VSP® New Hampshire Medicaid
Network Manual

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

EFFECTIVE JANUARY 1, 2021

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VSP'S MEDICAID PLAN

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

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

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

ENROLLMENT/DOCTOR PARTICIPATION

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

Eligibility & Authorization

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

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

There are several ways to obtain an authorization:

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

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

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

Coordination of Benefits

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

EXAM COVERAGE

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

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

For Telemedicine information refer to: Telemedicine.

Referrals

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

CPT Category II Codes for Eye Exams for Patients with Diabetes

As a health-focused vision care company, VSP highly encourages providers to use CPT Category II codes. The use of Category II codes for Healthcare Effectiveness Data and Information Set (HEDIS®) performance measures helps confirm that you are providing the best quality patient care and further emphasizes the essential role Doctor of Optometry play in overall healthcare. Providing this information also decreases the administrative burden of pulling chart notes for requested patients.

WHAT ARE CPT CATEGORY II CODES?

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

BILLING CPT CATEGORY II CODES

- CPT Category II codes are billed in the procedure code field, the same as CPT Category I codes.
- Bill CPT Category II codes with a $0.00 charge amount.
- If you receive a claim denial, your reporting code will still be included in the quality measure.

When billing eye exams for patients with diabetes use the following optometry-related CPT Category II codes, when applicable:

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

MATERIALS COVERAGE

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

Lenses

Lenses are available to the patient based on state regulations.

Covered basic lenses are established by state regulations.

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

Repair and Refitting Spectacles

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

Do not bill a dispensing code for repairs.

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

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

Replacement

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

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

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

Frames

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

Visually Necessary Contact Lenses

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

LABORATORY

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

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

Lab Price Schedule

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

COST

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

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

Base lens includes:

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

SUBMITTING CLAIMS/BILLING & REIMBURSEMENT

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

Submit Medicaid claims:

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

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

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

Exams:

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

Exams or Materials:

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

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

Any exceptions are noted in the Client Detail pages.

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

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

Coordination of Benefits

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

For Electronic Claims

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

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

For Paper Claims

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

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

NEW HAMPSHIRE MEDICAID CLIENT DETAILS

Member Identification Number

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

Medicaid Appointment Availability Requirements

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

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

Exam

Members are eligible once every 12 months.

Materials Eligibility

Members are eligible once every 12 months.

FRAME

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

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

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

LENSES

diopter. The refractive error is at least plus or

minus .50 diopter according to the type of refractive error, in each eye.

TWO PAIR IN LIEU OF BIFOCALS

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

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

- Cannot wear bifocal satisfactorily
- Patient currently has two pairs of eyeglasses
- There is a safety concern.

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

TRIFOCAL LENS

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

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

LENS ENHANCEMENTS

Polycarbonate lenses are covered for all ages.

The following lens enhancements are covered if visually necessary:

- Tints
- Photochromic
- Progressive
- AR
- UV
- Polarization
- High Index

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

MISCELLANEOUS VISION SERVICES

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

VISUALLY NECESSARY CONTACT LENSES

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

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

Bill with the appropriate diagnosis codes and modifier KX for the visually necessary contact lens fitting/dispensing, and visually necessary contact lenses. Visual necessity must be documented in the patient's file.

VISION THERAPY

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

Patient Responsibility

COVERED SERVICES/MATERIALS

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

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

NON-COVERED SERVICES/MATERIALS

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

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

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

MISSED APPOINTMENTS

Medicaid members may not be billed for missed appointments.

Repair

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

Replacement

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

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

Timely Filing

Providers must file claims within one hundred and twenty (120) days from the date of service to ensure compliance with New Hampshire Medicaid guidelines. Claims received outside of this timeframe may be denied for untimely submission.

Primary EyeCare Coverage

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

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

Primary EyeCare

Americans with Disability Access Guidelines

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

Patient Rights and Responsibilities

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

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

VSP NEW HAMPSHIRE MEDICAID PLAN

WELL SENSE HEALTH PLAN
PROFESSIONAL FEE SCHEDULE FOR ROUTINE SERVICES

Effective 5/1/2020

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

Exam Services

92002	Intermediate exam, new patient	$ 42.35
92004	Comprehensive exam, new patient	$ 77.33
92012	Intermediate exam, established patient	$ 38.87
92014	Comprehensive exam, established patient	$ 60.89
92015	Determination of refractive state	$ 21.84
S0620	Routine ophthalmological examination including refraction; new patient	$ 99.17
S0621	Routine ophthalmological examination including refraction; established patient	$ 82.73

