways must be unobstructed and marked by a readily visible "Exit" sign.
- Post diagrammed emergency evacuation routes in a visible location at all elevators, stairs, and exits.
- List emergency phone numbers in an accessible location(s) that includes:
  - Local emergency response services (e.g., fire, police/sheriff, ambulance).
  - Emergency contacts (e.g., office managers, supervisors, etc.).
  - Appropriate state, county, city, and local agencies (e.g., local poison control number).

Adherence to infection control and prevention practices is essential to providing safe and quality patient care. VSP has adopted the recommendations of the Centers for Disease Control and Prevention (CDC) and the Occupational Safety and Health Administration (OSHA) as part of its network doctor office location standards. Use standard precautions to care for all patients across all settings where healthcare is delivered including:

Hand Hygiene

- Ensure healthcare personnel perform hand hygiene with soap and water or use alcohol-based hand cleansers before contact with each patient.
- Ensure that supplies necessary for adherence to hand hygiene are readily accessible in all areas where patient care is being delivered.

Contact Lens Care

In accordance with the Centers for Disease Control and Prevention contact lens information for eye care providers and public health professionals:

Clean contact lenses according to the manufacturer's guidelines.

1. Rub and rinse contact lenses with contact lens disinfecting solution according to manufacturer's guidelines, including and not limited to multipurpose solutions and/or hydrogen peroxide-base systems.
2. Use fresh cleaning or disinfecting solution each time lenses are cleaned and stored.
3. Do not use saline solution or rewetting drops to disinfect lenses. Neither solution is an effective or approved disinfectant.

Contact lens storage

1. Contact lens cases should be rubbed and rinsed with sterile contact lens solution (not tap water), emptied, and left open to dry between each use.
2. Replace used storage cases at least once every three months.

Environmental Cleaning and Disinfection

- Clean and disinfect surfaces in the patient care environment and other frequently touched surfaces.
- Use proper sterilization and decontamination of instrumentation and testing devices that come into contact with patients before each use.
- Promptly clean and decontaminate spills of blood or other potentially infectious materials.

Bloodborne Pathogens Standard

In accordance with federal, state, and local regulations VSP follows the Occupational Safety and Health Administration (OSHA) standards for bloodborne pathogens. The current OSHA Bloodborne Pathogen Standard (29 CFR 1910.1030) can be obtained from the OSHA Publications Office, 200 Constitution Avenue, N.W., Washington, DC 20210, or through the OSHA website (www.osha.gov).

Patients' Rights and Responsibilities

We're committed to mutually respectful relationships between patients and doctors. We expect these relationships will lead to effective healthcare while recognizing people are individuals who all have different needs. We explain our expectations and set up guidelines for cooperation between patients, doctors, and clients. Patients can find this information at **vsp.com**.

Our patients have the right to receive services and information in their preferred language and they have the right to receive information about their rights. **Our patients have the right to be treated with consideration, dignity, respect and to have VSP doctors:**

- Provide complete information about their eye care and any proposed procedures and alternatives regardless of cost or benefit coverage.
- Allow patients to control decisions about their eye care treatment.
- Provide 24-hour access for ocular emergencies.
- Maintain privacy and confidentiality regarding their care.
- Make appropriate preventive health services available.
- Give prompt and reasonable responses to questions and requests.
- Provide information regarding their services and qualifications.
- Provide the VSP grievance procedures if there is dissatisfaction with services.
- Obtain input regarding services and assist them with any problems.

Our patients have the responsibility to follow preventative eye care guidelines, and:

- Check the health care benefits and exclusions of their coverage.
- Establish and maintain a relationship with their primary eye care provider.
- Give eye care providers complete and accurate information needed in order to care for them.
- Notify eyecare provider if they are going to be late or need to reschedule an appointment.
- Know the cost (co-payment, deductible, co-insurance) of their care.
- Carry out the treatment plan agreed upon with their eye care provider or primary care physician.
- Know how to access urgent, emergency and out-of-area medical eye care services.

Under the Americans with Disabilities Act of 1990, eye doctors and other health care providers are required under this federal law to provide American Sign Language (ASL) interpreter services, at no cost to the patient, to patients who need and request ASL interpreter services.

If you or a member of your staff are ASL-fluent, you may, of course, communicate with hearing-impaired patients in that manner. If neither you nor a member of your staff have fluency in ASL, make arrangements for an ASL face-to-face interpreter to assist at no cost to the patient or to you. If you need help finding an ASL interpreter, you may contact VSP Customer Care at **800.615.1883**.

VSP provides Cultural Competency training on the Training & Support section of VSPOnline. Several resources addressing topics of interpretation services, better communication, health literacy and census information is available in addition to the training modules.

VSP has implemented a Language Assistance Program (LAP) to provide linguistic services to enrollees who prefer to conduct their affairs in a language other than English including the availability of free interpreter services at the time of an appointment for patients who request them.

Document Translation and Alternative Formats

Members who prefer their VSP member materials in a language other than English can receive free translation of VSP member documents, including alternative formats such as Braille, large format and audio. You may contact VSP Customer Care at **800.615.1883** for more information.

Interpretation

VSP provides telephone interpretation services to any VSP member who prefers to communicate with VSP about their benefits in a language other than English, including TTY/TDD for those who are hearing impaired.

VSP members who want to discuss their benefits in another language can call VSP at **800.877.7195** and indicate their language need. Members can also visit **vsp.com** to see a list of VSP practices where language(s) other than English are spoken.

You are required to keep your office(s) language capabilities current so members know where they can receive services in languages other than English. We encourage you to review practice information quarterly on VSPOnline at **eyefinity.com**.

Practices must keep in mind that family, friends, and minor children are considered untrained health interpreters. Using family, friends, and minor children poses a problem with patient privacy. In addition, family may impose their view of the patient and their health that can lead to less than the highest quality care desired. To request face-to-face interpretation services at no cost to you or your patient, contact VSP customer Care at **800.615.1883.**

Note:

Oregon HB 2359 requires health care providers to utilize health care interpreters on the health care interpreter registry operated by Oregon Health Authority (OHA) to provide interpretation services.

Note:

If a patient insists that the provider or staff communicate with bilingual family or friends, document in the member patient record that the VSP member refuses interpreter services and/or uses friend or family to interpret.

Documentation

The following items should be documented in the patient's medical record and/or patient history form:

- Patient's preferred written and spoken language
- Refusal of interpreter (if applicable)
- Use of interpreter and who (family member, minor, friend, doctor, office staff, or trained professional interpreter)
- Patient requests to have interpretation services

It is suggested to also document the patient's race and ethnicity with an option for the patient not disclose this information.

Complaints and Grievances

We make every attempt to resolve patient concerns quickly and to their satisfaction. Doctors are responsible for making sure their staff knows our complaint process and gives our complaint/grievance form to patients when they ask. You can find master copies of these forms on **VSPOnline** at **eyefinity.com**. The **VSP Member Complaint/Grievance Form**is available in Spanish, and Chinese.

VSP Members Privacy and Confidentiality

VSP Members have a right to request confidential communications.

VSP will provide Privacy and Confidentiality for all VSP Members including Victims of Violence and Endangered Individuals.

VSP shall permit subscribers and enrollees to request, and shall accommodate requests for, confidential communication in the form and format requested by the individual, if it is readily producible in the requested form and format, or at alternative locations. The confidential communication request shall be valid until the subscriber or enrollee submits a revocation of the request or a new confidential communication request is submitted.Confidential communication request submitted on behalf of a minor will generally expire when the minor turns 18. Confidential communication request submitted on behalf of a minor will generally expire when the minor turns 18.

The confidential communication request shall apply to all communications that disclose medical information or provider name and address related to receipt of medical services by the individual requesting the confidential communication.

Without the express consent of the requestor, VSP shall **not** disclose to the policyholder or another insured covered under the policy: (1) the address, phone number, or any other personally identifying information of the covered individual or any child residing with the covered individual; (2) the nature of the health care services provided to the covered individual; (3) the name, address, and phone number of the provider of the covered health care services; or (4) any other information from which there is a reasonable basis to believe the foregoing information could be obtained.

Inform the patient that they may request privacy and confidentiality by following these steps:

1. Download the **Request to Restrict Use and Disclosure of Protected Health Information Form** here
2. Print and complete the form
3. Mail it to:

VSP Privacy Office
3333 Quality Drive, MS 16H
Rancho Cordova, CA, 95670

1. Fax to: 916.851.4851 or
2. Email: HIPAA@vsp.com,or
3. Call VSP at **800.877.7195**if you require assistance in completing the form.

VSP will implement Confidential Communication Requests within 7 days of receipt of an electronic request or within 14 calendar days of receipt by first-class mail.

For more information on domestic violence services, refer patient to the National Domestic Violence Hotline at: **800.799.7233** or TTY **800.787.3224**.

Contact Information

Refer patients to VSP at **800.877.7195** or vsp.com if they ask about their Protected Health Information in regard to:

- Restrictions on the use or disclosure of Protected Health Information

- Amendments to Protected Health Information
- Revoking authorizations
- Explaining use or disclosure of Protected Health Information
- Copies of Protected Health Information

(Updated November 2, 2021)

VISION SERVICE PLAN

PROVIDER DISPUTE RESOLUTION PROCEDURE

I. OVERVIEW AND PURPOSE

Introduction

Vision Service Plan, a California not-for-profit corporation ("**VSP**"), is committed to providing high quality health care to its enrollees through VSP's network of contracted Providers. As part of this commitment, VSP maintains a fast, fair, and cost-effective dispute resolution mechanism that Providers may use to resolve billing, payment, or contract disputes. This Dispute Resolution Procedure ("**DRP**") is available to contracted Providers for Quality Management disputes, Fraud and Abuse Claim disputes, and contract disputes. This DRP is also available to non-contracted Providers as it relates to Fraud and Abuse Claim disputes. The separate policies for resolution of these different types of Provider disputes are explained below. For all intents and purposes, the term "Provider or Providers" encompasses only those optometrists and/or ophthalmologists licensed to practice in their respective states.

