VSP® Oregon Medicaid
Network Manual

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

Effective January 1, 2020

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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.

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.

VSP OREGON MEDICAID CLIENT DETAILS

Member Identification Number

CareOregon: Members are reported by an alphanumeric identification number.

Exam

20 and under: Eligible for exam every 12 months.

Pregnant women, 21 and over: Eligible for exam every 24 months.

> **Note:** CareOregon covers services for children (20 and under) and pregnant women only.

REFRACTION

For procedure code 92015, the allowed amount is included in the reimbursement amount of the exam procedure code. See Coordination of Benefits for exceptions.

COORDINATION OF BENEFITS

For patients with Medicare and Medicaid coverage:

- Bill eye exams 92002, 92004, 92012, 92014 and 92015 to Medicare and bill VSP as secondary. Allowed amount for the eye refraction is $6.00

For additional information on coordination of benefits, see **Submitting Claims/Billing & Reimbursement**.

Materials Eligibility

20 and under: Eligible for eyeglasses every 12 months.

Pregnant women, 21 and over: Eligible for eyeglasses every 24 months.

LENS OPTIONS

Photochromic and Solid Tints/dyes: Photochromics (V2744) and solid tints/dyes (V2745) are only payable for patients with documented albinism and pupillary defects.

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

Scratch coating: Scratch coating is a covered benefit. The reimbursement is included in the reimbursement of the base lens and additional payment will not be made for the scratch coating. See Patient Responsibility.

High Index: Patient must meet the following criteria:

- Power is +/- 10 or greater in any meridian in either eye; or
- Prism diopters are +10 diopters in either lens.

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

Polycarbonate lenses: Patient must meet at least one of the benefit criteria listed below.

- Children ages 0-20
- Patients with developmental disabilities
- Patients who are blind in one eye and need protection for the other eye, regardless of whether a vision correction is required

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

PLANO OR NON-PRESCRIPTION LENSES

Plano or non-prescription lenses are limited to patients with one eye requiring no correction and with blindness in the other eye. The purpose of this exception is to offer protection to the remaining functional eye.

FRAME OPTIONS

Deluxe frame: If the patient has an unusual circumstance or visual needs that prevent the patient from selecting any of the existing covered frames, use V2025 to bill for the deluxe frame. See Patient Responsibility.

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

FRAME CASE

One frame case must be provided to the patient as it is a covered material and included in the frame reimbursement.

VISUALLY NECESSARY CONTACT LENSES AND FITTING/DISPENSING

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

Patient Responsibility

COVERED SERVICES/MATERIALS

The doctor must accept payment by VSP as payment in full for services rendered and make no additional charge to any person for covered services or materials.

- Scratch coating: The cost of scratch coating is included in the reimbursement of the base lens. The member cannot be billed for the cost of the scratch coating.
- Deluxe Frame: If a specialty frame (V2025) is required, the member can't be billed the difference between the VSP allowed amount and your usual and customary charge.

NON-COVERED SERVICES/MATERIALS

Reminder: Progressive lenses are considered a type of lens and not a lens option.

- Lenses: If the patient selects a lens not included on the VSP Oregon Medicaid Plan Professional Fee Schedule, the patient is responsible for the entire cost of the lens.

- Lens Options: If the patient selects a lens option not included on the VSP Oregon Medicaid Plan Professional Fee Schedule, the patient must pay for the entire cost of that option. Any non-covered lens options would be a private transaction. Bill VSP for lens and frame if they are listed as covered materials on the VSP Oregon Medicaid Plan Professional Fee Schedule.
- Frame**:** If the patient selects a frame that exceeds the allowance, the patient is responsible for the entire cost of the frame. Do not bill VSP for a frame that exceeds the frame allowance. For frame requirements, see Deluxe Frame section.

You may bill the patient for non-covered services or materials if all of the following requirements are met:

- 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 or equivalent that clearly states that 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 non-covered services or materials. Treat this as a private- transaction and follow your private-pay patient policy.

