VSP® Arizona Medicaid
Network Manual

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

Effective January 1, 2019

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VSP'S MEDICAID PLAN

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

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

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

ENROLLMENT/DOCTOR PARTICIPATION

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

Eligibility & Authorization

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

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

There are several ways to obtain an authorization:

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

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

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

Coordination of Benefits

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

EXAM COVERAGE

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

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

Referrals

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

MATERIALS COVERAGE

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

Lenses

Lenses are available to the patient based on state regulations.

Covered basic lenses are established by state regulations.

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

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.

ARIZONA MEDICAID CLIENT DETAILS

Effective October 1, 2018, VSP will administer Medicaid vision services for **Magellan Complete Care of Arizona**. Please review the benefit details below.

Envolve Vision administers routine eyecare services for Health Net Access Medicaid members. Click here for detailed information on how to access Envolve Vision's policies and procedures and to check member eligibility status.

Member Identification Number

Members are reported by an alpha/numeric ID number (the letter "A" plus eight numbers, e.g., A12345678).

Exam

20 and under: Members are eligible for a routine exam once every State fiscal year (October 1 to September 30).

21 and over: Members are not eligible for exams.

Materials Eligibility

Note: All procedure codes for materials dispensing must be billed with the appropriate modifier:

NU – new equipment
RA – replacement
KX – visual necessity must be documented in the patient's file.

20 and under: Members are eligible for lenses and frames once every State fiscal year (October 1 to September 30).

21 and over: Members are not eligible for materials. However, members are covered for post-cataract services. Refer to the Post Cataract Eligibility section for complete information.

LENS MATERIALS

Use modifier NU to identify new lenses. Use RA when replacing lenses.

Mirror Coating and Plastic Gradient

20 and under: Mirror coating (V2799) or a tint of any color, solid gradient or equal, excludes photochromatic, and are not covered unless visually necessary.

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

FRAME

Only standard frames are covered (V2020). Use modifier NU to identify new frame. Use RA when replacing frame.

Visually Necessary Contact Lenses

Visually necessary contact lenses are covered if visually necessary. Use modifier NU to identify new lenses. Use RA when replacing lenses. When submitting a claim for piggyback

lenses, you must bill with all appropriate codes and provide the following information in Box 19: Piggyback lenses.

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

When glasses to be worn over contact lenses are visually necessary, 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 to be worn over contact lenses 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.

POST-CATARACT ELIGIBILITY

Some members are covered for post-cataract services. Refer to Patient Record Report for eligibility.

Call VSP at **800.615.1883** to obtain an authorization number for post-cataract services.

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) is covered 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 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 options are covered following cataract extraction when visually necessary and documented by the treating physician:

- Photochromic (V2744)
- Anti-reflective coating (V2750)
- UV lenses (V2755)
- Oversize lenses (V2780)

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

FRAMES

Only standard frames are covered (V2020).

Low Vision

20 and under: Low vision evaluations, low vision aids, and fitting of low vision 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 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.

21 and over: Low Vision is not covered.

Coordination of Benefits

If the member has vision care coverage through another carrier(s), please bill the other carrier(s) first. Once you have received the Explanation of Benefits (EOB), the Remittance Advice or denial letter from the primary insurance, please submit a copy of the documentation along with the claim to VSP. Medicaid is the payer of last resort.

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 their 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 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.

Repair and Replacement

Authorization is required; please call VSP at **800.615.1883** for an authorization number.

20 and under: Repair or replacement as needed. Authorization is required; please call VSP at **800.615.1883** for an authorization number.

21 and over: Repair and replacement is not covered.

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 as needed. 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 (92065) with appropriate diagnosis code(s).

21 and over: Vision Therapy is not covered.