Dispensing and Material Services

92340	Fitting of spectacles, except for aphakia; monofocal	$ 25.78
92341	Fitting of spectacles, except for aphakia; bifocal	$ 33.51
92342	Fitting of spectacles, except for aphakia; multifocal	$ 16.50

Frames

V2020	Frame	$30.93
V2025	Deluxe frame (Medicare COB Only) See VSP New Hampshire Medicaid Client Details.	Submit Medicare EOB or EOP for pricing*
V2756	Eye glass case	$0.52

Spectacle Lenses

Single Vision Lenses, per lens (Scratch resistant coating included in lens fee):		
V2100	Sphere, plano to ± 4.00d	$ 5.98
V2101	Sphere, ± 4.12 to ± 7.00d	$ 7.25
V2102	Sphere, ± 7.12 to ± 20.00d	$ 10.90
V2103	Spherocylinder, plano to ± 4.00d sphere, 0.12 to 2.00d cylinder	$ 10.92
V2104	Spherocylinder, plano to ± 4.00d sphere, 2.12 to 4.00d cylinder	$ 9.54
V2105	Spherocylinder, plano to ± 4.00d sphere, 4.25 to 6.00d cylinder	$ 10.68

Single Vision Lenses, per lens (Scratch resistant coating included in lens fee):		
V2106	Spherocylinder, plano to ± 4.00d sphere, over 6.00d cylinder	$ 10.92
V2107	Spherocylinder, ± 4.25 to ± 7.00d sphere, 0.12 to 2.00d cylinder	$ 8.17
V2108	Spherocylinder, ± 4.25 to ± 7.00d sphere, 2.12 to 4.00d cylinder	$ 9.99
V2109	Spherocylinder, ± 4.25 to ± 7.00d sphere, 4.25 to 6.00d cylinder	$ 10.64
V2110	Spherocylinder, ± 4.25 to ± 7.00d sphere, over 6.00d cylinder	$ 10.88
V2111	Spherocylinder, ± 7.25 to ± 12.00d sphere, 0.25 to 2.25d cylinder	$ 11.07
V2112	Spherocylinder, ± 7.25 to ± 12.00d sphere, 2.25 to 4.00d cylinder	$ 11.29
V2113	Spherocylinder, ± 7.25 to ± 12.00d sphere, 4.25 to 6.00d cylinder	$ 13.73
V2114	Spherocylinder, sphere over ± 12.00d	$ 21.09
V2115	Lenticular, myodisc	$ 20.92
V2118	Lens, aniseikonic single	$ 20.92
V2121	Lenticular lens, single	$ 21.72
V2199	Specialty single vision	Submit invoice for pricing*

Bifocal Lenses, per lens (Scratch resistant coating included in lens fee):		
V2200	Sphere, plano to ± 4.00d	$ 8.52
V2201	Sphere, ± 4.12 to ± 7.00d	$ 10.84
V2202	Sphere, ± 7.12 to ± 20.00d	$ 15.83
V2203	Spherocylinder, plano to ± 4.00d sphere, 0.12 to 2.00d cylinder	$ 15.79
V2204	Spherocylinder, plano to ± 4.00d sphere, 2.12 to 4.00d cylinder	$ 10.97
V2205	Spherocylinder, plano to ± 4.00d sphere, 4.25 to 6.00d cylinder	$ 11.07
V2206	Spherocylinder, plano to ± 4.00d sphere, over 6.00d cylinder	$ 14.05
V2207	Spherocylinder, ± 4.25 to ± 7.00d sphere, 0.12 to 2.00d cylinder	$ 11.01
V2208	Spherocylinder, ± 4.25 to ± 7.00d sphere, 2.12 to 4.00d cylinder	$ 11.13
V2209	Spherocylinder, ± 4.25 to ± 7.00d sphere, 4.25 to 6.00d cylinder	$ 10.85
V2210	Spherocylinder, ± 4.25 to ± 7.00d sphere, over 6.00d cylinder	$ 14.90
V2211	Spherocylinder, ± 7.25 to ± 12.00d sphere, 0.25 to 2.25d cylinder	$ 11.82
V2212	Spherocylinder, ± 7.25 to ± 12.00d sphere, 2.25 to 4.00d cylinder	$ 11.77
V2213	Spherocylinder, ± 7.25 to ± 12.00d sphere, 4.25 to 6.00d cylinder	$ 24.68
V2214	Spherocylinder, sphere over ± 12.00d	$ 41.04
V2215	Lenticular, myodisc	$ 34.32
V2218	Lens aniseikonic bifocal	$ 37.41
V2219	Lens bifocal seg width over	$ 7.22
V2220	Add over 3.25d	$ 7.22
V2221	Lenticular lens, bifocal	$ 24.23
V2299	Specialty bifocal	Submit invoice for pricing*

