VSP® West Virginia Medicaid
Network Manual

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

Effective January 1, 2019

Note: This manual remains the sole and exclusive property of VSP. The information contained in this manual is confidential and proprietary, and the VSP network provider is granted a limited personal and nontransferrable license for use of the content of this manual during participation on the VSP network. The contents of this manual may not be used, copied, and/or reproduced for any other purpose, or disclosed and/or disseminated to any third party for any purpose whatsoever, without the prior written consent of VSP. If, for any reason, the manual recipient no longer participates on the VSP network, the doctor hereby agrees, and is directed, to immediately destroy this manual, all copies, and any and all amendments and addenda that may be issued by VSP from time to time.

VSP'S MEDICAID PLAN

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

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

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

ENROLLMENT/DOCTOR PARTICIPATION

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

Eligibility & Authorization

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

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

There are several ways to obtain an authorization:

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

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

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

Coordination of Benefits

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

EXAM COVERAGE

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

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

Referrals

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

MATERIALS COVERAGE

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

Lenses

Lenses are available to the patient based on state regulations.

Covered basic lenses are established by state regulations.

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

Frames

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

Visually Necessary Contact Lenses

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

LABORATORY

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

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

Lab Price Schedule

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

COST

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

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

Base lens includes:

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

SUBMITTING CLAIMS/BILLING & REIMBURSEMENT

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

Submit Medicaid claims:

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

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

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

Exams:

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

Exams or Materials:

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

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

Any exceptions are noted in the Client Detail pages.

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

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

Coordination of Benefits

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

For Electronic Claims

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

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

For Paper Claims

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

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

WEST VIRGINIA MEDICAID CLIENT DETAILS

Effective September 26, 2016, CoventryCares changed its name to Aetna Better Health of West Virginia.

Coverage can vary by client. Please make sure to check eligibility before providing services to patients. Please review client's special handling information below:

- Traditional Medicaid Program
- Mountain Health Choices

Member Identification Number

Members are reported by an 11-digit identification number.

Traditional Medicaid Program

Exam

AETNA BETTER HEALTH MEMBERS

20 and under: Members are eligible for exam every 12 months.

21 and over: Members are eligible for an exam every 12 months.

UNICARE MEMBERS

20 and under: Members are eligible for exam every 12 months.

21 and over: Members are covered for post-cataract services. See **Post Cataract Enhancement Clients** for complete information.

UniCare members with diabetes are entitled to one routine exam every 12 months. Call VSP at **800.615.1883** to obtain an authorization number.

Note: Bill annual eye exams for diabetic patients without ocular complications or symptoms as a routine exam. If, during the course of the routine exam, you discover a medical condition, you should still report and bill the visit as routine. You can then follow up with additional services and/or procedures, as appropriate, to treat or monitor the pathology and bill the appropriate medical CPT codes.

Materials Eligibility

20 and under: Members are eligible for materials every 12 months.

- Photochromic lenses are covered for members with a diagnosis of albinism (E70.20 - E70.9)
- Ultraviolet lenses are covered for members with a diagnosis of aphakia (H27.00 - H27.03, Q12.3, Z96.1)

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

---

21 and over: Members are eligible for visually necessary contact lenses every 12 months. See Visually Necessary Contact Lenses.

Visually Necessary Contact Lenses

20 and under:

- Aphakia
- Keratoconus
- Anisometropia
- Anisekonia

21 and over:

- Surgical aphakia (unilateral or bilateral, but not pseudoaphakia).
- Keratoconus

Piggyback lenses are a covered benefit for patients who aren't able to tolerate rigid gas permeable contact lenses. This requires the use of soft contact lenses and rigid gas permeable contact lenses, in the manner of a piggyback fitting. When submitting a claim for piggyback lenses you must bill for both soft and rigid contact lenses in conjunction with modifier KX. In Box 19 indicate **Piggyback Lenses**.

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

GLASSES TO WEAR OVER CONTACTS BENEFIT

Spectacle lenses with frame to wear over visually necessary contacts are covered benefits for patients with the following conditions:

- Aphakia
- H27.01 - H27.03 or Q12.
- High ametropia — 10.00 diopters or greater
  - Presbyopia
- H52.4
  - Accommodative disorder
  - Binocular function disorder
  - Different prism requirements for distance and near vision
  - Keratoconus*

A prescription is required for the lenses. When glasses are visually necessary to wear over contact lenses, call VSP at **800.615.1883** to request the spectacle lenses and frame authorization number at the same time or within 30 days of the contact lens claim submission date.

