Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

MEDICAID PURCHASING ADMINISTRATION (MPA)

Vision Care

Billing Instructions

WAC 388-544-0010 through WAC 388-544-0600

Copyright Disclosure

About this publication

This publication supersedes all previous Department/MPA *Vision Care Billing Instructions* and Numbered Memos published by the Washington State Department of Social and Health Services, Health and Recovery Services Administration.

The Department encourages Vision Care Providers to also refer to the current version of the *Physician-Related Services (RBRVS) Billing Instructions* for further billing codes.

> **Note:** The Department now reissues the entire billing manual when making updates, rather than just a page or section. The effective date and revision history are now at the front of the manual. This makes it easier to find the effective date and version history of the manual.

Effective Date

The effective date of this publication is: **07/01/2010**.

2010 Revision History

This publication has been revised by: Numbered Memo 10-50

Document	Subject	Issue Date	Pages Affected
# Memo 10-50	Vision Care: Fee Schedule, General Ordering Information Updates, Add EPA Number and Limit, Add Process for an Order That Has Not Been Picked Up by a Client.	**06/28/2010**	**C.4, D.4** and **E.2**

How Can I Get Department/MPA Provider Documents?

To download and print Department/MPA provider numbered memos and billing instructions, go to the Department/MPA website at http://hrsa.dshs.wa.gov (click the ***Billing Instructions and Numbered Memorandum*** link).

Table of Contents

Table of Contents (cont.)

Important Contacts

Note: This section contains important contact information relevant to Vision Care. For more contact information, see the Department/MPA *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See the Department/MPA *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html
Finding out about payments, denials, claims processing, or Department managed care organizations	
Electronic or paper billing	
Finding Department documents (e.g., billing instructions, # memos)	
Private insurance or third-party liability, other than Department managed care	
Where do I order hardware?	Order hardware from the Department's contractor: **Airway Optical** 11919 West Sprague Avenue PO Box 1959 Airway Heights, WA 99001-1959 Customer Service Phone 1-888-606-7788 (toll free) Fax: 1-888-606-7789 (toll free)
Who do I contact if I have a client who needs low vision aids?	**Community Services for the Blind and Partially Sighted (Seattle)** Phone: 1-800-458-4888 (toll free) **Lilac Blind Foundation (Spokane)** Phone: 1-800-422-7893 (toll free)
How do I obtain prior authorization or a limitation extension?	For all requests for Prior authorization or Limitation Extension, the following documentation is "Required": • A completed, TYPED ProviderOne request form, DSHS 13-835. This request form MUST be the initial page when you submit your request. • A completed Vision Care Limitation Extension Form, DSHS 13-739, and all the documentation listed on this form and any other medical justification. Fax your request to: 1-866-668-1214. See the Department/MPA *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html

Definitions & Abbreviations

This section defines terms and abbreviations, including acronyms, used in these billing instructions. Please refer to the Department/MPA *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for a more complete list of definitions.

Authorization number - A 9-digit number assigned by the Department that identifies individual requests for services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pended, or denied.

Benefit Service Package - A grouping of benefits or services applicable to a client or group of clients.

Billing Provider - A provider of medical or medically related services, equipment, or supplies that submits claims for the services or equipment. A billing provider can be the same as the performing or rendering provider or it can be a medical group or billing agent with a different name and identifier.

Blindness - A diagnosis of visual acuity for distance vision of 20/200 or worse in the better eye with best correction or a limitation of the client's visual field (widest diameter) subtending an angle of less than 20 degrees from central.
[WAC 388-544-0050]

Conventional soft contact lenses or **rigid gas permeable contact lenses** - Federal Drug Administration (FDA)-approved contact lenses that do not have a scheduled replacement (discard and replace with new contacts) plan. The soft lenses usually last one year, and the rigid gas permeable lenses usually last two years. Although some of these lenses are designed for extended wear, the Department generally approves only those lenses that are designed to be worn as daily wear (remove at night). [WAC 388-544-0050]

Disposable contact lenses - FDA-approved contact lenses that have a planned replacement schedule (e.g., daily, every two weeks, monthly, quarterly). The contacts are then discarded and replaced with new ones as scheduled. Although many of these lenses are designed for extended wear, the Department generally approves only those lenses that are designed to be worn as daily wear (remove at night). [WAC 388-544-0050]

Expedited prior authorization (EPA) - A form of authorization used by the provider to certify that the Department-published clinical criteria for a specific vision care service(s) have been met. [WAC 388-544-0050]

Expedited prior authorization number - A 9-digit number created by the provider to bill the Department for diagnoses, procedures, and services that meet the Department's EPA criteria.