Claims Payment Dispute

Claim payment disputes ("**CPD(s)**") arise when a Provider contests or denies a claim payment reimbursement, makes an appeal, or requests a reconsideration of a claim or group of claims if those claim(s) have been denied, adjusted, or contested. CPDs are not handled pursuant to this DRP. CPDs are processed pursuant to the requirements of Section 1300.71.38 ("**CCR 1300.71.38"**), of Title 28, California Code of Regulations unless required by other state law. CPDs are managed under Claim Appeals in the Eligibility and Authorization Section of the **VSP Provider Reference Manual** ("**PRM**"), found online at eyefinity.com. All CPDs are handled and resolved by VSP without charge to the Provider. There is no right to appeal a CPD determination under this DRP, or by a challenge in court.

Dispute Resolution Procedure Overview

This **DRP** includes the processes established to provide VSP and Providers (collectively "the Parties") with a fair and cost-effective process for the final determination of Fraud and Abuse Claim disputes, contract disputes and Quality Management disputes, as defined below, between the Parties. Such disputes shall be decided using this DRP, as may be modified from time to time and, accordingly, could be finally decided by an arbitrator, and not by any federal, state, or local court or agency. The DRP is not intended to waive any rights, remedies, or claims afforded to either party with the California Department of Managed Healthcare ("**DMHC**"). The privileges and protections afforded by the Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11111, shall govern and apply to all aspects of this DRP, except as otherwise set forth herein.

Fraud and Abuse Claim Disputes

The FBI has identified healthcare billing fraud as the fastest growing white-collar crime in America. Accordingly, California and many other states require licensed health care plans, like VSP, to establish and maintain an active Anti-Fraud and Abuse Program. VSP's Anti-Fraud and

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Abuse Program operates largely through its Special Investigative Unit ("**SIU**"), which coordinates, investigates, and assesses the appropriate course of action for incidents involving fraud and abuse. SIU investigations are done in conjunction with VSP's Director of Optometry, Medical Director, the Office of the General Counsel, and appropriate internal business partners. VSP seeks recovery of all damages and penalties permitted by law in any Fraud and Abuse Claim. A fraud claim is one where a Provider knowingly makes or causes to be made a false or fraudulent claim for payment of a health care benefit ("**Fraud**"). An abuse claim is one where the Provider, through inadvertence or neglect, causes a false claim to be made without knowingly or intentionally misrepresenting facts, but nonetheless obtains payment for health care services when payment was not in conformity with VSP's policies ("**Abuse**") (collectively, "**Fraud and Abuse Claim**" or "**FAC**"). A FAC may originate from third-party reports, hotline reports, or data analysis. SIU investigations of a FAC may include an announced or unannounced Provider audit.

When VSP notifies a Provider that VSP has determined that the Provider has submitted one or more Fraud and Abuse Claims, and the Provider disputes VSP's determination, the Provider must submit the dispute through VSP's DRP process. FAC disputes may lead to termination from VSP's network of contracted Providers.

Contract Disputes

Contract disputes between a contracted Provider and VSP concern disputes related to the interpretation, application, intent, termination, and breach of the Network Doctor Agreement ("**NDA**"). VSP and contracted Providers must first submit a contract dispute through this DRP prior to filing a Demand for Arbitration. Unless otherwise stated in the Provider's NDA, exhaustion of the Provider Dispute Resolution/Written Submission process ("**PDR**") below is a prerequisite to pursuing binding arbitration. Contract disputes may lead to termination from VSP's network of contracted Providers.

Quality Management Disputes

VSP maintains a Quality Management Program ("**QM Program**") that ensures Providers comply with their respective NDA and VSP's patient-care policies and procedures. The QM Program is based on health care industry standards set by the American Medical Association ("**AMA**"), National Committee of Quality Assurance ("**NCQA**") and other state and federal guidelines. VSP's QM Program includes clinical peer review of patient medical records and quality of care grievances. Providers failing to meet the QM Program requirements are subject to corrective action up to and including termination from VSP's network of contracted Providers.

Providers receiving corrective action notifications and who dispute VSP's Quality Management findings, must submit the dispute through this DRP process. Unless otherwise stated in the Provider's NDA, exhaustion of the PDR process below is a prerequisite to pursuing binding arbitration.

Generally, such Quality Management disputes will address issues such as: Provider malpractice, professional misconduct, negative finding from a quality assurance medical record review or other peer review proceedings, audit disputes that result from negligent or mistaken billing or that are otherwise not in conformity with VSP's Policies, and criminal and civil wrongs committed by a Provider based on patient complaints or obtained from reporting from the National Practitioner Data Bank ("**NPDB**"), state/federal agencies and other third-party complaints. ("**QM Disputes**").

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Confidentiality

All facts, records, data, and information used, acquired, or exchanged in preparation for, submission, and hearings hereunder ("**Materials**") shall be used and maintained with strict confidentiality and shall not be disclosed to any third party. The Materials shall only be used by the Parties to the extent necessary to carry out the purposes of the DRP. The Materials may be subject to subpoena or discovery as may be required by law. The confidentiality of the Materials shall survive the final actions, decisions, awards and any modification or termination of the NDA or DRP. The DRP is a proprietary document belonging solely to VSP. In no event shall the DRP be shared, distributed, or published to any third party or filed in court without the prior written consent of VSP or appropriate court protective order. Silence in response to any Request for Disclosure shall not be deemed as consent to any disclosure.

Dispute Resolution Costs

The Provider is not responsible for any administrative costs associated with either the PDR or the peer review process as more fully set forth below. Each Party is responsible for their respective attorneys' fees and costs, except as provided for in Arbitration which has its own separate rules as more fully set forth below

II. PROVIDER DISPUTE RESOLUTION ("PDR")/Written Submission

Notice of Adverse Action / Right to Contest or Deny

If VSP intends to take adverse action against a Provider as provided above, VSP will send an Adverse Action Notice to the Provider. The Adverse Action Notice shall contain the following information:

- The action(s) or proposed action(s) that VSP intends to take against the Provider (e.g., restitution, probation, termination, etc.);
- A summary of the factual basis for the action(s) to be taken;
- That a Provider can dispute the Adverse Action Notice with instructions on how to commence dispute resolution;
- In Fraud and Abuse matters, where an audit was conducted pursuant to Health and Safety Code sections 1371, 1348 and other relevant statutes and regulations, a spreadsheet summary of the audit that identifies the claim number, name of the patient, the date of service and a clear explanation of the basis upon which VSP believes that the amount paid on the claim is in excess of the amount due, including interest and penalties on the claim. In addition, the Adverse Action Notice shall include the information required by Health and Safety Code section 1371, subdivision (b)(2) and any other applicable statutes and regulations.

If VSP intends to terminate a Provider by removing them from the network and/or terminating their ability to submit claims, the Provider may remain on the VSP Doctor Network and/or submit claims until a Written Determination of the dispute is made, as more fully set forth below. However, VSP, in its sole and absolute discretion, may terminate the Provider from the network and/or the right to submit claims immediately if there is reasonable cause to conclude any of the following:

- Provider's conduct presents a past or present risk of harm to any patient.
- Provider's conduct presents an unacceptable quality of care issue to any patient.

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- Provider's conduct constitutes intentional fraud, misrepresentation or gross indifference in the submission of true and accurate claims;
- Provider's conduct constitutes incompetence or willful indifference in treating a patient's vision or other health care needs;
- Provider's license or other lawful authority to practice has expired, been terminated, or is in any other form of suspension, probation or conditional status;
- Provider has refused to allow an audit of his/her practice(s); or
- Other reasonable cause exists.

VSP's failure to immediately terminate the Provider shall not create an inference that any one or all of the above situations have not occurred; shall not infer that termination is not warranted in the particular case; and shall not act as a waiver to prevent VSP from deciding to terminate the Provider at a later time.

For all Adverse Action Notices, the completion of this PDR process is a condition precedent to the commencement of either the Peer Review Hearing or binding arbitration.

For purposes of this DRP, and unless otherwise provided, Notices are deemed made when deposited in the U.S. mail, sent by email or by other means as agreed to in writing by the Parties. The date of "receipt" will be five (5) working days after the date of mailing, or, if emailed, the date the email was received. Should any deadline fall on a weekend or holiday, the new deadline shall be the next working day. "Working day" means Monday through Friday, excluding recognized federal holidays per CCR section 1300.71 (13) and the working day after Thanksgiving and the working day before Christmas.

Dispute Resolution Administrator

The VSP Dispute Resolution Administrator ("**DRA**") manages all procedural DRP matters and communications between the Provider, VSP and the submissions made pursuant the DRP. The current DRA is Melanie Trammell. Her contact information is: VSP, Attn: Melanie Trammell, 3333 Quality Drive, MS 163, Rancho Cordova, CA 95670, email: drpdispute@vsp.com, phone: (916)851-4092.

Submission of Dispute

Upon receipt of an Adverse Action Notice, a Provider may contest or deny the Adverse Action Notice. To contest or deny the Adverse Action Notice, the Provider shall send a Notice of Contest/Denial ("**Contest/Denial**") to the DRA at the address identified above. The deadline for submission of a Contest/Denial is as follows:

- For an Adverse Action regarding a Fraud and Abuse Claim Dispute, the Provider shall send the Contest/Denial within forty-five (45) working days of receipt of the Adverse Action Notice. The Adverse Action Notice shall be deemed uncontested and final if a Contest/Denial is not received within this time frame, with no further right to any challenge or appeal.

- For an Adverse Action regarding any other dispute or challenge covered by this DRP, the Provider shall send the Contest/Denial within 365 calendar days of the Adverse Action Notice. However, VSP may impose an effective date of action within an Adverse Action

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Notice (other than one regarding a Fraud and Abuse Claim dispute) that is less than the 365 calendar days if consistent with applicable law.

The Contest/Denial shall state and provide the factual and legal basis upon which the Provider believes that restitution and/or termination are not warranted. The Contest/Denial shall at a minimum include:

- the Provider's name, identification number and contact information;
- the name and contact information of legal counsel, if any;
- a clear identification of the claims from the audit that are disputed, the date(s) of service of each claim, and the basis of the contest or denial as to each claim;
- a clear explanation of the basis upon which the Provider believes that restitution, termination or other remedy sought by VSP and identified in the Notice is not warranted or in error; and
- if applicable, a clear statement of all legal issues being raised.