*For patients with keratoconus, request an authorization number for spectacle lenses and frame to be worn over contacts within 12 months of the contact lens claim submission date. Please have the relevant criteria information available when calling. Visual necessity must be documented in the patient's file.

Low Vision

Low vision evaluations, low vision aids, and fitting of low vision aids are covered if visually necessary. Call VSP at **800.615.1883** to obtain an authorization number for Low Vision claim(s).

EXAM SERVICES

To report low vision evaluations and fitting of low vision aids, use CPT code 92499.

LOW VISION AIDS

Only basic and essential low vision aids are a benefit. Please submit a manufacturer's invoice.

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

Vision Therapy

20 and under: Vision Therapy is covered. Call VSP at **800.615.1883** to obtain an authorization number for Vision Therapy claim(s). Bill exam services (92060) and/or vision therapy sessions.

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

21 and over: Vision Therapy is not covered.

Patient Responsibility

COVERED SERVICES/MATERIALS

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

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

NON-COVERED SERVICES/MATERIALS

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

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

purchase non-covered services or materials as a private-pay customer. Keep the form in the patient's records.

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

MISSED APPOINTMENTS

Medicaid members may not be billed for missed appointments.

Repair

20 and under: Members are covered for repair. The repair must be cost-efficient and not exceed the cost of new eyeglasses (*e.g.,* lenses or frames are damaged, scratched or bent but may be repaired and refitted instead of replaced). Repair is unlimited. Authorization is required; please call VSP at **800.615.1883** for an authorization number. Document repairs in the patient's medical record.

21 and over: Members are not covered.

Replacement

20 and under: Members are covered for replacement. Authorization is required; please call VSP at **800.615.1883** for an authorization number.

Complete Replacements: Covers one replacement pair of eyeglasses (between eye exams) due to loss, breakage or theft, once every 12 months. A complete replacement includes both the lenses and the frame. Frame will be replaced only when the patient's current frame can no longer be used. Lenses will be replaced for members who meet one of the following criteria:

- Vertical prism change of 1D
- Horizontal prism change of 3D or more
- Sphere change of ±0.50D
- Axis change of 10° for prescriptions less than 1D cylinder
- Axis change of 5° for prescriptions from 1D to 2D cylinder
- Axis change of 2.5° for prescriptions 2.25D cylinder or greater
- Any change that provides one line improvement on the standard visual acuity chart
- Breakage or loss of a lens or lenses

Individual replacement of frames or lenses is a covered benefit as long as the criteria listed above is met. Additionally, these replacements must be cost effective and may not exceed the cost of new eyeglasses.

21 and over: Members are not covered.

Mountain Health Choices

BASIC CHILD – UNICARE ONLY

20 and under: Members in this program are subject to a $750 annual maximum allowance for all services and materials.You can balance bill the patient for any amount beyond the $750 annual maximum allowance.

Contact lenses are not a covered benefit.

Repair

All repairs are subject to a $750 annual maximum. For Repair criteria, please refer to the Repair section under the Traditional Program above.

Replacement

All replacements are subject to a $750 annual maximum. For Replacement criteria, please refer to the Replacement section under the Traditional Program above.

Low Vision

All Low Vision services and materials are subject to a $750 annual maximum. For Low Vision criteria, please refer to the Low Vision section under the Traditional Program above.

Vision Therapy

All Vision Therapy services are subject to a $750 annual maximum. For Vision Therapy criteria, please refer to the Vision Therapy section under the Traditional Program above.

ENHANCED CHILD – UNICARE ONLY

MATERIALS ELIGIBILITY

Both eyeglasses and elective contact lens services and materials are covered once every 12 months.

Elective Contact Lenses

Contact lens services and materials are subject to a $120 annual maximum allowance. You can balance bill the patient for any amount beyond the $120 annual maximum allowance.

Visually Necessary Contact Lenses

Members are covered for visually necessary contact lenses in lieu of glasses. See Visually Necessary Contact Lenses under the Traditional Medicaid Program section for specific benefit coverage criteria.