- The first 6 digits of the EPA number must be **870000**;
- The last 3 digits must be the code number of the diagnostic condition, procedure, or service that meets the EPA criteria.

Extended wear soft contacts - Contact lenses that are designed to be worn for longer periods than daily wear (remove at night) lenses. These can be conventional soft or disposable lenses designed to be worn for several days and nights before removal.

Hardware - Eyeglass frames and lenses and contact lenses. [WAC 388-544-0050]

ICD-9 CM Diagnosis Codes – Classifies morbidity and mortality information for statistical purposes, indexing of hospital records by disease and operations, data storage, and retrieval. The disease classification has been expanded to include health-related conditions and to provide greater specificity at the fifth-digit level of detail. These fifth digits are not optional; they are intended for use in recording the information substantiated in the clinical record.

Limitation extension - A process for requesting and approving reimbursement for covered services whose proposed quantity, frequency, or intensity exceeds that which the Department routinely reimburses. Limitation extensions require prior authorization.

Medically necessary – See WAC 388-500-0005.

National Provider Identifier (NPI) – A system for uniquely identifying all Providers of health care services, supplies, and equipment.

Prior authorization - A form of authorization used by the provider to obtain the Department's written approval for a specific vision care service(s). The Department's approval is based on medical necessity and must be received before the service(s) are provided to clients as a precondition for payment. [WAC 388-544-0050]

ProviderOne – Department of Social and Health Services (the Department) primary provider payment processing system.

ProviderOne Client ID- A system-assigned number that uniquely identifies a single client within the ProviderOne system; the number consists of nine numeric characters followed by WA.
For example: 123456789WA.

Services Card – A plastic "swipe" card that the Department issues to each client on a "one- time basis." Providers have the option to acquire and use swipe card technology as one method to access up-to-date client eligibility information.

- The Services Card replaces the paper Medical Assistance ID Card that was mailed to clients on a monthly basis.
- The Services Card will be issued when ProviderOne becomes operational.
- The Services Card displays only the client's name and ProviderOne Client ID number.
- The Services Card does not display the eligibility type, coverage dates, or managed care plans.
- The Services Card does not guarantee eligibility. Providers are responsible to verify client identification and complete an eligibility inquiry.

Specialty contact lens design - Custom contact lenses that have a more complex design than a standard spherical lens. These specialty contact lenses (e.g., lenticular, aspheric, or myodisc) are designed for the treatment of specific disease processes, such as keratoconus, or are required due to high refractive errors. This definition of specialty contact lens does not include lenses used for surgical implantation. [WAC 388-544-0050]

Stable visual condition - A client's eye condition has no acute disease or injury; or the client has reached a point after any acute disease or injury where the variation in need for refractive correction has diminished or steadied. The client's vision condition has stabilized to the extent that eyeglasses or contact lenses are appropriate and that any prescription for refractive correction is likely to be sufficient for one year or more. [WAC 388-544-0050]

Usual and customary fee - The rate that may be billed to the Department for a certain service or equipment. This rate may not exceed:

1) The usual and customary charge billed to the general public for the same services; or
2) If the general public is not served, the rate normally offered to other contractors for the same services.

Visual field exam or testing - A process to determine defects in the field of vision and test the function of the retina, optic nerve and optic pathways. The process may include simple confrontation to increasingly complex studies with sophisticated equipment. [WAC 388-544-0050]

About the Program

What Is the Purpose of the Vision Care Program?

The purpose of the Department's Vision Care program is to provide the following vision care services and hardware to eligible Department clients:

- Eye care services (eye examinations, refractions, etc.);
- Prescription eyeglasses (frames and lenses);
- Contact lenses;
- Ocular prosthetics; and
- Eye surgery.