Trifocal Lenses, per lens (Scratch resistant coating included in lens fee): Trifocal lenses are only allowed by the Medicaid Plan when visually necessary. Service must be billed with modifier KX. Visual necessity must be documented in the patient's file. See VSP New Hampshire Medicaid Client Details.		
V2300	Sphere, plano to ± 4.00d	$ 11.87
V2301	Sphere, ± 4.12 to ± 7.00d	$ 12.46
V2302	Sphere, ± 7.12 to ± 20.00d	$ 21.95
V2303	Spherocylinder, plano to ± 4.00d sphere, 0.12 to 2.00d cylinder	$ 12.18
V2304	Spherocylinder, plano to ± 4.00d sphere, 2.25 to 4.00d cylinder	$ 12.22
V2305	Spherocylinder, plano to ± 4.00d sphere, 4.25 to 6.00d cylinder	$ 12.79
V2306	Spherocylinder, plano to ± 4.00d sphere, over 6.00d cylinder	$ 20.49
V2307	Spherocylinder, ± 4.25 to ± 7.00d sphere, 0.12 to 2.00d cylinder	$ 21.04
V2308	Spherocylinder, ± 4.25 to ± 7.00d sphere, 2.12 to 4.00d cylinder	$ 20.13
V2309	Spherocylinder, ± 4.25 to ± 7.00d sphere, 4.25 to 6.00d cylinder	$ 20.23
V2310	Spherocylinder, ± 4.25 to ± 7.00d sphere, over 6.00d cylinder	$ 20.23
V2311	Spherocylinder, ± 7.25 to ± 12.00d sphere, 0.25 to 2.25d cylinder	$ 22.36
V2312	Spherocylinder, ± 7.25 to ± 12.00d sphere, 2.25 to 4.00d cylinder	$ 22.36
V2313	Spherocylinder, ± 7.25 to ± 12.00d sphere, 4.25 to 6.00d cylinder	$ 22.36
V2314	Spherocylinder, sphere over ± 12.00d	$ 22.36
V2315	Lenticular, myodisc	$ 33.81
V2318	Lens aniseikonic trifocal	$ 33.81
V2319	Lens trifocal seg width > 28	$ 4.64
V2320	Add over 3.25d	$ 4.64
V2321	Lenticular lens, trifocal	$ 9.06
V2399	Specialty trifocal	Submit invoice for pricing*

Variable Asphericity Lenses, per lens (Scratch resistant coating included in lens fee):		
V2410	**Variable asphericity lens; s**ingle vision, full field, glass or plastic	$ 35.35
V2430	**Variable asphericity lens;** bifocal, full field, glass or plastic	$ 35.35
V2499	**Variable asphericity lens; o**ther type	Submit invoice for pricing*

Miscellaneous Covered Options and Services, per lens:		
V2700	Balance lens	$ 5.16
V2710	Slab off prism, glass or plastic	$ 29.35
V2715	Prism	$ 2.58
V2718	Press-on lens, Fresnell prism	$ 18.12
V2730	Special base curve, glass or plastic	$ 5.16
V2760	Scratch resistant coating is included in the fee for spectacle lens	$ 0.00

Miscellaneous Covered Options and Services, per lens:		
V2784	Lens, polycarbonate or equal, any index	$ 3.09
Miscellaneous Covered Options and Services, per lens: Service must be billed with modifier KX. See VSP New Hampshire Medicaid Client Details for requirements. Visual necessity must be documented in the patient's file.		
V2744	Tint, photochromic	$ 27.27
V2745	Addition to lens, tint, any color, solid, gradient or equal (excludes photochromic, any lens material)	$ 5.16
V2750	Antireflective coating	$ 10.31
V2755	UV lens	$ 5.16
V2762	Polarization, any lens material	$ 18.03
V2770	Occluder lens	$ 5.16
V2781	Progressive lens	Submit invoice for pricing*
V2782	Lens, index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbonate	$ 18.03
V2783	Lens, index greater than or equal to 1.66 plastic or greater than or equal to 1.80 glass, excludes polycarbonate	$ 18.03
V2799	Miscellaneous vision service	Submit invoice for pricing*