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

Primary EyeCare

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

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 ARIZONA MEDICAID PLAN

PROFESSIONAL FEE SCHEDULE FOR ROUTINE SERVICES

Effective 2/1/14

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, established patient	$38.00
92004	Comprehensive exam, new patient	$50.00
92012	Intermediate exam, established patient	$35.00
92014	Comprehensive exam, established patient	$47.00
92015	Determination of refractive state	$5.00

Dispensing and Material Services

Frame Use modifier NU to identify new frame. Use modifier RA to identify replacement frame.		
V2020	Frame	$26.60

Dispensing:		
92340	Fitting of spectacles, except for aphakia, monofocal	$12.56
92341	Fitting of spectacles, except for aphakia, bifocal	$16.29
92342	Fitting of spectacles, except for aphakia, multifocal	$18.74

Single Vision Lenses, per lens: Use modifier NU to identify new lens(es). Use modifier RA to identify replacement lens(es).		
V2100	Sphere, plano to ± 4.00d	$6.38
V2101	Sphere, ± 4.12 to ± 7.00d	$6.38
V2102	Sphere, ± 7.12 to ± 20.00d	$10.21
V2103	Spherocylinder, plano to ± 4.00d sphere, 0.12 to 2.00d cylinder	$6.38
V2104	Spherocylinder, plano to ± 4.00d sphere, 2.12 to 4.00d cylinder	$6.38
V2105	Spherocylinder, plano to ± 4.00d sphere, 4.25 to 6.00d cylinder	$10.21
V2106	Spherocylinder, plano to ± 4.00d sphere, over 6.00d cylinder	$10.21
V2107	Spherocylinder, ± 4.25 to ± 7.00d sphere, 0.12 to 2.00d cylinder	$6.38
V2108	Spherocylinder, ± 4.25d to ± 7.00d sphere, 2.12 to 4.00d cylinder	$6.38
V2109	Spherocylinder, ± 4.25 to ± 7.00d sphere, 4.25 to 6.00d cylinder	$10.21
V2110	Spherocylinder, ± 4.25 to ± 7.00d sphere, over 6.00d cylinder	$10.21
V2111	Spherocylinder, ± 7.25 to ± 12.00d sphere, 0.25 to 2.25d cylinder	$10.21

Single Vision Lenses, per lens: Use modifier NU to identify new lens(es). Use modifier RA to identify replacement lens(es).		
V2112	Spherocylinder, ± 7.25 to ± 12.00d sphere, 2.25 to 4.00d cylinder	$10.21
V2113	Spherocylinder, ± 7.25 to ± 12.00d sphere, 4.25 to 6.00d cylinder	$10.21
V2114	Spherocylinder, sphere over ± 12.00d	$10.21
V2115	Lenticular, (myodisc)	$19.00
V2118	Aniseikonic lens	$19.00
V2121	Lenticular lens	$19.00
V2199	Specialty single vision. Must be billed with modifier KX. Visual necessity must be documented in the patient's file.	$10.21

Bifocal Lenses, per lens: Use modifier NU to identify new lens(es). Use modifier RA to identify replacement lens(es).		
V2200	Sphere, plano to ± 4.00d	$12.43
V2201	Sphere, ± 4.12 to ± 7.00d	$12.43
V2202	Sphere, ± 7.12 to ± 20.00d	$17.20
V2203	Spherocylinder, plano to ± 4.00d sphere, 0.12 to 2.00d cylinder	$12.43
V2204	Spherocylinder, plano to ± 4.00d sphere, 2.12 to 4.00d cylinder	$12.43
V2205	Spherocylinder, plano to ± 4.00d sphere, 4.25 to 6.00d cylinder	$17.20
V2206	Spherocylinder, plano to ± 4.00d sphere, over 6.00d cylinder	$17.20
V2207	Spherocylinder, ± 4.25 to ± 7.00d sphere, 0.12 to 2.00d cylinder	$12.43
V2208	Spherocylinder, ± 4.25 to ± 7.00d sphere, 2.12 to 4.00d cylinder	$12.43
V2209	Spherocylinder, ± 4.25 to ± 7.00d sphere, 4.25 to 6.00d cylinder	$17.20
V2210	Spherocylinder, ± 4.25 to ± 7.00d sphere, over 6.00d cylinder	$17.20
V2211	Spherocylinder, ± 7.25 to ± 12.00d sphere, 0.25 to 2.25d cylinder	$17.20
V2212	Spherocylinder, ± 7.25 to ± 12.00d sphere, 2.25 to 4.00d cylinder	$17.20
V2213	Spherocylinder, ± 7.25 to ± 12.00d sphere, 4.25 to 6.00d cylinder	$17.20
V2214	Spherocylinder, sphere over ± 12.00d	$17.20
V2215	Lenticular (myodisc)	$28.30
V2218	Aniseikonic	$28.30
V2219	Seg width over 28mm	$8.00
V2220	Add over 3.25d	$8.00
V2221	Lenticular lens	$28.30
V2299	Specialty bifocal. Must be billed with modifier KX. Visual necessity must be documented in the patient's file.	$17.20