General Guidelines [Refer to WAC 388-544-0010 (1)]

The Department covers the vision care services listed in these billing instructions, according to Department rules and subject to the limitations and requirements found in Section C of these billing instructions. The Department pays for vision care when it is:

- Covered;
- Within the scope of the eligible client's medical care program;
- Medically necessary (see *Definitions & Abbreviations*);
- Authorized, as required within these billing instructions, any applicable numbered memos, and Chapters 388-501 and 388-502 WAC; and
- Billed according to these billing instructions, any applicable numbered memos, and Chapters 388-501 and 388-502 WAC.

Prior Authorization [Refer to WAC 388-544-0010 (2) and (3)]

- Prior authorization (PA) is a form of authorization used by the provider to obtain the Department's written approval for a specific vision care service(s). The Department's approval is based on medical necessity and must be received before the service(s) are provided to clients as a precondition for payment.

- The Department does ***not*** require PA for covered vision care services that meet the clinical criteria found in Section C of these billing instructions.

- The Department requires PA for covered vision care services when the clinical criteria found in Section C of these billing instructions are not met, including the criteria associated with the expedited prior authorization (EPA) process. Please note that authorization requirements are not a denial of service.

- For PA, a provider must submit a written request to the Department (see Section D). The Department evaluates these requests on a case-by-case basis to determine whether they are medically necessary, according to the process found in WAC 388-501-0165.

Provider Requirements [WAC 388-544-0150 (1)]

Enrolled/contracted eye care providers must:

- Meet the requirements in Chapter 388-502 WAC;

- Provide only those services that are within the scope of the provider's license;

- Obtain all hardware, including the tinting of eyeglass lenses, and contact lenses for Department clients from the Department's designated supplier. See Section E for more information; and

- Return all unclaimed hardware and contact lenses to the Department's designated supplier using a postage-paid envelope furnished by the supplier.

Note: Please check the accuracy of all prescriptions and order forms submitted to the Department's contracted provider.

Who Is Eligible to Provide Vision Care Services to Department Clients? [WAC 388-544-0150 (2)]

The following providers are eligible to enroll/contract with the Department to provide and bill for vision care services furnished to eligible clients:

- Ophthalmologists;
- Optometrists;
- Opticians; and
- Ocularists.

Client Eligibility

Who Is Eligible? [Refer to WAC 388-544-0100 (1)]

Please see the Department/MPA *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

Note: Refer to the *Scope of Healthcare Services Table* webpage at: http://hrsa.dshs.wa.gov/Download/ScopeofHealthcareSvcsTable.html for an up-to-date listing of Benefit Service Packages.

Limited Coverage:

- The Department covers vision care under the Emergency Medical Only program [may also be referred to as the Alien Emergency Medical (AEM) program] **only** when the services are directly related to an emergency medical condition, and prior authorization is obtained.

- For Qualified Medicare Beneficiary only (QMB Medicare Only) clients, the Department pays for vision care only when Medicare allows the service and has made a payment or applied the payment to the client's deductible.

Department Managed Care Clients [Refer to WAC 388-544-0100 (2)]

When verifying eligibility using ProviderOne, if the client is enrolled in a Department managed care plan, managed care enrollment will be displayed on the Client Benefit Inquiry screen. Clients enrolled in Department managed care are covered for vision care services as follows:

- **Eye exams, refractions, and/or visual fields** must be requested and provided directly through the client's managed care plan.

- **Eyeglass frames, lenses, and contact lenses** must be ordered from the Department's contractor. These items are paid through fee-for-service. Refer to Section E – *Where and How do I Order*? Use the guidelines found in this billing instruction for clients enrolled in a Department managed care plan.

Note: To prevent billing denials, please check the client's eligibility **prior** to scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained from the plan. See the Department/MPA *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

Primary Care Case Management (PCCM)

For the client who has chosen to obtain care with a PCCM provider, this information will be displayed on the Client Benefit Inquiry screen in ProviderOne. These clients must obtain or be referred for services via a PCCM provider. The PCCM provider is responsible for coordination of care just like the PCP would be in a plan setting. The referral number is required in field **17a** on the CMS-1500 claim form.