Post Cataract

Pregnant women, 21 and over: One pair of additional glasses is covered within 120 days following cataract surgery. Please call VSP at **800.615.1883** for authorization and benefit information.

Repair

Authorization is required; please call VSP at **800.615.1883** to obtain an authorization.

The periodic adjustment of frames including tightening of screws is included in the original dispensing fee and should be conducted at no charge to the patient and is not eligible for reimbursement from VSP.

Authorized repairs may be billed using codes 92370 and 92371.

Replacement

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

20 and under: Unlimited replacement of lenses and frames if not due to patient negligence; no minimum diopter change required. Contact lens replacement is limited to visual necessity. Visual necessity must be documented in the patient's medical record.

Pregnant women, 21 and over: Replacement of frame fronts and temples are for patients with a visual condition that requires use of specialty temples. Replacement of eyeglass lenses are not a covered benefit.

Contact lens replacement is limited to visual necessity up to a total of two contacts every 12 months. Visual necessity must be documented in the patient's medical record.

Timely Filing

For VSP to comply with Oregon Medical Assistance Program guidelines for encounter data submission, claims must be filed within 120 days of the date of service.

Vision Therapy

Vision therapy is only covered for children (through age 20) for treatment of strabismus and other disorders of binocular eye movements. Call VSP at 800.615.1883 to obtain an authorization number for Vision Therapy claim(s). Bill the first six vision therapy sessions per calendar year with an appropriate diagnosis code (diagnosis codes may include but are not limited to those referenced in the Vision Therapy section of this manual).

Additional sessions should be billed with the appropriate diagnosis codes and modifier KX. Visual necessity must be documented in the patient's file.

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.

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.

VSP OREGON MEDICAID PLAN

PROFESSIONAL FEE SCHEDULE FOR ROUTINE SERVICES

Effective 5/1/2019

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	$49.00
92004	Comprehensive exam, new patient	$65.00
92012	Intermediate exam, established patient	$49.00
92014	Comprehensive exam, established patient	$65.00
92015	Refraction is included in the fee for the exam service	$0.00

Spectacle Services

Spectacle Dispensing, Complete Pair, New or Total Replacement:		
92340	Fitting of spectacles, except for aphakia, monofocal	$25.00
92341	Fitting of spectacles, except for aphakia, bifocal	$28.50
92342	Fitting of spectacles, except for aphakia, trifocal	$30.75
92352	Fitting of spectacle prosthesis for aphakia, monofocal	$26.00
92353	Fitting of spectacle prosthesis for aphakia, multifocal	$32.00
Repair and Refitting: See **VSP Oregon Medicaid Client Details** for requirements.		
92370	Dispensing for repair and fitting, except for aphakia	$23.10
92371	Dispensing for repair and fitting, prosthesis for aphakia	$16.61

Frame

V2020	Frame (includes case)	$12.00
V2025	Deluxe Frame Must be billed with modifier KX. See **VSP Oregon Medicaid Client Details** for requirements. Visual necessity must be documented in the patient's file.	$45.00
V2756	Eye glass case	**$0.00**

Spectacle

Single Vision Lenses, per lens (scratch resistant coating included in lens fee):		
V2100	Sphere, plano to ± 4.00D	$9.75
V2101	Sphere, ± 4.12 to ± 7.00D	$9.75
V2102	Sphere, ± 7.12 to ± 20.00D	$12.25