Repair and Refitting

92370	Repair and refitting spectacles, except aphakia	$ 15.47

Visually Necessary Contact Lenses

Visually Necessary Contact Lenses: Contacts are only allowed by the Medicaid Plan when visually necessary according to Medicaid's guidelines. Service must be billed with modifier KX. See VSP New Hampshire Medicaid Client Details for requirements. Visual necessity must be documented in the patient's file.		Maximum allowance per eye
V2500	PMMA, spherical	$100.00
V2501	PMMA, toric or prism ballast	$150.00
V2502	PMMA, bifocal	$150.00
V2503	PMMA, color vision deficiency	$100.00
V2510	Gas permeable, spherical	$100.00
V2511	Gas permeable, toric or prism ballast	$150.00
V2512	Gas permeable, bifocal	$150.00
V2513	Gas permeable, extended wear	$150.00
V2520	Hydrophilic, spherical	$100.00
V2521	Hydrophilic, toric or prism ballast	$150.00
V2522	Hydrophilic, bifocal	$150.00

V2523	Hydrophilic, extended wear	$150.00
V2530	Scleral	$164.63
V2531	Scleral, gas permeable	$309.14
V2599	Contact lens, other type	Submit invoice for pricing*

Visually Necessary Contact Lens Fitting and Dispensing Contacts lens fitting is only allowed by the Medicaid Plan when visually necessary according to Medicaid's guidelines. Service must be billed with modifier KX. See VSP New Hampshire Medicaid Client Details for requirements. Visual necessity must be documented in the patient's file.		
92072	Fitting of contact lens for management of keratoconus, initial fitting	$ 53.99
92310	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia	$ 25.78
92311	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, for aphakia, one eye	$ 43.30
92312	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, for aphakia, both eyes	$ 49.49
92313	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneoscleral lens	$ 37.12
92314	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and fitting by independent technician; corneoscleral lens, both eyes except for aphakia	$ 40.18
92315	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and fitting by independent technician; corneal lens for aphakia, one eye	$ 27.84
92316	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and fitting by independent technician; corneal lens for aphakia, both eyes	$ 34.02
92317	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and fitting by independent technician; corneoscleral lens	$ 18.56
92325	Modification of contact lens (separate procedure), with medical supervision of adaptation	$ 9.49
92326	Replacement of contact lens, single or both; maximum two units	$ 30.19

Vision Therapy

92060	Sensorimotor examination with multiple measurements of ocular deviation with interpretation and report	$ 21.65

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

MEDICAID ADDENDUM TO NETWORK DOCTOR AGREEMENT FOR THE STATE OF NEW HAMPSHIRE

The conditions and provisions set forth in this Addendum apply to health care services provided to Members enrolled in the Medicaid Care Management Program and the Managed Care Organization Program (herein "Members"). This Addendum shall form a part of the Network Doctor Agreement.

1. The MCO, VSP, and ND, shall adhere to all applicable State and federal laws and applicable regulations and sub-regulatory guidance which provides further interpretation of law, including subsequent revisions and any applicable federal and state laws that pertain to Member rights.
2. ND shall comply with the applicable provisions of the following:
   - Medicare: Title XVII of the Social Security Act, as amended; 42 U.S.C.A. Section 1395 et. seq.; related rules: Title 42 Chapter IV
   - Medicaid: Title XIX of the Social Security Act, as amended; 42 U.S.C.A. Section 1396 et seq. (specific to managed care: Section 1902(a)(4), 1903(m), 1905(t), and 1932 of the SSA); Related rules: Title 42 Chapter IV (specific to managed care: 42 CFR Section 438; see also 431 and 435)
   - CHIP: Title XXI of the Social Security Act, as amended; 42 U.S.C. 1397; Regulations promulgated thereunder: 42 CFR 457; 3.13.1.2.4 Regulations related to the operation of a waiver program under 1915c of the Social Security Act, including: 42 CFR 430.25, 431.10, 431.200, 435.217, 435.726, 435.735, 440.180, 441.300-310, and 447.50-57
   - State administrative rules and laws pertaining to transfers and discharges, such as RSA 151:26
   - State administrative rules and laws pertaining to confidentiality
   - American Recovery and Reinvestment Act
   - Title VI of the Civil Rights Act of 1964
   - The Age Discrimination Act of 1975
   - The Rehabilitation Act of 1973
   - Title IX of the Education Amendments of 1972 (regarding education programs and activities)
   - The ADA
   - 42 CFR Part 2;
   - Section 1557 of the of the Affordable Care Act. [42 CFR438.3(f)(1); 42 CFR 438.100(d)]
   - The provisions of Executive Order 11246, Equal Opportunity, dated September 24, 1965, and all rules and regulations issued thereunder, and any other laws, regulations, or orders which prohibit discrimination on grounds of age, race, ethnicity, mental or physical disability, sexual or affection orientation or preference, marital status, genetic information, source of payment, sex, color, creed, religion, or national origin or ancestry. [42 CFR 438.3(d)(4)]