Providers shall submit with their Contest/Denial any and all documents (patient charts, exam records, financial documentation, lab invoices, patient statements, legal documentation, etc.), statements and other evidence that they believe supports the Contest/Denial. The Provider's Contest/Denial shall be the Provider's sole opportunity to submit evidence in this process. A Provider may be asked to amend the Contest/Denial within forty-five (45) working days of receipt of the Contest/Denial if it has been determined that information is missing or otherwise incomplete. Where Fraud and Abuse Claims are uncontested, VSP shall be entitled to offset the amounts disclosed in the Notice, but only after giving the Provider ten (10) working days' notice prior to withholding those disclosed amounts.

Format of Contest/Denial

Documents submitted to the DRA must:

- be legible;
- include page numbers in the bottom right-hand corner;
- if provided electronically, in a commonly used file format (.doc, .csv, .xlsx, or .pdf) which is easy to open and print.

Documents not meeting the above requirements may be returned to the Provider to amend and resubmit. Please direct any questions regarding the submission of documents directly to the DRA.

Acknowledgment of Dispute

Upon receipt of Provider's Contest/Denial, VSP will acknowledge receipt of the Contest/Denial to the Provider's address identified in the Contest/Denial (a) within two (2) working days of the date of receipt of an electronic Contest/Denial; or (b) within fifteen (15) working days of the date of receipt of a mailed Contest/Denial.

VSP's Response

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Within fifteen (15) working days of receipt of a complete Contest/Denial, VSP shall provide to the DRA, its written response (**"Response"**) to the Contest/Denial. The Response shall include all documents, statements, or other evidence that supports VSP's position as to the Contest/Denial and the damages or other remedies being sought. This shall be VSP's sole opportunity to submit evidence in this process.

Written Determination

A Written Determination stating the pertinent facts and explaining the reasons for the determination shall be issued within forty-five (45) working days after the date of receipt of the Contest/Denial or amended Contest/Denial as required by CCR 1300.71.38 section (f) and any other applicable statutes and regulations. A Written Determination shall be final unless the Provider requests a Peer Review Hearing as more fully set forth below.

Decision and Payment

If the Written Determination concludes that the Provider owes VSP a monetary amount in restitution, the Provider shall pay VSP within fifteen (15) working days of issuance of the Written Determination unless Provider requests additional resolution measures as detailed below. If VSP owes a monetary amount in restitution, interest, or penalties to the Provider, VSP shall pay any outstanding amounts to the Provider within fifteen (15) working days of the issuance of the Written Determination. All Provider payments shall be mailed to the DRA at the address referenced above in the DRA section.

If the Provider fails to pay VSP within fifteen (15) working days and has not requested additional resolution measures, the Written Determination shall be deemed final and VSP may withhold/offset the Provider's payment from the Provider's current claims payments until the restitution is paid in full. The Written Determination shall serve as the Provider's fifteen (15) working days written notice of any intended withholding/offset.

Upon issuance of the Written Determination, a Provider has the option to appeal to either a Peer Review Hearing or to a de novo review through binding arbitration ("**Arbitration**"). At that time, a Provider may request a copy of VSP's Response, and any additional non-privileged documents taken into consideration in the process of rendering the Written Determination. If a Provider requests a Peer Review Hearing, they may still appeal to Arbitration if unsatisfied with the outcome of the Peer Review Hearing. VSP may only appeal to Arbitration after a Provider has requested a Peer Review Hearing and a Panel Determination has been rendered. See below for further details.

III. PEER REVIEW HEARING

Overview

Providers that are unsatisfied with the result of the PDR may request a Peer Review Hearing comprised of a panel of practicing Network Doctors. A request for or participation in a Peer Review Hearing does not waive the Provider's future right to request a de novo review through binding arbitration.

Peer Review Hearing Panel

The Chair of the Peer Review Hearing Panel ("**Panel Chair**"), who is appointed by the Chairman of the Board of Directors, shall appoint two (2) optometrists who are also VSP contracted Providers to serve on the Peer Review Hearing Panel ("**Panel**"). A majority of the Panel shall

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include peers with the same licensure as the Provider requesting the Peer Review Hearing. The Panel Chair shall be in charge of the Peer Review Hearing and shall make all determinations of the procedural conduct of the Peer Review Hearing. No Panel member shall be in direct economic competition with the affected Provider, and no Panel member shall be in a position to gain direct financial benefit from the outcome of the Peer Review Hearing. The fact that Panel members and Provider are on the same network shall not, standing alone, constitute direct economic competition within the meaning of this paragraph. Panel members shall be provided with copies of all the documents to be considered at the Peer Review Hearing and may attend in-person or by video conference.

Request for Peer Review Hearing

A Provider requesting a Peer Review Hearing must submit a Peer Review Hearing Request ("**Request**") within fifteen (15) working days of receipt of the Written Determination. The Request must include whether the Provider prefers to attend the Hearing in person or via video conference and if Provider will have counsel in attendance. The DRA determines whether the Hearing will be in-person or via video conference.

Acknowledgement of Request

The DRA will acknowledge ("**Acknowledgement**") the Request within five (5) working days of its receipt. The Acknowledgement will include the date in which the Provider's Request will be heard and will lay out any accompanying deadlines which will occur before the Peer Review Hearing is to take place.

Submission of Additional Evidence/Request to Include Witnesses

In addition to the initial documentation submitted during the PDR, both Parties will have an opportunity to submit additional relevant evidence, including the right to request witness testimony at the Peer Review Hearing, either in-person or via teleconference. The initial documentation submitted with the original Contest/Denial and VSP's subsequent Response will be considered by the Panel and **does not require resubmission.** Additional evidence must be submitted to the DRA within fifteen (15) working days after receipt of the Acknowledgment. The decision to include additional submitted evidence or witnesses is in the sole discretion of the Panel Chair.

Court Reporter

Either party, or the Panel, may arrange for a stenographic record of the proceeding to be kept by an independent certified court reporter. Notification must be submitted to the DRA within fifteen (15) working days after receipt of the Acknowledgment. The party giving notice of the use of a court reporter shall pay the expense for the reservation and for the original certified transcript. The opposing party and the Panel shall be permitted to purchase a copy of the transcript from the court reporter and shall only be required to pay the court reporter's usual and customary fee for a copy of the transcript. If the Panel requests a court reporter, the costs for the reservation of the court reporter and of the transcript(s), shall be equally shared by the Parties. With the exception of a court reporter and/or personal notes of the Hearing by the Parties, their counsel, the Panel, and the DRA, there shall be no audio, video, or other recording of the Hearing of any kind.

Peer Review Hearing

A. *Attendance/Response*. Provider and VSP shall attend the Peer Review Hearing as designated

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and shall respond fully and completely, under oath, to all questions from members of the Panel. If the Provider fails to attend the scheduled Peer Review Hearing, the Request shall be deemed rescinded, and the Written Determination shall be final with no further right to any challenge or appeal.

B. *Legal Counsel*. Each party may be accompanied by legal counsel at the Peer Review Hearing. However, only the Parties to the case will be permitted to present their respective case to the Panel. Unless the Panel Chair determines otherwise, each party may offer an opening and closing statement, may question witnesses (if any), and introduce previously produced documents as evidence during the Peer Review Hearing. As a peer-to-peer review, the Panel Chair may, and is encouraged to, facilitate a discussion of the evidence between the Provider and the members of the Panel. **Legal counsel shall not be permitted to call or question witnesses or argue the merits of the case or issues during the course of the Peer Review Hearing. The Provider may consult with counsel during the course of the Peer Review Hearing, but only insofar as it does not interrupt or delay the Peer Review Hearing.**

During closing arguments at the Peer Review Hearing, counsel for each party may give a closing statement that shall not exceed five (5) minutes, except as may be permitted by the Panel Chair. A closing statement shall be limited to the facts presented at the Peer Review Hearing and shall not identify, address, or include any new evidence. Each party shall bear their own legal fees, costs, and expenses.

In a Peer Review Hearing, where the Provider is a physician, and where the Request contains issue(s) concerning a final proposed action for which reporting is required under the California Business and Professions Code Section 805, and where the Provider is not represented by counsel in the Hearing, the Panel shall not be entitled to the presence of legal counsel at the Peer Review Hearing.

C. *Hearing Management.* The Panel Chair, in their sole and absolute discretion, shall manage the Hearing and the admission of evidence so as to timely consider the facts and address the issues to be heard.

D. *Scope of Evidence*. The rules of evidence and Code of Civil Procedure relating to the questioning of witnesses and presentation of evidence in court shall not apply to the Peer Review Hearing. Evidence offered and admitted shall be directly relevant to the issues designated in the Request. Regardless of the issues identified and raised by the Request, the Panel shall not consider testimony, evidence, or arguments challenging the validity, purpose, or reasoning of the NDA or DRP. Any such testimony or evidence will not be admitted or considered, regardless of its possible admissibility in a court of law or other tribunal. Any dispute regarding the NDA or this DRP shall, at either party's request, be submitted to binding arbitration pursuant to Section IV below.

E. *Adjournment and Conclusion*. The Panel Chair may adjourn, reconvene, or reopen the Peer Review Hearing at the convenience of the Panel or the Parties without special notice; and shall close the Peer Review Hearing upon determining that the record is complete. The Panel shall, thereafter, conduct their private deliberations and render their decision in writing.

Peer Review Panel Determination

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Within fifteen (15) working days after the close of the Peer Review Hearing and deliberations, the Panel shall issue to the Parties a reasoned decision ("**Panel Determination**") and provide notice of the right to request a de novo review through binding arbitration. Subject to the right of either party to request Arbitration, the Panel Determination shall be final and binding and there shall be no further right by either party to appeal or otherwise challenge the Panel Determination to VSP's Board of Directors, in court or other forum.

Decision and Payment

If the Panel Determination concludes that the Provider owes VSP a monetary amount in restitution, the Provider shall pay VSP within fifteen (15) working days of issuance of the Panel Determination. If VSP owes a monetary amount in restitution, interest, or penalties to the Provider, VSP shall pay any outstanding amounts to the Provider within fifteen (15) working days of the issuance of the Panel Determination.

If the Provider fails to pay VSP within the time referenced above, VSP may withhold/offset the Provider's payment for the Provider's current claims until the restitution is paid in full. The Panel Determination shall serve as the Provider's fifteen (15) working days written notice of any intended withholding/offset.

A Panel Determination shall be final unless either party requests binding arbitration. Any payments due by either party shall be stayed in the event that either party elects to continue to Arbitration.