V2103	Spherocylinder, plano to ± 4.00D sphere, 0.12 to 2.00D cylinder	$9.75
V2104	Spherocylinder, plano to ± 4.00D sphere, 2.12 to 4.00D cylinder	$9.75
V2105	Spherocylinder, plano to ± 4.00D sphere, 4.25 to 6.00D cylinder	$12.25
V2106	Spherocylinder, plano to ± 4.00D sphere, over 6.00D cylinder	$12.25
V2107	Spherocylinder, ± 4.25 to ± 7.00D sphere, 0.12 to 2.00D cylinder	$9.75
V2108	Spherocylinder, ± 4.25 to ± 7.00D sphere, 2.12 to 4.00D cylinder	$9.75
V2109	Spherocylinder, ± 4.25 to ± 7.00D sphere, 4.25 to 6.00D cylinder	$12.25
V2110	Spherocylinder, ± 4.25 to ± 7.00D sphere, over 6.00D cylinder	$12.25
V2111	Spherocylinder, ± 7.25 to ± 12.00D sphere, 0.25 to 2.25D cylinder	$12.25
V2112	Spherocylinder, ± 7.25 to ± 12.00D sphere, 2.25 to 4.00D cylinder	$12.25
V2113	Spherocylinder, ± 7.25 to ± 12.00D sphere, 4.25 to 6.00D cylinder	$12.25
V2114	Spherocylinder, sphere over ± 12.00D	$12.25
V2115	Lenticular (myodisc)	$24.25
V2121	Lenticular lens	$24.25
V2199	Specialty single vision	$12.25

Bifocal Lenses, per lens (scratch resistant coating included in lens fee):		
V2200	Sphere, plano to ± 4.00D	$11.25
V2201	Sphere, ± 4.12 to ± 7.00D	$11.25
V2202	Sphere, ± 7.12 to ± 20.00D	$13.75
V2203	Spherocylinder, plano to ± 4.00D sphere, 0.12 to 2.00D cylinder	$11.25
V2204	Spherocylinder, plano to ± 4.00D sphere, 2.12 to 4.00D cylinder	$11.25
V2205	Spherocylinder, plano to ± 4.00D sphere, 4.25 to 6.00D cylinder	$13.75
V2206	Spherocylinder, plano to ± 4.00D sphere, over 6.00D cylinder	$13.75
V2207	Spherocylinder, ± 4.25 to ± 7.00D sphere, 0.12 to 2.00D cylinder	$11.25
V2208	Spherocylinder, ± 4.25 to ± 7.00D sphere, 2.12 to 4.00D cylinder	$11.25
V2209	Spherocylinder, ± 4.25 to ± 7.00D sphere, 4.25 to 6.00D cylinder	$13.75
V2210	Spherocylinder, ± 4.25 to ± 7.00D sphere, over 6.00D cylinder	$13.75
V2211	Spherocylinder, ± 7.25 to ± 12.00D sphere, 0.25 to 2.25D cylinder	$13.75
V2212	Spherocylinder, ± 7.25 to ± 12.00D sphere, 2.25 to 4.00D cylinder	$13.75
V2213	Spherocylinder, ± 7.25 to ± 12.00D sphere, 4.25 to 6.00D cylinder	$13.75
V2214	Spherocylinder, sphere over ± 12.00D	$13.75
V2215	Lenticular (myodisc)	$27.75
V2220	Add over 3.25D	$4.00
V2221	Lenticular lens	$27.75
V2299	Specialty bifocal	$13.75

