

## CONTACT LENS BENEFITS

Beginning June 1, 2024, VSP implemented new criteria that requires an improvement in best corrected visual acuity (BCVA) by two lines, compared to spectacles for Visually Necessary Contact Lenses specialty conditions. See Visually Necessary Contact Lenses section below for details.

# Contact Lens Benefits

VSP patients may have the following contact lens benefits:

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

## Note:

For Visually Necessary Contact Lenses and Covered Contact Lenses, VSP will only cover an annual supply of materials based on the manufacturer's replacement schedule. No additional reimbursement for Visually Necessary Contact Lenses and Covered Contact Lenses shall be reimbursed by VSP through additional VSP plans/coverage the patient may have.

You may only coordinate benefits up to the annual supply of contact lens materials if plans permit. See Coordination of Benefits Between Multiple VSP® Plans in the VSP Manual.

Visually Necessary Contact Lenses and Covered Contact Lenses include the contact lens exam services and an annual supply of contact lens materials. Bill contact lens exam services with materials.

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

## Note:

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

## Eligibility & Authorization

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

## Copays

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

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

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

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

## Materials and Services Coverage

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

## VSP's minimum prescription criteria:

The combined power in any meridian is  $\pm 0.50$  diopters or greater in at least one eye or one of the following exceptions occurs:

- Necessary prism of 0.50 diopters or greater in at least one eye
- Anisometropia is  $+0.50$  diopters or greater in at least one eye
- Cylinder power is  $\pm 0.50$  diopters or greater in at least one eye

## Exclusions

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

- Corneal refractive therapy, orthokeratology, and contact lenses for myopia management are not covered under Visually Necessary Contact Lenses, Covered Contact Lenses, or the VSP Elements Plan. Patients can use their elective contact lenses allowance towards the cost of corneal refractive therapy, orthokeratology, or myopia management contact lens materials only. The contact lens fitting and evaluation portion of the treatment is a private transaction between you and the patient.
- Replacement of lost or damaged lenses
- Modifications of lenses
- Routine maintenance such as polishing, cleaning, etc.
- Refitting after the initial (90-day) fitting period
- Manufacture warranties
- Plano (non-prescription) lenses or lenses that don't meet our minimum prescription requirement
- Plano lenses to change eye color cosmetically
- Office visits to treat contact lens pathology
- Solutions and other contact lens supplies
- Bandage contact lenses aren't covered under VSP® plans but can be submitted under Essential Medical Eye Care for eligible patients. See Essential Medical Eye Care in this section.

## Visually Necessary Contact Lenses

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

**Note:**

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

## Benefit Coverage Criteria for Visually Necessary Base Contact Lenses

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

**Note:**

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

## Colored contact lenses (for Visually Necessary Contacts) are a covered benefit for patients with the following conditions:

- Achromatopsia – H53.51
- Albinism – E70.30, E70.310-E70.319
- Aniridia – Q13.1
- Coloboma of iris – Q13.0
- Other congenital malformations of iris (Polycoria; anisocoria (congenital)) – Q13.2
- Pupillary abnormalities – H21.561 through H21.563

**Note:**

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

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

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

### Scleral Lenses (For Covered Contacts and Visually Necessary Contacts)

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

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

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

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

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

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

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

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

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

 **Note:**

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

#### **Piggyback Lenses Benefit**

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

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

- Piggyback lenses

#### **Spectacle lenses to wear over contacts benefit**

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

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

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

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

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

#### **Submitting Claims**

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

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

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

Fax the Materials Verification Form to us at **916.851.4733**. Or mail to VSP, PO Box 495907, Cincinnati, OH 45249-5907. You can find the form in the VSPOnline section of **eyefinity.com** or in the Tools and Forms section of this manual.