Lenses

20 and under:

- Photochromic lenses are covered for members with a diagnosis of albinism (E70.20 - E70.9)
- Ultraviolet lenses are covered for members with a diagnosis of aphakia (H27.00 - H27.03, Q12.3, Z96.1)

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

Repair

For Repair criteria, please refer to the Repair section under the Traditional Program above.

Replacement

Replacements may be authorized once every twelve months due to loss, breakage, or theft. Contact lens replacements are allowed if the one of the prescriptive criteria listed under Replacement under the Traditional Program above is met.

Low Vision

Low Vision is covered for children. For Low Vision criteria, please refer to the Low Vision section under the Traditional Program above.

Vision Therapy

Vision Therapy is covered for children. For Vision Therapy criteria, please refer to the Vision Therapy section under the Traditional Program above.

Primary EyeCare

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

Covered benefits are administered according to the VSP policies and procedures in effect upon the date of service. Please click on the appropriate link below to view covered procedure codes for your state. Please note codes are only covered when appropriate based on your scope of licensure as well as the current laws, rules and regulations as determined by the State and Federal Government.

Primary EyeCare

VSP WEST VIRGINIA MEDICAID PLAN

PROFESSIONAL FEE SCHEDULE FOR ROUTINE SERVICES

Effective 4/1/2016

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

Note: Codes S0580 (Polycarbonate add-on, per lens) and S0590 (Integral lens service, miscellaneous) are temporary HCPCS codes. The "Calculate HCPCS and Continue" button on eClaim does not populate these temporary codes. To ensure correct payment, please manually enter S0580 or S0590 when billing for these services.

Exam Services

92002	Intermediate exam, new patient	$54.03
92004	Comprehensive exam, new patient	$99.94
92012	Intermediate exam, established patient	$56.92
92014	Comprehensive exam, established patient	$83.15
92015	Determination of refractive state	$14.16

Dispensing

Dispensing of eyeglasses is included in the payment of the spectacle lenses		
92340	**Fitting of spectacles, except for aphakia; monofocal**	**$0.00**
92341	**Fitting of spectacles, except for aphakia; bifocal**	**$0.00**
92342	**Fitting of spectacles, except for aphakia; multifocal, other than bifocal**	**$0.00**
92352	Fitting of spectacle prosthesis for aphakia; monofocal	**$0.00**
92353	Fitting of spectacle prosthesis for aphakia; multifocal	**$0.00**

Frames

V2020	Frames (includes case)	$70.00
V2756	Eye glass case	$0.00

Spectacle Services

Single Vision Lens, glass or plastic, per lens:		
V2100	Sphere, plano to ± 4.00D	$15.86
V2101	Sphere, ± 4.12 to ± 7.00D	$21.00
V2102	Sphere, ± 7.12 to ± 20.00D	$22.75
V2103	Spherocylinder, plano to ± 4.00D sphere, 0.12 to 2.00D cylinder	$21.35
V2104	Spherocylinder, plano to ± 4.00D sphere, 2.12 to 4.00D cylinder	$21.35

Single Vision Lens, glass or plastic, per lens:		
V2105	Spherocylinder, plano to ± 4.00D sphere, 4.25 to 6.00D cylinder	$24.83
V2106	Spherocylinder, plano to ± 4.00D sphere, over 6.00D cylinder	$26.58
V2107	Spherocylinder, ± 4.25 to ± 7.00D sphere, 0.12 to 2.00D cylinder	$23.08
V2108	Spherocylinder, ± 4.25d to ± 7.00D sphere, 2.12 to 4.00D cylinder	$24.83
V2109	Spherocylinder, ± 4.25 to ± 7.00D sphere, 4.25 to 6.00D cylinder	$26.58
V2110	Spherocylinder, ± 4.25 to ±7.00D sphere, over 6.00D cylinder	$28.33
V2111	Spherocylinder, ± 7.25 to ± 12.00D sphere, 0.25 to 2.25D cylinder	$24.83
V2112	Spherocylinder, ± 7.25 to ± 12.00D sphere, 2.25 to 4.00D cylinder	$26.58
V2113	Spherocylinder, ± 7.25 to ± 12.00D sphere, 4.25 to 6.00D cylinder	$29.75
V2114	Spherocylinder, sphere over ± 12.00D	$33.25
V2115	Lenticular lens, myodisc	$52.50
V2118	Aniseikonic lens, single	$26.58
V2121	Lenticular lens, single	$52.50
V2199	Specialty single vision	$33.25