Trifocal Lenses, per lens: Use modifier NU to identify new lens(es). Use modifier RA to identify replacement lens(es).		
V2300	Sphere, plano to ± 4.00d	$18.03
V2301	Sphere, ± 4.12 to ± 7.00d	$18.03
V2302	Sphere, ± 7.12 to ± 20.00d	$22.93
V2303	Spherocylinder, plano to ± 4.00d sphere, 0.12 to 2.00d cylinder	$18.03
V2304	Spherocylinder, plano to ± 4.00d sphere, 2.25 to 4.00d cylinder	$18.03
V2305	Spherocylinder, plano to ± 4.00d sphere, 4.25 to 6.00d cylinder	$22.93
V2306	Spherocylinder, plano to ± 4.00d sphere, over 6.00d cylinder	$22.93
V2307	Spherocylinder, ± 4.25 to ± 7.00d sphere, 0.12 to 2.00d cylinder	$18.03
V2308	Spherocylinder, ± 4.25 to ± 7.00d sphere, 2.12 to 4.00d cylinder	$18.03
V2309	Spherocylinder, ± 4.25 to ± 7.00d sphere, 4.25 to 6.00d cylinder	$22.93
V2310	Spherocylinder, ± 4.25 to ± 7.00d sphere, over 6.00d cylinder	$22.93
V2311	Spherocylinder, ± 7.25 to ± 12.00d sphere, 0.25 to 2.25d cylinder	$22.93
V2312	Spherocylinder, ± 7.25 to ± 12.00d sphere, 2.25 to 4.00d cylinder	$22.93
V2313	Spherocylinder, ± 7.25 to ± 12.00d sphere, 4.25 to 6.00d cylinder	$22.93
V2314	Spherocylinder, sphere over ± 12.00d	$22.93
V2315	Lenticular (myodisc)	$34.31
V2318	Aniseikonic lens	$34.31
V2319	Seg width over 28mm	$12.00
V2320	Add over 3.25d	$12.00
V2321	Lenticular lens	$34.31
V2399	Specialty trifocal. Must be billed with modifier KX. Visual necessity must be documented in the patient's file.	$22.93

Variable Asphericity Lenses, per lens: Use modifier NU to identify new lens(es). Use modifier RA to identify replacement lens(es).		
V2410	Single vision, full field, glass or plastic	$30.00
V2430	Bifocal, full field, glass or plastic	$55.00
V2499	Variable asphericity lens, other type. Must be billed with modifier KX. Visual necessity must be documented in the patient's file.	$55.00

Miscellaneous Covered Services, per lens: **Service must be billed with modifier KX. Visual necessity must be documented in the patient's file. See** VSP Arizona Medicaid Client Details **for requirements.** Use modifier NU to identify new lens(es). Use modifier RA to identify replacement lens(es).		
V2700	Balance lens	$36.16
V2710	Slab off prism, glass or plastic	$50.11

Miscellaneous Covered Services, per lens: **Service must be billed with modifier KX. Visual necessity must be documented in the patient's file. See** VSP Arizona Medicaid Client Details **for requirements.** Use modifier NU to identify new lens(es). Use modifier RA to identify replacement lens(es).		
V2715	Prism	$9.59
V2718	Press-on lens, fresnel prism	$23.57
V2730	Special base curve, glass or plastic	$16.91
V2744	Photochromic	$10.15
V2750	Antireflective coating	$14.79
V2755	UV lens	$10.28
V2760	Scratch resistant coating	$13.00
V2770	Occluder lens	$16.10
V2780	Oversize lens	$10.34
V2781	Progressive lens	$36.00
V2782	Lens, index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbonate	$39.11
V2783	Lens, index greater than or equal to 1.66 plastic or greater than or equal to 1.80 glass, excludes polycarbonate	$44.10
V2784	Lens, polycarbonate or equal, any index	$28.68
V2799	Vision service, miscellaneous	Submit invoice for pricing*