IV. BINDING ARBITRATION (DE NOVO REVIEW)

Requesting Binding Arbitration

At the request of either the Provider or VSP, a Panel Determination may be appealed to final and binding arbitration with venue in Sacramento, California. Except as may be provided herein, either party may request Arbitration under this provision. Arbitration may be requested in the following circumstances:

- By the Provider upon receipt of a Written Determination;
- By VSP or Provider upon receipt of a Panel Determination;
- By VSP or Provider in any controversy that relates to procedural/substantive issues of the DRP (section V below);
- By VSP or Provider in any and all other contests, denials, or controversies which may arise that are not otherwise provided for herein;
- By VSP if the Provider refuses to comply with an Adverse Action Notice, after having exhausted their rights to PDR and the Peer Review processes; or
- By VSP if Provider fails to comply with either the Written and/or Panel Determination and has failed to exhaust his/her remaining rights to Peer Review and/or Arbitration.

Arbitration shall consist of a de novo review of the findings from a Written and/or Panel Determination. A Request for Arbitration must be made within fifteen (15) working days of either a Written Determination or Panel Determination. The Request for Arbitration shall be made to the DRA at the address stated above.

If VSP intends to terminate the Provider as set forth in the Notice, and termination was upheld by either the Written Determination or Panel Determination, the Provider may remain on the VSP

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Doctor Network and/or submit claims until the arbitrator renders a decision as set forth below. However, VSP in its sole and absolute discretion, may terminate the Provider from the network and halt claims processing immediately as set forth above.

Meet and Confer

Within fifteen (15) working days of receipt of the Request for Arbitration, the party requesting arbitration ("**Claimant**") shall propose final and binding terms of settlement ("**Settlement Proposal**") to the other party ("**Respondent**"). Within five (5) working days of receipt of the Settlement Proposal, Respondent shall accept or reject the Settlement Proposal. If the Settlement Proposal is accepted by Respondent, the Parties shall proceed to draft and execute a settlement agreement, forthwith. The failure to respond to a Settlement Proposal made in accordance with this section, is considered a rejection of the Settlement Proposal.

If Respondent rejects the Settlement Proposal, the case shall proceed to Arbitration and the arbitrator shall be selected as set forth below.

If Claimant obtains an arbitration award that is equal to or greater than the Settlement Proposal, the Claimant shall be deemed the prevailing party for purposes of an award of arbitration costs, plus an award of reasonable attorneys' fees, which attorneys' fees shall not exceed $25,000. (California Civil Code Section 1717 shall not apply for purposes of determining the prevailing party.) If the arbitration award is less than the Settlement Proposal, Respondent shall be deemed the prevailing party for purposes of an award of arbitration costs, plus an award of attorneys' fees, which fees shall not exceed $25,000.

The failure or refusal, whether by intent, inadvertence, or neglect, to make a Settlement Proposal as set forth above, shall be deemed a waiver of any right by Claimant to recover any attorneys' fees, or arbitration, or other costs under the NDA, or any law regardless of the fact that Claimant may be the prevailing party in the arbitration.

If Claimant fails to provide a Settlement Proposal within fifteen (15) working days of receipt of the Request for Arbitration, the Respondent may propose a Settlement Proposal within twenty (20) working days of receipt of the Request for Arbitration. Within five (5) working days of receipt of the Settlement Proposal, Claimant shall accept or reject the Settlement Proposal. If Respondent obtains an arbitration award that is equal to or greater than the Settlement Proposal, the Respondent shall be deemed the prevailing party for purposes of an award of arbitration costs, plus an award of reasonable attorneys' fees, which attorneys' fees shall not exceed $25,000. (California Civil Code Section 1717 shall not apply for purposes of determining the prevailing party.) If the arbitration award is less than the Settlement Proposal, neither party shall be the prevailing party and both parties will be responsible for their own attorneys' fees and arbitration costs.

Demand for Arbitration / Selection of an Arbitrator

Demand for Arbitration - If a settlement is not reached or a proposal is not made as set forth above, Claimant shall within thirty (30) working days from the receipt of Request for Arbitration submit a Demand for Arbitration ("**Demand**") to the DRA.

Selection of an Arbitrator - The arbitration shall be heard before one (1) neutral arbitrator from JAMS, pursuant to the JAMS Streamlined Arbitration Rules & Procedures in effect at the time of

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the Request for Arbitration, ("**JAMS Rules**") unless otherwise agreed to in writing by the Parties. The arbitrator shall be a retired judge, or a retired attorney with over 20 years of practice; with experience in health care claims.

The Parties shall mutually agree on an arbitrator or, if they are unable to agree, have JAMS facilitate the arbitrator selection process. Once the Parties select an arbitrator, or it is determined that they are unable to agree, the DRA shall be advised. Once an arbitrator is identified, then the DRA shall complete a Stipulation for Arbitration, which requires the signature of both parties, and submit it along with the Demand to the JAMS Case Manager.

To the extent that the JAMS Rules are deleted or otherwise extinguished, the Commercial Rules of JAMS shall apply, except that discovery shall be limited to a document exchange between the Parties. In any Arbitration provided for herein, regardless of what the JAMS Rules reflect now or at any time in the future, there shall be no material, expert, or other witness depositions, interrogatories, or requests for admissions, unless otherwise agreed to between the Parties. The JAMS Rules can be found at https://www.jamsadr.com/rules-streamlined-arbitration. If there is any conflict between the JAMS rules and those within this DRP, the DRP shall prevail.

If JAMS declines to conduct the Arbitration, the Arbitration instead shall be administered by the American Health Lawyers Association ("**AHLA**"), and pursuant to the JAMS Rules referenced above, unless otherwise agreed to by the Parties or required by AHLA.

If an arbitrator is not requested in the manner and time periods set forth above, each of the Parties shall be deemed to have accepted the Written Determination and/or the Panel Determination, which **shall become final, binding and conclusive; shall be effective immediately**, shall not be subject to appeal or judicial review except to the limited extent provided by the Federal Arbitration Act (**"FAA"**), and shall be confirmed and judgment entered consistent therewith in the Sacramento County Superior Court, or any other court having competent jurisdiction. There shall be no right to seek further redress through any other legal action.

Arbitration Fees

Each JAMS arbitrator has their own schedule of fees applicable for Arbitrations. All fees shall be shared equally by the Parties and shall be payable to JAMS promptly upon request. If either party fails to pay their respective fees in accordance with any timeline set by JAMS (or AHLA)or as set forth below, the following shall apply:

- If Claimant fails to pay their share of fees by the JAMS deadline, or if none is provided within twenty (20) working days of the date of the JAMS invoice, it shall be concluded that the Claimant has failed to agree to participate in the Arbitration process and the Written Determination or Panel Determination shall become final and binding. There shall be no further right to appeal or to seek other redress; including challenge in court. The Written Determination or Panel Determination shall become final and effective immediately. In such case, Respondent may proceed with the Arbitration at their sole cost and expense, and without the Claimant's participation, solely for the purpose of finalizing the Written or Panel Determination as an arbitration award. No further involvement by Claimant shall be permitted.
- If Respondent fails their share of fees by the JAMS deadline, or if none is provided within twenty (20) working days of the date of the JAMS invoice, Claimant will have the right to

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pay and proceed with the Arbitration without the Respondent's participation. No further involvement by Respondent will be permitted.

- If Arbitration was requested by either party subsequent to a Section V dispute below and Claimant fails to timely pay their portion of the arbitration fees or costs , the claim shall be deemed waived and shall be considered time-barred. There shall be no further right to arbitrate or to seek relief of any kind, in any forum.

Record

Any party, or arbitrator (at the Parties shared expense), may arrange for a stenographic record of the proceeding to be kept by an independent certified court reporter. Any party wanting a record of the arbitration shall give notice to the arbitrator and the other party at least ten (10) working days prior to the arbitration. The party requesting the use of a court reporter shall pay for the reservation and for the original certified transcript. The opposing party and arbitrator shall be permitted to purchase a copy of the transcript from the court reporter and shall only be required to pay the court reporter's usual and customary fee for a copy of the transcript. If the arbitrator desires the use of a court reporter, the cost for the reservation and for the original certified transcript shall be equally shared by the Parties. With the exception of the court reporter and/or the personal notes of the Arbitration by the Parties, their counsel and the arbitrator, there shall be no audio, video, or other recording of the Arbitration of any kind.

Withdrawal

At any time prior to submitting a Demand to JAMS, the Request for Arbitration may be withdrawn by Claimant, with prejudice, with no further right to challenge or appeal. Once an arbitrator has been selected, no withdrawal will be permitted unless consented to in writing by Respondent and JAMS. Any fees then due and owed to JAMS shall be paid in full solely by the Claimant.

Class Action Waiver

Any Arbitration conducted herein will be conducted only on an individual basis by the Provider. A Provider waives any and all rights, if any, to bring a class action Arbitration for any disputes identified herein to include any other disputes related to the NDA and/or this DRP.

Award

The arbitration award shall be final, binding, and conclusive, shall be effective immediately, shall not be subject to appeal or judicial review except to the limited extent outlined by the FAA, and shall be enforceable by the Sacramento County Superior Court, or in any court with the competent jurisdiction. The award rendered by the arbitrator shall be considered an arbitration award for purposes of confirming an award under the California Code of Civil Procedure Section 1285, et. seq. The party seeking confirmation of the arbitration award shall be entitled to recover attorneys' fees and costs incurred in confirming the arbitration award.

V. OTHER DISPUTES

Other Disputes

Should any other disputes arise between the Parties, including any breach or compromise of the confidentiality provisions by either party or third party acting for or on behalf of a party, a good faith effort shall be made first to resolve the dispute(s). Notice of such dispute must be provided to the other party in writing. If the Parties are unable to resolve or reach a mutually agreement within twenty (20) working days of the party's receipt of the Notice of Dispute, either party may

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submit the dispute to binding arbitration pursuant to the rules and procedures provided herein. A Request for Arbitration must be made within sixty (60) working days of receipt of the Notice of Dispute.

For all disputes under Section V, any arbitration award shall be final, binding, and conclusive, shall be effective immediately, shall not be subject to appeal or judicial review except to the limited extent provided by the FAA and shall be enforceable in the Sacramento County Superior Court, or in any other court having competent jurisdiction. The award rendered by the arbitrator shall be considered an arbitration award for purposes of confirming an award under the California Code of Civil Procedure Section 1285, et. seq. The arbitration award may be entered in any court having competent jurisdiction. The party seeking confirmation of the arbitration award shall be entitled to recover attorneys' fees and costs incurred in confirming the arbitration award.