3. ND shall comply with any applicable federal and State laws that pertain to Member rights and observe and protect Member rights.
4. ND shall comply with the applicable requirements of the Americans with Disabilities Act (ADA). ND shall not directly or indirectly discriminate against Members who are qualified individuals with disabilities covered by the provisions of the ADA. ND agrees to provide physical access, reasonable accommodations, and accessible equipment for Members with physical or behavioral disabilities.
5. ND shall offer hours of operation that provide equal access and are no less than the hours of operation offered to commercial patients or are comparable to Medicaid FFS patients, if ND serves only Medicaid Members.
6. ND shall cooperate with the MCO Quality Assessment and Performance Improvement Program (QAPI Program).
7. ND shall remain neutral when assisting potential Members and Members with enrollment decisions.
8. VSP shall inform ND, at the time they enter into this Agreement, about the following requirements:
    a. Member grievance, appeal, and fair hearing procedures and timeframes;
    b. The Member's right to file grievances and appeals and the requirements and timeframe for filing;
    c. The availability of assistance to the Member with filing grievances and appeals;
    d. The Member's right to request a State fair hearing after VSP has made a determination on a Member's appeal which is adverse to the Member;
    e. The Member's right to request continuation of benefits that VSP seeks to reduce or terminate during an appeal of State fair hearing filing, if filed within the permissible timeframes (although the Member may be liable for the cost of the continued benefits while the appeal or State fair hearing is pending if the final decision is adverse to the Member).
9. ND shall comply with the Affordable Care Act and the MCO's or VSP's policies and procedures that require ND to report and return any overpayments identified within sixty (60) calendar days from the date the overpayment is identified, and to notify VSP in writing of the reason for the overpayment. Overpayments that are not returned within sixty (60) calendar days from the date the overpayment was identified may be a violation of State or federal law.
10. ND shall screen its staff prior to entering into this Agreement and monthly thereafter against the Exclusion Lists. In the event ND identifies that any of its staff is listed on any of the Exclusion Lists, ND shall notify VSP within three (3) business days of learning that such staff member is listed on any of the Exclusion Lists and immediately remove such person from providing services under this Agreement.
11. ND shall maintain books, records, documents and other evidence pertaining to services rendered, equipment, staff, financial records, medical records, and the administrative costs and expenses incurred pursuant to this Agreement as well as medical information relating to the Members as required for the purposes of audit, or administrative, civil and/or criminal investigations and/or prosecution or for the purposes of complying with the requirements.
12. ND shall make available, for the purposes of an audit, evaluation, or inspection by the MCO, DHHS, MFCU, DOJ, the OIG, and the Comptroller General or their respective designees: Its premises, Physical facilities, Equipment, Books, Records, Contracts, and Computer, or other electronic systems relating to its Medicaid Members. These records,

books, documents, etc., shall be available for any authorized State or federal agency, including but not limited to the MCO, DHHS, MFCU, DOJ, and the OIG or their respective designees, ten (10) years from the final date of the Agreement period or from the date of completion of any audit, whichever is later.