Bifocal Lens, glass or plastic, per lens:		
V2200	Sphere, plano to ± 4.00D	$19.60
V2201	Sphere, ± 4.12 to ± 7.00D	$24.50
V2202	Sphere, ± 7.12 to ± 20.00D	$26.25
V2203	Spherocylinder, plano to ± 4.00D sphere, 0.12 to 2.00D cylinder	$24.85
V2204	Spherocylinder, plano to ± 4.00D sphere, 2.12 to 4.00D cylinder	$24.85
V2205	Spherocylinder, plano to ± 4.00D sphere, 4.25 to 6.00D cylinder	$28.35
V2206	Spherocylinder, plano to ± 4.00D sphere, over 6.00D cylinder	$30.10
V2207	Spherocylinder, ± 4.25 to ± 7.00D sphere, 0.12 to 2.00D cylinder	$26.60
V2208	Spherocylinder, ± 4.25 to ± 7.00D sphere, 2.12 to 4.00D cylinder	$28.35
V2209	Spherocylinder, ± 4.25 to ± 7.00D sphere, 4.25 to 6.00D cylinder	$30.10
V2210	Spherocylinder, ± 4.25 to ± 7.00D sphere, over 6.00D cylinder	$31.85
V2211	Spherocylinder, ± 7.25 to ± 12.00D sphere, 0.25 to 2.25D cylinder	$28.35
V2212	Spherocylinder, ± 7.25 to ± 12.00D sphere, 2.25 to 4.00D cylinder	$30.10
V2213	Spherocylinder, ± 7.25 to ± 12.00D sphere, 4.25 to 6.00D cylinder	$33.25
V2214	Spherocylinder, sphere over ± 12.00D	$36.75
V2215	Lenticular, myodisc	$52.50
V2218	Aniseikonic lens, bifocal	$30.10
V2219	Lens bifocal seg width over 28 mm	$29.00
V2220	Add over 3.25D	$24.00
V2221	Lenticular lens, bifocal	$52.50
V2299	Specialty bifocal	$36.75

Trifocal Lens, glass or plastic, per lens:		
V2300	Sphere, plano to ± 4.00D	$23.10

Trifocal Lens, glass or plastic, per lens:		
V2301	Sphere, ± 4.12 to ± 7.00D	$28.00
V2302	Sphere, ± 7.12 to ± 20.00D	$29.75
V2303	Spherocylinder, plano to ± 4.00D sphere, 0.12 to 2.00D cylinder	$28.35
V2304	Spherocylinder, plano to ± 4.00D sphere, 2.25 to 4.00D cylinder	$30.10
V2305	Spherocylinder, plano to ± 4.00D sphere, 4.25 to 6.00D cylinder	$31.85
V2306	Spherocylinder, plano to ± 4.00D sphere, over 6.00D cylinder	$33.60
V2307	Spherocylinder, ± 4.25 to ± 7.00D sphere, 0.12 to 2.00D cylinder	$30.10
V2308	Spherocylinder, ± 4.25 to ± 7.00D sphere, 2.12 to 4.00D cylinder	$31.85
V2309	Spherocylinder, ± 4.25 to ± 7.00D sphere, 4.25 to 6.00D cylinder	$33.60
V2310	Spherocylinder, ± 4.25 to ± 7.00D sphere, over 6.00D cylinder	$35.35
V2311	Spherocylinder, ± 7.25 to ± 12.00D sphere, 0.25 to 2.25D cylinder	$31.85
V2312	Spherocylinder, ± 7.25 to ± 12.00D sphere, 2.25 to 4.00D cylinder	$33.60
V2313	Spherocylinder, ± 7.25 to ± 12.00D sphere, 4.25 to 6.00D cylinder	$36.75
V2314	Spherocylinder, sphere over ± 12.00D	$40.25
V2315	Lenticular, myodisc	$52.50
V2318	Aniseikonic lens, trifocal	$33.60
V2319	Lens trifocal seg width over 28 mm	$34.00
V2320	Add over 3.25D	$29.00
V2321	Lenticular lens, trifocal	$52.50
V2399	Specialty trifocal	$40.25