VI. GENERAL PROVISIONS

Except as may be required by law, no VSP agent or employee is authorized to make material changes or alterations to this DRP without first obtaining approval from VSP's Board of Directors or another Committee or Officer appointed thereby. Absent exigent circumstances or as required by law, any material alteration to this DRP shall go into effect upon thirty (30) calendar days' notice to Provider through the usual means of communication. Fraud and Abuse Claim disputes, contract disputes and Quality Management disputes shall be handled pursuant to the DRP in effect at the time the Contest/Denial submission is made as set forth herein. A Request for Arbitration shall be handled pursuant to the DRP in effect at the time that the Request for Arbitration is made.

If any provision of this DRP is held by an arbitrator to be invalid, void, or unenforceable, the remaining provisions will continue in full force and effect without being impaired or invalidated in any way. Any such determination will only be operative with respect to the Provider that is a party to the arbitration proceeding. Any ambiguity or conflicting provision of the DRP shall be interpreted to give full meaning to the intent and purpose of the DRP.

The provisions of the DRP shall survive termination of the effective NDA.

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Quality Assurance Program

Our Quality Assurance (QA) program partners with you to deliver the highest quality eye care to VSP patients. The program also educates you and your staff about our QA policies and procedures. This program follows state and federal regulations and guidelines from accrediting organizations like the National Committee for Quality Assurance (NCQA).

Note:

Our Quality Assurance department protects patient records, confidentiality, and all proprietary information. For more information, refer to VSP's Privacy Procedures.

Medical record reviews involve an internal mail-in review or an on-site office review. QA requests only VSP patient records during these reviews. Electronic-record documentation is acceptable if findings are included. We use clinical peer reviewers trained in our policies and procedures to assess and grade reviews.

Patient medical records are submitted to VSP and reviewed by clinical peers who verify the exam and treatment for each patient follows established criteria and is properly documented.

Medical record reviews have up to three levels and may occur at any time. Each level requires ten, randomly selected VSP patient records. The patient names are chosen from claims billed in your name. A patient record with a different doctor noted as the one who performed the exam will not be reviewed and may impact the result of your review.

A peer reviewer accesses each record based on VSP's exam and documentation standards and returns the results to the QA administrator who informs you of the review outcome. A QA contact name is provided and you may call at any time for clarification of the review results.

Educational Review (Routine Review)

The first review you'll receive is a routine educational review. The review is assessed for a pass or non-pass and the results are communicated to you.

If you pass this educational review, no follow up review or financial assessment will occur.

A non-passing outcome will result in a First Formal review in approximately six months. This timeframe allows correction of the initial identified discrepancies.

First Formal Review

You will receive a First Formal review, requiring another ten VSP patient medical records, when you do not pass the prior educational review.

If you pass this First Formal, no follow up review or financial assessment will occur.

A non-passing outcome results in a financial assessment for each record with discrepancies at a maximum of $100.00. A Second Formal follow up review will occur in approximately six months. This timeframe allows the doctor to correct identified discrepancies.

Second Formal Review

You will receive a Second Formal review, requiring another ten VSP patient medical records, when you do not pass the prior First Formal review. This is the last review level to demonstrate you meet VSP's exam and documentation standards.

A $500.00 fee is assessed and collected at the time of the Second Formal review.

If you pass this Second Formal, no other follow up review or additional financial assessment will occur.

Non-passing outcomes, at a minimum, lead to higher financial assessments for records with discrepancies based on the doctor's 12-month claim volume and may result in a recommendation for possible contract termination from our network.

Quality Management Program

VSP has a comprehensive Quality Management (QM) and Quality Improvement (QI) Program that presents a framework for ensuring quality eye care for members accessing VSP's doctors. The QM/QI Program Description defines the goals, scope, structure, function and other components for the QM/QI Program at VSP.

Purpose

VSP's QM/QI Program ensures quality vision and eye health care to members accessing VSP's doctors. The program is designed to objectively and systematically monitor and evaluate the quality and appropriateness of care and services. We strive to continuously pursue opportunities for improvement and problem resolution.

Policy

It is the policy of the organization to ensure:

- Compliance with VSP approved policies and procedures for the QM/QI process
- Adherence to guidelines, standards and criteria set by government, accrediting agencies, and other regulatory agencies as appropriate
- The QM/QI Program accommodates the contractual requirements and benefit design of each client/health plan

Goals

The goals of the QM/QI program include, but are not limited to, the following:

- To develop, implement and coordinate all activities that are designed to improve the processes by which care and services are delivered
- To provide tools, resources and training for staff involved in quality of care processes with clinician oversight and guidance
- To identify inappropriate practice patterns and opportunities to improve patient care
- To evaluate the effectiveness of implemented changes in order to continuously improve the quality of care and service provided by VSP and doctors to VSP customers (members, clients, and health plans)
- To ensure that there are documented mechanisms to evaluate the effects of the QM/QI Programs utilizing member and doctor satisfaction data
- To ensure that QM/QI policies and procedures are reviewed, revised and approved, as needed, by the QM Committee
- To utilize efficient and appropriate communication channels to deliver QM information to appropriate individuals
- To facilitate documentation, reporting and follow-up of Credentialing and QM/QI activities in order to facilitate excellence in vision care services and outcomes.

Quality Improvement Process

Overview

The QI process includes documented policies and procedures utilized in monitoring, reviewing and improving care and services provided to VSP members by VSP doctors. VSP may use applicable provider data for quality improvement activities.

Policy

The QM/QI policy review occurs annually and is revised as needed. Procedural revisions and revisions with clinical impact are reviewed and approved by the QM Committee. VSP's clients and regulatory agencies receive material revisions to the policy or procedures, as required.

Patient Safety

Patient safety is reviewed and addressed. Interventions are identified and implemented. Patient safety activities include, but are not limited to:

- Potential Quality of Care Complaints/Grievances
- Credentialing/Recredentialing
- QA Doctor Reviews
- Clinical Practice Guidelines / algorithms
- Member Surveys

QI Work Plan

The QI Work Plan is approved by the Board of Directors annually. Quarterly updates to the work plan reflect progress on QM/QI activities and are evaluated annually. The QM Committee reviews the updates and evaluations before forwarding to the Board of Directors.

Improvement Activities

Development, implementation and review activities include, but are not limited to the following:

Potential Quality of Care Complaints and Grievances

- Doctor Trends
- Complaint type trends
- Credentialing/Recredentialing and Professional Review

- Doctor Improvement Action Plan

Member, Client and VSP Doctor Satisfaction

- QA Report/Evaluations
- QA Doctor Reviews
- Company Satisfaction Survey Results

Risk Management

- Clinical Practice Guidelines and Algorithms
- Assessment of New Technology

Benefit Utilization

- Identification of outlier practice patterns that may identify under or over utilization

Reimbursement

Reimbursement - California (CA)

For the VSP Signature Plan® and VSP Choice Plan® we reimburse doctors according to a unique fee payment methodology. Our goal is to pay doctors as fairly as we can while, at the same time, provide an eyecare plan to clients at a competitive price.

We reimburse you for providing VSP Signature Plan® and VSP Choice Plan® exams (diagnostic services) and lens and frame dispensing services. Refer to the VSP Signature Plan in the **Plans and Coverages** section for more information.

(CA)

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Doctors' usual and customary (U&C) fees are first filed with VSP during the credentialing process. VSP uses this information to determine each doctor's payable fees for providing services to VSP patients.

(CA)

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Assigned Fee Reports (AFRs) reflect the doctor-submitted U&Cs and VSP-determined payable amounts for exams, basic lens, and frame services based on VSP Plan type. Access your Assigned Fee Report for your practice on **VSPOnline** at **eyefinity.com** by clicking the **View Fees** link under **Practice/Doctor Updates** in the **Administration** area.

Signature Network

Your VSP Signature Plan reimbursement schedule is contained in your **Assigned Fee Report** on **VSPOnline**.

Choice Network

Your VSP Choice Plan reimbursement schedule is contained in your Assigned Fee Report on **VSPOnline**.

Other Networks

Our VSP Advantage and Medicaid Plans have fee schedules for each state. View fee schedules for plans you participate with by accessing your Assigned Fee Report on **VSPOnline**. You may also view the Medicaid fee schedule by accessing the **Medicaid Manual** on **VSPOnline**.

(CA)

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Your VSP Choice Plan reimbursement schedule is contained in your Assigned Fee Report on **VSPOnline**.

Other Networks

Our VSP Advantage and Medicaid Plans have fee schedules for each state. View fee schedules for plans you participate with by accessing your Assigned Fee Report on **VSPOnline**. You may also view the Medicaid fee schedule by accessing the **Medicaid Manual** on **VSPOnline**.

Our Board of Directors establishes maximum amounts that can be reimbursed for exams and for lens and frame services by geographic region. The board reviews these confidential amounts when applicable.

(CA)

Our Board of Directors establishes maximum amounts for exams and for lens and frame services by geographic payment region. The board reviews these confidential amounts when applicable.

You will receive your bifocal dispensing fee PLUS a service fee for progressive lenses. If covered by the member's plan, both the bifocal dispensing and applicable service fee are paid by VSP. For non-covered progressives, see **Lens Enhancements Chart** for information on patient charges.

(CA)

You will receive your bifocal dispensing fee PLUS a service fee for progressive lenses. If covered by the member's plan, both the bifocal dispensing and applicable service fee are paid by VSP. For non-covered progressives, see **Lens Enhancements Chart** for information on patient charges.

We deposit payment to your bank account via Electronic Funds Transfer (EFT) following your state’s established pay schedule and include payment for claims turned in and received during specified pay periods. An Explanation of Payments (EOP) itemizing the claims paid with checks and post statements is available to view on **VSPOnline**. As a best practice, you are encouraged to deposit checks within 14 days of the date the check was written.

Important!

All VSP payments will be made by EFT, also known as direct deposit. Network doctors must be enrolled in order to receive payment. Doctors can enroll their practice online or by contacting Customer Service at **800.615.1883**.

Our payment schedule includes cutoff dates. Claims must be processed by these dates for them to be paid on your next check. Cutoffs usually fall five to 10 days before the last day of the payment period. We can’t guarantee internal processing time, but claims turned in at least five working days before the cutoff usually are paid on the upcoming check.