#### **Reimbursement for Visually Necessary Contact Lenses and Covered Contact Lenses**

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

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

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

 **Note:**

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

## Covered Contacts and Visually Necessary Contact Lens Base Maximums

HCPCS	HCPCS Description	Annual Replacement <sup>1</sup>	Planned Replacement <sup>1</sup>	Daily Replacement <sup>1</sup>
V2500*	Contact lens, pmma, spherical, per lens	\$251	—	—
V2501*	Contact lens, pmma, toric or prism ballast, per lens	\$385	—	—
V2502*	Contact lens, pmma, bifocal, per lens	\$491	—	—
V2503*	Contact lens, pmma, color vision deficiency, per lens	\$405	—	—
V2510*	Contact lens, gas permeable, spherical, per lens	\$450	—	—
V2511*	Contact lens, gas permeable, toric, prism ballast, per lens	\$650	—	—
V2512*	Contact lens, gas permeable, bifocal, per lens	\$750	—	—
V2513*	Contact lens, gas permeable, extended wear, per lens	\$500	—	—
V2520	Contact lens, hydrophilic, spherical, per lens	\$375	\$525	\$900
V2521	Contact lens, hydrophilic, toric, or prism ballast, per lens	\$525	\$650	\$1000
V2522	Contact lens, hydrophilic, bifocal, per lens	\$537	\$650	\$1200
V2523**	Contact lens, hydrophilic, extended wear, per lens	\$475	\$600	—
V2530*	Contact lens, scleral, gas impermeable, per lens	\$499	—	—
V2531*	Contact lens, scleral, gas permeable, per lens	\$987	—	—
V2599**	Contact lens, other type	\$1,150	\$1,500	—
Piggyback		\$1,150	\$1,500	—

<sup>1</sup>Annual Replacement is 1-2 units. Planned Replacement is 3-360 units. Daily Replacement is 361+ units.

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

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

### Benefit Coverage Criteria for Visually Necessary Specialty Contact Lenses

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

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

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

Description	ICD-10 Codes:
Absence of iris (Aniridia)**	Q13.1
Achromatopsia**	H53.51
Adherent leukoma**	H17.01 - H17.03
Albinism**	E70.30, E70.310 - E70.319
Aphakia**	H27.01 - H27.03
Band keratopathy	H18.421- H18.423
Bullous keratopathy	H18.11 - H18.13
Central corneal opacity	H17.11 - H17.13
Coloboma of iris**	Q13.0
Congenital aphakia**	Q12.3
Congenital corneal opacity	Q13.3
Corneal ectasia	H18.711 - H18.713
Corneal scars and opacities	H17.00 - H17.9, A18.59
Corneal staphyloma	H18.721 - H18.723
Corneal transplant failure	T86.8411 - T86.8413
Corneal transplant rejection	T86.8401 - T86.8403
Corneal transplant status	Z94.7
Deep vascularization of cornea	H16.441 - H16.443
Endothelial corneal dystrophy	H18.511 - H18.513
Enophthalmos due to atrophy of orbital tissue**	H05.419
Epithelial (juvenile) corneal dystrophy	H18.521- H18.523
Folds and rupture in Bowman's membrane	H18.311 - H18.313
Granular corneal dystrophy	H18.531 – H18.533
Keratoconus, stable	H18.611 - H18.613
Keratoconus, unspecified	H18.601 - H18.603
Keratoconus, unstable	H18.621 - H18.623
Keratoconjunctivitis sicca, in Sjogren's syndrome	M35.01
Keratomalacia	H18.441 - H18.443
Lattice corneal dystrophy	H18.541 - H18.543
Localized vascularization of cornea	H16.431 - H16.433
Covered for significant cases only where corneal neovascularization is a complication of inflammatory, infectious or autoimmune corneal pathologies	
Macular corneal dystrophy	H18.551 - H18.553
Minor opacity of cornea	H17.811 - H17.813

Description	ICD-10 Codes:
Nodular corneal degeneration	H18.451 - H18.453
Other calcerous corneal degeneration	H18.43
Other congenital corneal malformations	Q13.4
Other congenital malformations of iris (Polycoria; anisocoria (congenital)) **	Q13.2
Other corneal degeneration	H18.49
Other corneal scars and opacities	H17.89
Other hereditary corneal dystrophies	H18.591 – H18.593
Other keratitis	H16.8
Other tuberculosis of eye	A18.59
Peripheral corneal degeneration	H18.461 - H18.463
Covered for marginal corneal degenerations, such as pellucid and Terrien, or as a result of previous ocular disease or trauma	
Peripheral opacity of cornea	H17.821 - H17.823
Pupillary abnormality**	H21.561 - H21.563
Recurrent erosion of cornea	H18.831 - H18.833
Unspecified corneal deformity	H18.70
Unspecified corneal degeneration	H18.40
Unspecified corneal membrane change	H18.30
Unspecified corneal scar and opacity	H17.9
Unspecified hereditary corneal dystrophies	H18.501 - H18.503
Vitamin A deficiency with xerophthalmic scars of cornea	E50.6

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

**Note:**

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

## Visually Necessary Contact Lens Specialty Maximums

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

<sup>1</sup>Annual Replacement is 1-2 units. Planned Replacement is 3-360 units. Daily Replacement is 361+ units.