Variable Asphericity Lens, glass or plastic, per lens:		
V2410	Variable asphericity, single vision, full field	$98.00
V2430	Variable asphericity, bifocal, full field	$118.00
V2499	Variable asphericity, other type	$118.00

Miscellaneous Covered Options and Services, per lens:		
S0580	Polycarbonate add-on	$13.50
V2700	Balance lens	$21.51
V2710	Slab off prism, glass or plastic	$28.00
V2715	Prism	$10.50
V2718	Press-on lens, Fresnel prism	$17.80
V2730	Special base curve, glass or plastic	$10.50
V2770	Occluder lens	$7.00
V2780	Oversize lens	$5.25
Miscellaneous Covered Options and Services, per lens: Services must be billed with modifier KX. Visual necessity must be documented in the patient's file.		
V2744	Photochromatic. See **West Virginia Medicaid Client Details** for required diagnosis codes.	$10.50

Miscellaneous Covered Options and Services, per lens:		
V2755	Ultraviolet lens. See **West Virginia Medicaid Client Details** for covered conditions.	$8.75
V2799	Vision item or service, miscellaneous	Submit invoice for pricing*
S0590	Integral lens service, miscellaneous (reported separately)	$5.00
92499	Unlisted ophthalmological service or procedure	Submit invoice for pricing*

Repair and Refitting:		
92370	Repair and refitting of spectacles, except for aphakia	$20.72
92371	Repair and refitting of spectacles for aphakia	$7.34

Contact Lenses

Visually Necessary Contact Lenses Contacts are only allowed by the Medicaid Plan when visually necessary according to Medicaid's guidelines. Service must be billed with modifier KX. See **VSP West Virginia Medicaid Client Details** for requirements. Visual necessity must be documented in the patient's file.		Maximum allowance per eye
V2500	PMMA, spherical	$76.05
V2501	PMMA, toric or prism ballast	$115.84
V2502	PMMA, bifocal	$142.70
V2503	PMMA, color vision deficiency	$131.43
V2510	Gas permeable, spherical	$103.81
V2511	Gas permeable, toric, prism ballast	$149.16
V2512	Gas permeable, bifocal	$176.12
V2513	Gas permeable, extended wear	$147.98
V2520	Hydrophilic, spherical	$97.58
V2521	Hydrophilic, toric, or prism ballast	$169.88
V2522	Hydrophilic, bifocal	$165.33
V2523	Hydrophilic, extended wear	$140.89
V2530	Scleral, gas permeable	$208.68
V2599	Not otherwise classified	$169.88

Visually Necessary Contact Lenses Fitting and Dispensing
Contacts are only allowed by the Medicaid Plan when visually necessary according to Medicaid's guidelines. Service must be billed with modifier KX. See **VSP West Virginia Medicaid Client Details** for requirements. Visual necessity must be documented in the patient's file.

92310	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia	$65.31
92311	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, for aphakia, one eye	$66.89
92312	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, for aphakia, both eyes	$76.59
92313	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneoscleral lens	$63.21
92314	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens, both eyes, except for aphakia	$52.72
92315	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens for aphakia, one eye	$46.16
92316	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens for aphakia, both eyes	$58.23
92317	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneoscleral lens	$48.53
92325	Modification of contact lens (separate procedure), with medical supervision of adaptation	$25.71
92326	Replacement of contact lens	$21.77

Low Vision Aids

Low Vision Aids are only allowed by the Medicaid Plan when visually necessary according to Medicaid's guidelines. Service must be billed with modifier KX. Visual necessity must be documented in the patient's file.		
V2600	Hand held low vision aids and other nonspectacle mounted aids	Submit invoice for pricing*
V2610	Single lens spectacle mounted low vision aids	Submit invoice for pricing*
V2615	Telescopic and other compound lens system, including distance vision telescopic, near vision telescopes and compound microscopic lens system	Submit invoice for pricing*

Vision Therapy

Vision Therapy services must be billed with modifier KX. Visual necessity must be documented in the patient's file.		
92060	Sensorimotor evaluation	$43.54
92065	Orthoptic and/or pleoptic training	$33.84

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

PO Box 997100
Sacramento, CA 95899-7100
800.615.1883
vsp.com