(CA)

VSP will reimburse covered services provided via telehealth on the same basis and to the same extent as covered services delivered in-person.

Services Subject to Review/Audit

All of Network Doctor's performance data, services and materials provided to VSP Patients, and claims submitted to VSP, are subject to review and audit. Upon request, and at their own expense, a Network Doctor must furnish patient records, in the time frame requested, to VSP or any or all Enrollees for whom claims have been submitted to VSP for payment. Network Doctor shall fully cooperate with any VSP review or audit activity, including, without limitation, in-office audits and inspections, business audits, special investigation audits, medical record reviews and all similar VSP investigative or quality assurance efforts. For quality and authentication purposes, Network Doctor understands and agrees that some audits may be unannounced. Network Doctor shall not refuse to permit an audit because an audit was not announced in advance, may be disruptive or for any other reason. Should Network Doctor refuse to permit an audit for any reason, Network Doctor may be subject to termination for failure to comply with the Network Doctor Agreement and/or restitution in an amount to be determined by VSP. Network Doctor agrees to cooperate with, abide by, and adhere to, all rulings of any VSP quality assurance or peer review committee. All records, data and information acquired by or prepared for any VSP quality assurance or peer review committee shall be held in confidence, except to the extent necessary to carry out the purposes of such review activities, and shall not be subject to subpoena or discovery, except as may be required by law or as otherwise required in the Agreement.

The confidentiality requirements set forth above, shall survive the expiration or termination of the Network Doctor Agreement Network Doctor further agrees that upon request, Network Doctor will timely furnish case records to VSP of any or all Enrollees for whom claims have been submitted, and that VSP may use any information so obtained for statistical, actuarial, scientific, peer review or other reasonable purposes, including applicable state and federal law requirements, provided that no professional confidence shall be breached thereby. Network Doctor also agrees that utilization and claims information may be released to MCOs and peer review groups. The confidentiality of VSP Patient medical information shall not be compromised. Network Doctor shall reimburse VSP in a timely manner for its reasonable out-of-pocket expenses and costs incurred in audit(s)/inspection(s) resulting in restitution due to improper billing. These costs shall include the reasonable market value of the time spent by VSP's Special Investigative Unit or Provider Quality Auditors for travel to and from the practice being audited, for recovery of necessary records, to conduct the audit, and the reasonable market value of the time spent to review and finalize the audit results.

While VSP encourages the use of the Well Vision Savings Statement to show VSP's value to the patient, it does not constitute an acceptable financial record for audit purposes. In accordance with VSP policy, all financial records must be itemized for the services and/or materials provided to the patient, regardless of whether the patient incurred any out-of-pocket expenses. The financial record keeping should include the appropriate CPT/HCPC codes and descriptions, quantities, and the amounts billed to and paid by the patient and insurers (including coordination of benefits).

CONTACT LENSES

Itemized financial records must be kept for all VSP patients and must include the following for visually necessary, covered and elective contact lenses:

- Patient name
- Date of service
- CL brand
- Type
- Quantity and date dispensed
- U&C cost for services (fitting and evaluation)
- U&C cost for materials
- Amount billed to insurance
- Amount paid by the patient
- Method of payment
- Material manufacture invoice(s) or indication of dispensing from stock

Under the Visually Necessary Contact Lens plan benefit, the patient is only charged the appropriate copayment, but you must still keep itemized records as noted above.

When billing VSP for contact lenses, you must keep a list of U&C fees and costs for services and materials for reference. This must be shown and a copy provided to any VSP Representative upon request.

GLASSES

Itemized financial records must be kept for all VSP patients and must include the following for glasses:

- Patient name
- Date of service
- Lens type
- Lens options
- Frame make, model and retail cost
- Frame invoices with acquisition costs
- Date dispensed
- Amount billed to insurance
- Amount paid by the patient

- Method of payment
- Material order(s) and lab invoice(s)

Failure to keep and provide itemized records for any services or materials rendered may result in the denial of payment for billed services and materials.

Submitting Patient Conditions Requirement

As a health-focused vision care company, VSP places an emphasis on early detection of chronic conditions through an eye exam. Your medical findings are then integrated in a HIPAA-compliant manner with the healthcare system to provide holistic care to patients.

Doctors are required to submit patient conditions through eClaim on **eyefinity.com**, practice management software or paper claims. Patient condition submission is monitored as part of the Quality Assurance (QA) Program and results are provided in the QA Review Summary. Outcomes identifying the need for improvement will require the doctor's acknowledgement of the results and an improvement action plan.

When you submit patient conditions, VSP can demonstrate to clients, health plans, and disease management companies the full scope of services you provide and reinforce the role of vision care as a key component of overall health care. We see the value resonate in the form of new and renewed contracts, which bring more VSP members to your practice. VSP also helps health plans increase their HEDIS and Star quality ratings by reporting annual eye exams received by patients with diabetes. Additionally, VSP uses this information to direct patients with diabetes and prediabetes back to your office if they have not received an eye exam in 14 months.

Note:

More information on HEDIS and Star quality ratings can be found on **VSPOnline**. Under **Administration** select **Submitting Patient Conditions** and then click on the **HEDIS and Star Ratings** tab.

- Promotes and quantifies optometry's participation in medical care.
- Helps facilitate medical care for your patients.
- Brings patients into your office and helps keep them there.
- Provides opportunity for your practice to earn additional revenue.

VSP offers additional reimbursement* when you include diagnosis codes for patients with chronic conditions. For each patient identified, you can earn:

- $5 for reporting diabetes and/or diabetic retinopathy.**
- $2 for reporting hypertension and/or high cholesterol.

Note:

Payment won't exceed $5 and isn't cumulative. If a $5 condition and a $2 condition are checked, then $5 is paid. If two $2 conditions are checked, $2 is paid. The patient's medical record must indicate any condition submitted on a claim.

*Additional reimbursement only applies to VSP Signature Plan® and VSP Choice Plan® claims billed with one of the following exam codes: 92002, 92004, 92012, 92014, S0620 or S0621 and one or more patient condition.
**VSP WellVision Exam® claims with a date of service of January 1, 2024, and later must include the following to earn the $5 patient condition payment.

- Indicate the patient has diabetes or diabetic retinopathy via the patient condition checkbox in eClaim on eyefinity.com or include the appropriate diagnosis code, and
- Include the appropriate diabetic eye exam CPT Category II code.

When submitting a claim, check the appropriate box(es) on eClaim and/or enter diagnosis codes for the patient's conditions. This includes diabetes, diabetic retinopathy, hypertension high cholesterol, and patients at risk of prediabetes. Additional conditions like glaucoma and age-related macular degeneration can be noted using diagnosis codes.

Refer to the following section for more information on submitting patient conditions including the eClaim process and applicable diagnosis codes.

- **Eligibility and Authorization**

Submitting Claims/Timelines

Patient Education

Patient education resources are available to you on **VSPOnline**. Under **Administration** select **Submitting Patient Conditions** and then click on the **Resources** tab. Use this information to educate your patients and demonstrate that your role in their care may include more than an annual eye exam.

The patient's chief complaint or presenting symptoms determines the primary diagnosis on the claim. If the primary diagnosis is a medical eye condition, and you participate on the patient's medical insurance panel, you may bill their medical insurance as primary and coordinate benefits with VSP as secondary. Some major medical plans cover routine annual eye exams, or an exam for patients with conditions such as diabetes, regardless of whether they present with medical symptoms. **If the medical plan is going to be billed, it is extremely important to explain this to the patient.**

If the patient has no medical chief complaint and the medical plan does not cover routine/annual eye exams, bill VSP.

Note:

Proper documentation of the patient's chief complaint, medical condition(s), related eye symptoms, and high-risk medications should all be recorded in the presenting reasons for the patient's visit

For further details, refer to VSP's COB guidelines.

VSP's Privacy Commitment

All VSP employees, upon employment, get privacy and security training and agree to abide by our “Confidentiality of Information” policy. Our policy explains the importance of protecting the confidentiality of medical records, personal information, insurance claims and other materials. Violating this policy can lead to disciplinary action up to and including termination.

Medical Directors, Optometry Directors, Clinical Consultants, and Clinical Committee Members also get Privacy and Security training. They must sign a Conflict of Interest and Confidentiality Statement.

Any patient specific or Protected Health Information is confidential. This information is shared only with people who have a need to know and authority to get such information, as explained above.

We’ll only use and disclose patient Protected Health Information when needed to coordinate vision care treatment, to disclose information to the patient’s employer/plan sponsor to the extent permitted by law, for payment and healthcare operations, or as required or permitted by law.

Our legal department reviews any court order or subpoena for disclosure of confidential information to determine the order’s legitimacy, the reason for disclosure, and limitations on information disclosed.

All patient information is stored for the amount of time required by law and company policy in locked files accessible only for the above reasons.

System stored patient information is protected by system security measures block unauthorized access. We’ve also implemented security policies and procedures required by HIPAA. We currently employ industry-standard, system-security measures to protect electronically stored and transmitted information.

Our network doctors’ offices must maintain confidentiality and guard patients’ Protected Health Information against loss, defacement, tampering, or use by unauthorized people. The contracted doctor’s office must maintain a policy of confidentiality for patient medical record information.

If we uncover a confidentiality violation by a network doctor, either through an onsite visit or a complaint/grievance, our Quality Assurance Committee and our staff determine steps needed to restore confidentiality. We consult our Human Resources department if one of our employees was involved in violating confidentiality.

Our Notice of Privacy Practices will be provided to any member, client, or network doctor on request

We respect the privacy of our website users. We don’t collect personal information from anyone who simply visits our website.

Patients who enter personal information should know all communication between their computers and our Web servers is encrypted using secured server technology (SSL). Our secure server software is the industry standard and among the best software available today for secure transactions.

VSP’s Fraud, Waste and Abuse Policy

VSP considers insurance fraud and abuse as professionally unacceptable and criminal behavior and takes every precaution to ensure such activities are detected, eliminated, and referred to appropriate governmental authorities. VSP will vigorously pursue all fraudulent and abusive activities and supports all efforts to combat such practices by enforcing the following measures concerning, but not limited to, the health care provider, contract laboratories, VSP employees, clients, agents, and patients.