13. ND shall comply with MCO and State policies related to transition of care policies set forth by DHHS and included in the DHHS model Member Handbook.
14. VSP shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification or against any provider that serves high- risk populations or specializes in conditions that require costly treatment. This paragraph shall not be construed to prohibit an organization from:
    a. Including providers only to the extent necessary to meet the needs of the organization's Members,
    b. Establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization, or
    c. Using different reimbursement amounts for different specialties or for different practitioners in the same specialty.
15. If VSP declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for the decision.
16. VSP's provider selection policies and procedures shall not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment.
17. ND shall comply with the time, distance and wait standards.
18. VSP/MCO shall not require ND to enter into an exclusive contracting arrangement with the MCO as a condition for network participation.
19. ND shall accept the Member's Medicaid identification card as proof of enrollment in the MCO until the Member receives his/her MCO identification card.
20. ND shall notify VSP within one (1) business day of being cited by any State or federal regulatory authority.
21. The MCO shall implement and maintain arrangements or procedures for notification to DHHS when it receives information about a change in a participating provider's circumstances that may affect the participating provider's eligibility to participate in the managed care program, including the termination of this Agreement. The MCO shall notify DHHS within seven (7) calendar days of any significant changes to the participating provider network. As part of the notice, the MCO shall submit a transition plan to DHHS to address continued Member access to needed service and how the MCO shall maintain compliance with its contractual obligations for Member access to needed services.
22. VSP shall permit ND up to one hundred and twenty (120) calendar days to submit a timely claim. VSP shall establish reasonable policies that allow for good cause exceptions to the one hundred and twenty (120) calendar day timeframe.
23. VSP shall collect data from ND in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for state Medicaid quality improvement and Care Coordination efforts.
24. VSP shall not make payments to ND for a provider-preventable condition that meets the following criteria:
    a. Is identified in the Medicaid State Plan;
    b. Has been found by NH, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;
    c. Has a negative consequence for the Member;

d. Is auditable; and
e. Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure performed on the wrong body part, or surgical or other invasive procedure performed on the wrong patient.

25. Upon request, the MCO and ND and VSP shall permit DHHS, MFCU or any other authorized State or federal agency, or duly authorized representative, access to the MCO's and ND's and VSP's premises during normal business hours to inspect, review, audit, investigate, monitor or otherwise evaluate the performance of the MCO and ND and VSP. The MCO and ND and VSP shall forthwith produce all records, documents or other data requested as part of such inspection, review audit, investigation, monitoring or evaluation. Copies of records and documents shall be made at no cost to the requesting agency. A record includes but is not limited to: medical records; billing records; financial records; any record related to services rendered, and quality, appropriateness, and timeliness of such service; any record relevant to an administrative, civil or criminal investigation or prosecution; and any record of a VSP-paid claim or encounter, or a VSP-denied claim or encounter.
26. Upon request, the MCO, ND or VSP shall provide and make staff available to assist in such inspection, review, audit, investigation, monitoring or evaluation, including the provision of adequate space on the premises to reasonably accommodate DHHS, MFCU or other State or federal agencies.
27. ND agrees that DHHS, CMS, MFCU, the OIG, the Comptroller General, or any other authorized State or federal agency or duly authorized representative shall be permitted to inspect the premises, physical facilities, and equipment where Medicaid-related activities are conducted at any time.
28. As set forth in NDA section B.3.b, ND shall not discriminate against eligible Members, including because of sexual identity, in accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d, Section 504 of the Rehabilitation Act of 1973, 29 U.S.C Section 794, the ADA of 1990, 42 U.S.C. Section 12131 and rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation. Furthermore, ND shall not discriminate against eligible persons or Members on the basis of their health or behavioral health history, health or behavioral health status, their need for health care services, amount payable to the MCO on the basis of the eligible person's actuarial class, or pre-existing medical/health conditions.
29. ND shall comply with all VSP policies and procedures, as further set forth in NDA section B.8, and including without limitation, VSP's Deficit Reduction Act policy, the PRM, VSP's compliance program, the MCO's Member Grievance and Appeals processes and VSP's provider appeal processes (Dispute Resolution Process), VSP's clean claims and prompt payment requirement; ADA requirements, clinical practice guidelines and prior authorization requirements.
30. In addition to section C.8 of the NDA, VSP shall not prohibit or otherwise restrict ND acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient: for the Member's health status, medical care or treatment options, including any alternative treatment that may be self-administered; for any information the Member needs in order to decide among all relevant treatment options; for the risks, benefits and consequences of treatment or non-treatment, and to express preferences about future treatment decisions. Furthermore, VSP shall not take punitive action against a provider who either requests an expedited resolution or supports a Member's appeal.
31. ND shall report or submit all encounter records in an accurate and timely fashion such that the MCO can meet all its DHHS reporting requirements.

32. Any reporting obligations that VSP or MCO may have to ND shall be set forth in the PRM.

In the event of conflict between the terms of this Addendum and the terms of the Agreement, the terms of this Addendum are controlling. All other terms and conditions contained in the Network Doctor Agreement remain in full force and effect.

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