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

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

## Submitting Claims/Billing & Reimbursement

### Submitting the Claim



#### Important!

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



#### Important!

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

	Contact Lens Exam Copay with Materials Allowance	Exam And (Combined Contact Lens Allowance)	Total Allowance	Covered Contacts or Visually Necessary Contact Lenses
<b>Eye Exam (WellVision Exam)</b>	Use your patient's routine benefit for exam services.		Bill the appropriate CPT code and your U&C fee. Bill with contact lens exam if provided, and materials.	Use your patient's routine benefit for exam services.
<b>Contact Lens Exam Services</b>	Bill the appropriate CPT code and your U&C fee for the contact lens exam provided.		Bill the appropriate CPT code and your U&C fee for the contact lens exam provided. Bill with materials.	Contact lens exam services are covered under the materials claim. Bill the appropriate CPT code and your U&C fee for the contact lens exam provided. Bill with materials.
<b>Contact Lens Materials</b>	For Visually Necessary Contact Lenses, regardless of plan type, member must be eligible for materials. Covered Contact Lenses and Visually Necessary Contact Lenses coverage includes the contact lens exam services and an annual supply of contact lens materials. <ul style="list-style-type: none"> <li>• Member must be eligible for materials.</li> <li>• Bill the appropriate HCPCS code(s) for the materials provided.</li> <li>• Submit your U&amp;C fee and indicate the number of units (contacts) dispensed. To maximize your patient's benefit, dispensing an annual supply of contact lenses at one time is required under the Covered Contact Lenses and the Necessary Contact Lenses benefits.</li> <li>• Each contact lens is considered one unit. Bill the total number of units provided based on the type of lenses dispensed:</li> </ul> <b>Unit Count, Type of contacts</b> 1–2 units, Conventional (non-disposable) contacts 3–52 units, Planned replacement (month/quarter) or 14-day disposables 53–106 units, 7-day disposables 107–361+ units, 1-day disposables To ensure proper payment for piggyback contact lenses, bill all the appropriate HCPCS code(s) for materials provided. For hybrid contacts, bill with the miscellaneous contact lens code.			

## Reimbursement

### **Important!**

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

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

Contact Lens Exam Copay with Materials Allowance		Exam And (Combined Contact Lens Allowance)	
<b>VSP</b>	You'll receive your assigned fee for the eye exam.	You'll receive your assigned fee for the eye exam.	
<b>Payment</b>	In addition, we'll pay you 85% of your U&C fees, less the patient copay, for a contact lens exam  We will also pay your U&C fees for materials up to your patient's contact lens materials allowance.	In addition, we'll pay 85% of your contact lens exam U&C fee and your U&C fee for materials up to your patient's Exam And contact lens allowance.  Contact lens exam only (no materials): VSP will reimburse you up to \$60. Contact lens materials only (contact lens exam services received elsewhere): If your patient is not eligible for services, contact VSP at 800.615.1883 for more information.	
<b>Balance</b>	Your patient is responsible for the contact lens exam copay or 85% of your U&C fees, whichever is less, and the difference between their contact lens materials allowance and U&C fee for materials.	Your patient is responsible for the difference between their allowance and 85% of U&C fee for a contact lens exam fee and 100% of your U&C fee for materials.  Contact lens exam only (no materials): Your patient is responsible for your U&C fee for a contact lens exam at 85% of U&C, less the \$60 paid by VSP.	
Total Allowance	Visually Necessary Contact Lenses	Covered Contact Lenses	
<b>VSP</b>	We'll pay your exam and contact lens exam fees at 85% of U&C plus your U&C fees for materials up to the patient's total contact lens allowance.	You'll receive your assigned fee for the eye exam.  In addition, on the Visually Necessary Contact Lens claim, we'll pay up to the maximum allowed for the HCPCS code and quantity of contact lenses provided. Maximum allowed amount applies to the combination of 85% of your U&C fee for the contact lens exam and your U&C fee for materials.	We'll pay up to the maximum allowed for the HCPCS code and quantity of contact lenses provided. Maximum allowed amount applies to the combination of 85% of your U&C fee for the contact lens exam and your U&C fee for materials.
<b>Balance</b>	Your patient is responsible for the difference between their allowance and your discounted fees for the eye exam and contact lens exam plus your U&C fee for materials.	For an annual supply, don't balance bill your patient for the difference between your U&C fee and our allowable amount.	For an annual supply, don't balance bill your patient for the difference between your U&C fee and our allowable amount.

**Note:**

Failure to record your contact lens exams, fittings and follow-ups may result in the denial of payment for services.

Ensure that your medical records accurately support the diagnosis submitted on the claim when billing for Visually Necessary Contact Lenses. By doing so your payment will not be denied if the diagnosis billed is substantiated by the clinical findings documented in the patient's record.

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