Repair/Refitting (**see Arizona Medicaid Client Details**):		
92370	Repair and refitting spectacles, except for aphakia	$23.56
92371	Repair and refitting spectacles, spectacle prosthesis for aphakia	$9.23

Visually Necessary Contact Lenses		
Visually Necessary Contact Lenses Contact lenses are only allowed by the Medicaid Plan when visually necessary according to Medicaid's guidelines. Service must be billed with modifier KX. Visual necessity must be documented in the patient's file. See VSP Arizona Medicaid Client Details for requirements. Use modifier NU to identify new contact lens(es). Use modifier RA to identify replacement contact lens(es).		Maximum allowance per eye
V2500	PMMA, spherical	$61.24
V2501	PMMA, toric or prism ballast	$96.30
V2502	PMMA, bifocal	$140.90
V2503	PMMA, color vision deficiency	$97.81
V2510	Gas permeable, spherical	$82.31

V2511	Gas permeable, toric or prism ballast	$133.04
V2512	Gas permeable, bifocal	$154.46
V2513	Gas permeable, extended wear	$141.71
V2520	Hydrophilic, spherical	$72.62
V2521	Hydrophilic, toric or prism ballast	$126.43
V2522	Hydrophilic, bifocal	$164.05
V2523	Hydrophilic, extended wear	$104.85
V2530	Scleral	$155.30
V2531	Scleral, gas permeable	$370.15
V2599	Contact lens, not otherwise classified.	$164.05

Visually Necessary Contact Lens Fitting and Dispensing
Contact lens fitting and dispensing is only allowed by the Medicaid Plan when visually necessary according to Medicaid's guidelines. Visual necessity must be documented in the patient's file. Service must be billed with modifier KX. See VSP Arizona Medicaid Client Details for requirements.

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	$71.88
92311	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, one eye	$75.87
92312	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, both eyes	$86.47
92313	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneoscleral lens	$75.77
92314	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and fitting by independent technician; corneal lens, both eyes, except for aphakia	$59.18
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	$57.28
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	$77.16
92317	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and fitting by independent technician; corneoscleral lens	$55.70
92325	Modification of contact lens	$28.23
92326	Replacement of contact lens	$26.94

Low Vision Services

Low Vision services are only allowed by the Medicaid Plan when visually necessary according to Medicaid's guidelines. Service must be billed with modifier KX. See VSP Arizona Medicaid Client Details for requirements. Visual necessity must be documented in the patient's file.		
92354	Fitting of spectacle mounted low vision aid; single element system	$29.38
92355	Fitting of spectacle mounted low vision aid; telescopic/other compound lens system	$25.68
92499	Unlisted ophthalmological service or procedure Use this code to bill for low vision exams	$70.00
V2600	Hand held low vision and other nonspectacle mounted aids Use modifier NU to identify new equipment. Use modifier RA to identify replacement.	Submit invoice for pricing*
V2610	Single lens spectacle mounted low vision aids Use modifier NU to identify new equipment. Use modifier RA to identify replacement.	Submit invoice for pricing*
V2615	Telescopic and other compound lens system, including distance vision, telescopic Use modifier NU to identify new equipment. Use modifier RA to identify replacement.	Submit invoice for pricing*

Vision Therapy

Orthoptic and/or Pleoptic Training. Service must be billed with modifier KX. Visual necessity must be documented in the patient's file. See VSP Arizona Medicaid Client Details **for requirements.**		
92060	Sensorimotor examination with multiple measurements of ocular deviation	$47.65
92065	Orthoptic and/or pleoptic training, with continuing direction and evaluation	$39.22

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