The components of our Fraud, Waste and Abuse Business Plan are:

- The Fraud, Waste and Abuse Policy
- Education
- Prevention and Internal Controls
- Detection
- Investigation
- Sanctions and Disciplinary Action
- Full Cooperation with Law Enforcement and Regulatory Authorities
- Reporting
- Applicable Regulations and Laws

VSP recognizes that the best defense against becoming a victim of fraudulent or abusive behavior is an educated work force capable of preventing, detecting and eliminating such activities. VSP is dedicated to providing appropriate education and training in this area. Company-wide training of all employees will cover the following topics:

- VSP's Fraud and Abuse Policy
- The true costs of insurance fraud and how it directly affects them
- Definition of what constitutes fraud and abuse, including money laundering
- Indicators of fraudulent and abusive activities
- Reporting of suspected fraud and abuse
- Roles and responsibilities of the Special Investigative Unit (SIU)
- Responsibilities of each employee in reporting suspected or known fraudulent or abusive activities

Education and training for providers, contract laboratories, clients, agents, and patients concerning fraud and abuse will consist of:

- Definition of what constitutes fraud and abuse
- Indicators of fraudulent and abusive activities
- Repercussions of fraud and abuse
- Reporting of suspected fraud and abuse

VSP will maintain a comprehensive system of internal controls designed to prevent and detect occurrences of fraud and abuse. The system of internal controls will consist of:

- An organizational structure which segregates functions of claims processing, claims recording, and claims payment as well as maintenance of patient and provider membership tables and provider and laboratory fee tables
- Procedures incorporated into the manual work flow to maximize the probability that questionable claims will be identified and investigated
- System checks that identify all claims which meet pre-set indicators and criteria that are known to be outside the norm of our industry standards and services
- Provider peer review processes and procedures
- Internal claim audits of a statistically valid sampling
- A system of supervisor accountability for the review and approval of their unit’s actions

Well-trained personnel are able to routinely spot indicators of fraud and abuse. VSP’s SIU will coordinate all information received and lead any investigations regarding the detection and reporting of fraudulent and abusive activities.

Detection of fraud or abuse can come from the following areas:

Claims Processors

- All claims processors will be familiar with the indicators of fraud and abuse
- Suspicious claims will be reviewed to determine if any misrepresentation has occurred
- Pertinent information will be documented
- Any fraudulent or abusive claim submissions will be forwarded to the SIU for appropriate action

Claims Auditors

- The claims auditors will continuously review reimbursement claims received during the normal course of daily audits with the purpose of identifying fraud and abuse

- The claims auditors will be made available to perform special reviews of any situation where fraud or abuse is suspected

Customer Care Representatives

- All customer care representatives will be familiar with the indicators of fraud and abuse
- Calls concerning provider fraud and abuse will be documented and the information forwarded to the SIU.
- All non-provider calls concerning fraud and abuse will be documented and the information forwarded to the SIU.

Quality Management Specialists

- All quality management specialists will be familiar with the indicators of fraud and abuse.
- Any potential fraud or abuse issues that are identified during a quality assurance review will be forwarded directly to the SIU.

SIU

- The SIU will routinely run reports against our claims systems to identify activities that are uncharacteristic of our industry.
- Abnormal utilization patterns will be researched and appropriate action taken.

Hotline

- An Anti-Fraud Hotline has been made available for all parties (providers, contract laboratories, employees, clients, agents, and patients) to report any suspected fraud or abuse.
- The toll-free number is **800.877.7236**.

All cases of suspected fraudulent or abusive activities employed/practiced by providers, contract laboratories, VSP employees, agents, clients, or patients will be fully investigated with the involvement of the SIU and VSP Legal Counsel as needed. The following items will be considered to be a part of the investigation:

- Information gathering
- Claim validity
- Scope of the investigation
- Ability to prosecute
- Ability to recover monies owed
- On-site or desk level investigations conducted by VSP personnel
- Use of outside investigators and experts

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- Claim validity
- Scope of the investigation
- Ability to prosecute
- Ability to recover monies owed
- On-site or desk level investigations conducted by VSP personnel
- Use of outside investigators and experts

Fraudulent and/or abusive billing practices could result, without limitation, in the following sanctions and/or disciplinary actions:

- Providers—suspension or removal from the VSP doctor network, assessment and collection of restitution, assessment and collection of reasonable audit costs and expenses, referral to the appropriate state's governing Board of Optometry, Board of Ophthalmology, or Medical Boards, referral to the appropriate state's law enforcement or other government agency(ies) and reporting to the National Practitioner Data Bank and/or other appropriate data reporting agency
- Contract Laboratories—suspension or removal from the approved listing of VSP laboratories and restitution collected
- VSP employees—termination and restitution collected
- Agents—suspension or removal as VSP agent, restitution collected, and referral to the appropriate state's governing Insurance Department

Upon the expiration or termination of the VSP Network Doctor Agreement, a doctor will no longer be or be considered a VSP Network Doctor. From the date of expiration or termination onward, unless the parties otherwise agree in a separate writing, the doctor, in any capacity, unless prohibited or limited by law, will: (a) no longer directly or indirectly submit any VSP patient claims for reimbursement to VSP for any purpose, (b) directly or indirectly advertise or indicate in any manner or in any way that he/she is a VSP Network Doctor, affiliated with or authorized by VSP and/or a VSP out of network provider, or any variation thereof, (c) act as, or hold himself/herself out to the public to be, a VSP Network Doctor and/or a VSP out of network provider, or any variation thereof and/or (d) submit any VSP patient claims for reimbursement to VSP as an out of network provider. The doctor will promptly advise all VSP patients that as of the date of expiration or termination, he/she no longer is a participant on the VSP doctor network. The doctor shall not issue/make any disparaging, slanderous and/or libelous remarks regarding/concerning VSP and its business to any VSP client, VSP patient and/or any third party for any reason whatsoever.

In cases where sufficient evidence is gathered to indicate that fraudulent activity has in fact occurred, VSP's Corporate Legal Counsel will coordinate actions with law enforcement agencies as well as be prepared to initiate civil litigation in furtherance of all anti-fraud objectives. VSP will cooperate fully with all law enforcement agencies in the subsequent prosecution of fraudulent activities.

The SIU will collect data and maintain documentation of investigations to provide support for Company actions. Cases under review or turned over to law enforcement for prosecution will be documented and reported to the Corporate Compliance Officer quarterly. The Corporate Compliance Officer will report the quarterly results to the Finance Committee of the Board. To meet standards of compliance, the SIU will report to states and requesting clients as required. The Company will also evaluate the effectiveness of its anti-fraud and abuse efforts on an annual basis.

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VSP helps administer many Federal and State healthcare programs such as Medicare and Medicaid that apply the following laws and regulations:

Anti-Kickback Statute

Prohibits anyone from knowingly and willfully soliciting or receiving anything of value in return for referring healthcare goods or services for which payment may be made in whole or in part under a federal health care program. The penalties are severe. If a person or entity is found guilty of violating the statute, a fine of up to $25,000 or imprisonment of up to five years may be imposed.

Certain provider activities are “safe harbors” that are outlined in the law.

In addition to the Federal Anti-Kickback Statute, many states have adopted state anti-kickback statutes. Many of these statutes have the same elements and penalties as the Federal Anti-Kickback Statue.

Federal Physician Self-Referral

Prohibits a physician (or immediate family member) who has a financial relationship with an entity from making a referral to that entity for furnishing a designated health service (DHS) for which Medicare or Medicaid would otherwise pay. Congress provided for a number of exceptions to this prohibition and gave CMS the authority to create additional exceptions.

Federal False Claim Act

Federal False Claim Act prohibits any individual or business from submitting, or causing someone else to submit, to the government a false or fraudulent claim payment. These false claims acts apply to all types of goods, services and government contracting, and have been particularly effective in combating healthcare fraud. The fines for filing a false claim includes up to three times the government damage plus $5,500 to $11,000 per false claim.

In addition to the Federal False Claim Act, many states have adopted state false claim statutes. Many of these statutes have the same elements and penalties as the Federal False Claim Act.

Use of The VSP® Name and Logo

According to either the Network Doctor Agreement on file with VSP, or the Limited License Agreement entered into between you and VSP, VSP granted you a nonexclusive, nontransferable, limited and revocable license to only use the mark "VSP" and the registered VSP logo(s) in accordance with the guidelines set forth in this PRM, and in connection with, the your activities in providing eyecare services and materials ("Limited License".) This Limited License is only valid upon VSP's receipt of a Network Doctor Agreement signed by you and upon VSP's final credentialing approval of you.

You can use the registered service mark "VSP®" and our registered logo (the "VSP Marks") as long as you have a valid Network Doctor Agreement and/or Limited License Agreement with VSP.

The Limited License granted to you permits you to use the VSP Marks for advertising inside your office or on your website. Use on social media or external advertising in any form requires VSP's consent. You may not use the VSP Marks on any permanent exterior signage.

Download one from **VSPOnline** at **eyefinity.com**.

Follow these guidelines to ensure you stay in compliance with other VSP specifications, policies, and applicable approvals.

Smaller Ads and Promotions

These types of ads and promotions do not require VSP review and pre-approval before they run:

- Business cards or letterhead (only if promoting "VSP® members welcome")
- Value or promotional pack discount mailings
- In-office supplies (e.g., posters, brochures)
- Print and online ads (e.g., Yellow Pages, newspaper, practice website)
- Marketing and promotional materials (e.g., reminders and referral mailings, newsletters)

Larger, Mass Media Ads, and Promotions

Larger signs, ads or promotions require VSP approval before installation or being made visible to the public. Complete an Ad Approval Request form and submit it to VSP with the plans and specifications of your sign or ad.

Always include the ® symbol on the first reference to VSP in text, showing that it's a registered service mark. For example:

- VSP® members welcome
- VSP® network provider
- VSP® Vision Care

Important!

All VSP payments will be made by EFT, also known as direct deposit. Network doctors must be enrolled in order to receive payment. Doctors can enroll their practice online or by contacting Customer Service at **800.615.1883**.

Only use the full-color, all-white, or all-black logo provided.