Trifocal Lenses, per lens (scratch resistant coating included in lens fee):		
V2300	Sphere, plano to ± 4.00D	$15.25
V2301	Sphere, ± 4.12 to ± 7.00D	$15.25
V2302	Sphere, ± 7.12 to ± 20.00D	$17.75
V2303	Spherocylinder, plano to ± 4.00D sphere, 0.12 to 2.00D cylinder	$15.25
V2304	Spherocylinder, plano to ± 4.00D sphere, 2.25 to 4.00D cylinder	$15.25
V2305	Spherocylinder, plano to ± 4.00D sphere, 4.25 to 6.00D cylinder	$17.75
V2306	Spherocylinder, plano to ± 4.00D sphere, over 6.00D cylinder	$17.75
V2307	Spherocylinder, ± 4.25 to ± 7.00D sphere, 0.12 to 2.00D cylinder	$15.25
V2308	Spherocylinder, ± 4.25 to ± 7.00D sphere, 2.12 to 4.00D cylinder	$15.25
V2309	Spherocylinder, ± 4.25 to ± 7.00D sphere, 4.25 to 6.00D cylinder	$17.75
V2310	Spherocylinder, ± 4.25 to ± 7.00dD sphere, over 6.00D cylinder	$17.75
V2311	Spherocylinder, ± 7.25 to ± 12.00D sphere, 0.25 to 2.25D cylinder	$17.75
V2312	Spherocylinder, ± 7.25 to ± 12.00D sphere, 2.25 to 4.00D cylinder	$17.75
V2313	Spherocylinder, ± 7.25 to ± 12.00D sphere, 4.25 to 6.00D cylinder	$17.75
V2314	Spherocylinder, sphere over ± 12.00D	$17.75
V2320	Add over 3.25D	$4.50
V2399	Specialty trifocal	$17.75

Variable Asphericity Lenses, per lens (scratch resistant coating included in lens fee):		
V2410	Single vision, full field, glass or plastic	$21.54
V2430	Bifocal full field, glass or plastic	$26.54
V2499	Other type	$26.54

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 Oregon Medicaid Client Details** for requirements. Visual necessity must be documented in the patient's file.		Maximum allowance per eye
V2500	Contact lens, PMA, spherical	$150.00
V2501	PMMA, toric or prism ballast	$150.00
V2502	PMMA, bifocal	$150.00
V2503	Contact lens, PMMA, color vision deficiency	$150.00
V2510	Contact lens, gas permeable, spherical	$150.00
V2511	Contact lens, gas permeable, toric or prism ballast	$150.00
V2512	Gas permeable, bifocal	$150.00
V2513	Gas permeable, extended wear	$150.00
V2520	Contact lens, hydrophilic, spherical	$150.00
V2521	Contact lens, hydrophilic, toric or prism ballast	$150.00

V2522	Contact lens, hydrophilic, bifocal	$150.00
V2523	Contact lens, hydrophilic, extended wear	$150.00
V2530	Contact lens, scleral, gas impermeable	$150.00
V2531	Contact lens, scleral, gas permeable	$150.00
92325	Modification of contact lens, with medical supervision of adaptation	$26.52
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. Service must be billed with modifier KX. See **VSP Oregon 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	$85.46
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	$60.58
92311	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, one eye	$63.84
92312	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, both eyes	$74.44

Miscellaneous

Miscellaneous Covered Options and Services, per lens:		
V2710	Slab off prism, glass or plastic	$34.00
V2718	Press-on lens, Fresnel prism	$18.65
Prism, special base curve, scratch resistant coating and tracings are included in the base lens fee.		
V2715	**Prism**	**$0.00**
V2730	**Special base curve, glass or plastic**	**$0.00**
V2760	**Scratch resistant coating**	**$0.00**
Miscellaneous Covered Options and Services, per lens: Service must be billed with modifier KX. See **VSP Oregon Medicaid Client Details** for requirements. Visual necessity must be documented in the patient's file.		
V2744	Photochromic	$10.50
V2745	Addition to lens, tint, any color, solid, gradient or equal (excludes photochromic, any lens material)	$7.00
V2782	Lens, index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbonate	$25.00
V2783	Lens, index greater than or equal to 1.66 plastic or greater than or equal to 1.80 glass, excludes polycarbonate	$30.00
V2784	Lens, polycarbonate or equal, any index	$15.00

Vision Therapy

Orthoptic and/or Pleoptic Training:		
92060	Sensorimotor examination with multiple measurements of ocular deviation with interpretation and report.	$12.00
92065	Orthoptic and/or pleoptic training, with continuing medical direction and evaluation. Service must be billed with modifier KX. See **VSP Oregon Medicaid Client Details** for requirements. Visual necessity must be documented in the patient's file.	$33.02

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