- On color paper, use only the all-white or all-black logo. For Yellow Pages and newspaper advertisements, use the all-black logo only.
- Don't duplicate the logo stock typefaces or modify the logo in any way.
- The logo and all text within the logo, including the "Vision care for life" tagline, must be legible.
- When using the VSP logo on your website, you can link it to **vsp.com**.
- When using the logo in your print or online materials, you can proportionately resize it, but it can't be any smaller than one-half inch in height.
- The space around the logo should be free from other graphics or messages.
- The minimum clear space around the logo must be equal to the height of the "p" in VSP.
- Always consult your designer/printer to ensure correct formatting.

- Don't include the VSP logo on any sign that includes anything other than the doctor's name and or name of the optometry practice.
- Don't use the VSP logo with slogans, messages, pricing, or written statements or promises.
- Don't use the VSP name or logo in advertisements that contain any statement of price or offer of discounts (e.g., $25% off, "free sunglasses with any purchase," or "two pairs of glasses for the price of one.")
- Don't send mail to employees of a VSP client.
- Don't use the term "Vision Service Plan" or other VSP trademarked assets. You may only use VSP or VSP Vision Care when referring to your network participation.
- Don't use the VSP name and/or logo more than twice in a single media (e.g., the same advertisement, newsletter article, mailing, etc.)
- Don't refer to clients contracted with VSP (e.g., "Employees of ABC Inc. are accepted here.")

The marks "VSP," "Vision Service Plan," "Vision Care for Life", "VSP Vision Care" our registered logos and other VSP trademarked assets (the "VSP Marks") are registered or common law marks owned by VSP. Unauthorized use of VSP Marks may violate your Agreement with VSP.

Violation of your signed Agreement could result in monetary penalties, the revocation of your license agreement and/or VSP terminating its contract with you.

If your contract with VSP is terminated, you must immediately remove all references to your VSP network participation.

For questions or more information, please call **800.615.1883** or email: providernetworkdevelopment@vsp.com.

VSP Savings Statement

It is recommended that VSP doctors use the VSP Savings Statement with VSP patients. Studies show patients are more satisfied when they get a statement during an office visit.

Note:

You may use your own version of a savings statement (i.e., OfficeMate's patient fee slip); provided it contains similar information to the VSP Savings Statement reinforcing the value the patient receives from their coverage.

An automated version of the VSP Savings Statement is available when doctors submit a patient's claim through the Eyefinity® eClaim system. The statement is automatically completed based on a patient's claim information entered into eClaim and is available through the Report Window on **eyefinity.com**.

To help offices use the automated VSP Savings Statement, we've also implemented several new requirements:

- A patient signature is no longer required on the statement.
- If you dispense contact lenses or glasses, the automated statement can be provided when a patient picks up materials.
- Doctors don't need to keep a copy of patients' completed statements.

If patients don't order materials, please give them VSP Savings Statements during the office visit.

Doctors can get blank copies of the statement in the "Tools and Forms" section or under "Working with VSP" on **VSPOnline** at **eyefinity.com**. Doctors may give a paper copy to patients if they choose.

You can show you gave a savings statement by choosing the right check box when submitting claims through Eyefinity's eClaim system.

At this time, patients in the following plans and programs shouldn't get savings statements:

- Medicaid and SCHIPS
- VSP Primary EyeCare Plan℠
- VSP Diabetic Eyecare Plus Program℠
- VSP Laser VisionCare℠
- Vision Therapy
- Repair

VSP Electronic Funds Transfer and Explanation of Payment Policies

All VSP network doctors must be enrolled in Electronic Funds Transfer (EFT), also known as direct deposit. Doctors can enroll their practice online or call **800.615.1883**.

Printed Explanation of Payment (EOP) documents will not be mailed. EOPs are accessible through **eyefinity.com**. Call **800.615.1883** for assistance accessing your online EOP.

Resources

Glossary

Terms:	Definition:
Acute EyeCare	A VSP product covering patients who need urgent care.
Administrative Simplification	Administrative Simplification, or Title II of the Health Insurance Portability and Accountability Act (HIPAA), will standardize specific electronic transactions used in the healthcare industry. This requires protecting patient privacy and ensuring the security, integrity and authenticity of health information.
Algorithm	In this context, a step-by-step description of the suggested procedure for monitoring and/or treating certain conditions. Algorithms are intended to provide guidance only; they never replace a doctor's professional judgment.
Allowance	The maximum amount, in dollars, we will pay toward a certain service.
Authorization	The process of making sure a patient's eyecare may be covered by VSP. Authorization doesn't guarantee payment for a service.
Benefit	In this context, the type and amount of coverage for a service.
Birthday Rule	A way to determine the primary vision plan for dependent children covered by more than one plan. In this case, the primary plan is the one held by the parent whose birthday comes first in the calendar year.
Claim	A healthcare provider's request to a health plan for payment and the necessary accompanying information.
CMS-1500	Formerly HCFA-1500. A federally approved claim form used to record the patient's condition and bill for services rendered.
Coordination of Benefits	Also called COB. The process of coordinating multiple plans for a single patient visit.
Contract Lab	An optical lab that has signed a contract with us to make lenses for our patients.
Copay	Payment collected from a patient before services are given. Copays vary between plans, clients and levels of coverage.
Coverage	A term showing that the cost of a certain service provided to a patient will be reimbursed by us in part or in full.
CPT Code	"Current Procedural Technology Code." An identifying code and descriptive term used to report services and procedures.
Credentialing	The process of ensuring our doctors meet standards including current licensing and board certification, as applicable.
CVC	Video Display Terminal. This term is used mainly when talking about our Computer VisionCare plan.
Diabetic Eyecare Program	A VSP product that provides medical eyecare services for patients with Type 1 diabetes.
Dispensing	The process of providing materials, such as lenses, frames and contact lenses to patients.
Eligibility	Whether a patient can get VSP benefits.
Encounter Data	Detailed patient demographic, health and health insurance information collected from a CMS-1500 claim form.
Fee-For-Service Plan (FFS)	Health coverage in which doctors and other providers receive a fee for each service such as an office visit, test, procedure or other healthcare service. The plan will either pay the medical provider directly or reimburse the patient for covered services after the patient has paid the bill and filed an insurance claim. Patients can get medical care from doctors they choose.
First-Time Redo	The one-time remaking of a lens that falls within our first-time redo policy.
Frame Overage	The dollar amount patients must pay when they choose a frame whose cost exceeds both the patient's wholesale and retail frame allowance.
Gender Rule	A way to designate a primary vision plan for dependent children covered by more than one vision plan. In this case, the father usually holds the primary plan.
Half-Pair Lens enhancemen	Typically refers to a patient lens enhancement when the doctor or patient requests the enhancement on only one lens, rather than a pair of prescription lenses.
HCPCS	HCFA's Common Procedure-Coding System. A list of descriptive terms and identifying codes for reporting medical services given by healthcare providers.
Health Maintenance Organization (HMO)	A type of health plan that provides care through a network of doctors in particular geographic or service areas. HMOs coordinate the healthcare services patients receive.
HEDIS	Healthcare Effectiveness Data and Information Set. A set of standardized measures designed to assess health plan performance.
HIPAA	The Health Insurance Portability and Accountability Act (HIPAA) is federal legislation intended to improve the portability and continuity of health benefits, to ensure greater accountability for healthcare fraud and to simplify administering health insurance.
Independent Lab	An optical lab not under contract with us.
Interim Benefit	A supplemental benefit (offered by some VSP clients) that covers services before the patient's next eligibility date. Interim benefits particularly apply when there are significant changes in the patient's prescription.
IVR	Interactive Voice Response. This is our automated system allowing doctors to access patient eligibility and coverage by phone.

Terms:	Definition:
Laser VisionCare	A VSP eyecare plan offering coverage for laser procedures.
Lens Enhancements	Cosmetic lens features or enhancements. Patients pay the Patient Copay unless their plans cover that enhancement. Examples of lens enhancements include tints, polycarbonate and anti-reflective coatings.
Medical Record Review	Patient medical records are submitted to VSP and reviewed by OD/MD auditors who verify the exam and treatment for each patient follows established criteria and is properly documented.
Member	A person enrolled in a VSP plan who is the primary insured.
NCQA	National Committee for Quality Assurance. This is an independent, not-for-profit organization setting health plan accreditation standards.
Order of Benefits	The sequence in which benefits are exhausted, beginning with primary plans, secondary plans and then numerically succeeding plans.
Overage	Amount the patient pays the doctor (in addition to the copay) for services and products not covered by any plan.
Medical Record Review	Patient medical records are submitted to VSP and reviewed by OD/MD auditors who verify the exam and treatment for each patient follows established criteria and is properly documented.
PCP	Primary Care Physician. The doctor the patient usually visits.
Preferred Provider Organization (PPO	A fee-for-service option where a member can choose plan-selected providers who have agreements with the plan. When a member uses a PPO provider, they pay less money out-of-pocket for medical service than when they use a non-PPO provider.
Primary Coverage	In coordination of benefits, the primary coverage is held by the person whose benefits will be exhausted before benefits from secondary and other plans are used.
Primary EyeCare	A VSP product that provides supplemental medical eyecare services for the detection, treatment and management of ocular and/or systemic conditions that produce ocular or visual symptoms.
Primary Plan	The plan held by the person whose benefits are exhausted first, following the order of benefits.
Referral	The process doctors use to direct patients to consult with another doctor.
Reimbursement	Money paid to doctors for covered services
Explanation of Payment (EOP)	A statement explaining service payments and adjustments included in VSP doctor reimbursements. Also called an Explanation of Benefits (EOB) or Remittance Advice (RA).
Schedule of Allowances	A list of services patients are covered for, and the amounts to which patients are covered, according to their plans.
Secondary Allowance	The amount available for each benefit when VSP is the secondary plan.
Secondary Coverage	In coordination of benefits, secondary coverage is held by the person whose benefits are used after benefits from the primary plan have been exhausted.
Secondary Plan	The plan held by the person whose benefits are used after primary plan benefits have been used.
Service for Service	The secondary allowance is applied first to the same service or product of the primary plan (exam to exam, lens to lens, frame to frame, etc.). Any benefit amounts remaining after applying the allowance to a like benefit can be used for other services.
Service Verification	The process for making sure a service is covered and we'll reimburse you for that service before you give that service. You'll be notified which services need special processing to obtain a case number.
U&C; U&C Fees	Usual and Customary Fees. These are a doctor's standard, unmodified charges for given services.
VSP Network Doctor	An optometrist or ophthalmologist who's signed a contract to take part in our doctor network.