Note: To prevent billing denials, please check the client's eligibility **prior** to scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained from the PCCM provider. Please see the Department/MPA *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

Note: For further information on the Department's managed care plans, see the Department's website: http://hrsa.dshs.wa.gov/HealthyOptions.

Coverage

Examinations, Refractions, Visual Field Testing, and Vision Therapy

Eye Examinations and Refraction Services
[Refer to WAC 388-544-0250 (1)]

The Department covers, without prior authorization (PA), eye examinations and refraction services with the following limitations:

- Once every 24 months for asymptomatic clients 21 years of age or older;
- Once every 12 months for asymptomatic clients 20 years of age or younger; or
- Once every 12 months, regardless of age, for asymptomatic clients of the Division of Developmental Disabilities.

Does the Department Cover Additional Examinations and Refraction Services? [Refer to WAC 388-544-0250 (2)]

Yes! The Department covers additional examinations and refraction services outside the limitations described above when:

- The provider is diagnosing or treating the client for a medical condition that has symptoms of vision problems or disease;
- The client is on medication that affects vision; or
- The service is necessary due to lost or broken eyeglasses/contacts. In this case:
  - ✓ Authorization is not required for clients 20 years of age or younger or for clients of the Division of Developmental Disabilities, regardless of age.
  - ✓ Providers must follow the Department's expedited prior authorization (EPA) process to receive payment for clients 21 years of age or older. See **EPA # 610** in Section D – *Authorization.* Providers must also document the following in the client's file:
    - ➢ The eyeglasses or contacts are lost or broken; and
    - ➢ The last examination was at least 18 months ago.

Visual Field Exams [Refer to WAC 388-544-0250 (3)]

The Department covers visual field exams for the diagnosis and treatment of abnormal signs, symptoms, or injuries. Providers must document all of the following in the client's record:

- The extent of the testing;
- Why the testing was reasonable and necessary for the client; and
- The medical basis for the frequency of testing.

Vision Therapy [Refer to WAC 388-544-0250 (4)]

The Department covers vision therapy which involves a range of treatment modalities including:

- Lenses;
- Prisms;
- Filters;
- Occlusion or patching; and
- Eye exercises/vision training/orthoptics/pleoptics, which are used for eye movement and fixation training.

The Department requires PA for eye exercises/vision training/orthoptics/pleoptics.

Coverage

Eyeglasses (Frames and/or Lenses) and Repair Services

Eyeglasses (Frames and/or Lenses) [Refer to WAC 388-544-0300 (1)]

The Department covers eyeglasses, without prior authorization (PA), as follows:

- When the following clinical criteria are met:
  - ✓ The client has a stable visual condition;
  - ✓ The client's treatment is stabilized;
  - ✓ The prescription is less than 18 months old; and
  - ✓ One of the following minimum correction needs in at least one eye is documented in the client's file:
    - ➢ Sphere power equal to, or greater than, plus or minus 0.50 diopter;
    - ➢ Astigmatism power equal to, or greater than, plus or minus 0.50 diopter; or
    - ➢ Add power equal to, or greater than, 1.0 diopter for bifocals and trifocals.
- With the following limitations:
  - ✓ Once every 24 months for clients 21 years of age or older;
  - ✓ Once every 12 months for clients 20 years of age or younger; or
  - ✓ Once every 12 months, regardless of age, for clients of the Division of Developmental Disabilities.

Accommodative Esotropia or Strabismus [WAC 388-544-0300 (2)]

The Department covers eyeglasses (frame/lenses), without PA, for clients who are 20 years of age or younger with a diagnosis of accommodative esotropia or any strabismus correction. In this situation, the client is not subject to the clinical criteria listed in "Eyeglasses (Frames and/or Lenses)."

Back-up Eyeglasses [Refer to WAC 388-544-0300 (3)]

The Department covers one pair of back-up eyeglasses for clients who wear contact lenses as their primary visual correction aid (see *Contact Lenses*, page C.11) with the following limitations:

- Once every 6 years for clients 20 years of age and older;
- Once every 2 years for clients 20 years of age and younger or regardless of age for clients of the Division of Developmental Disabilities.

Durable or Flexible Frames [Refer to WAC 388-544-0325 (1)]

The Department covers durable or flexible frames, without PA, when the client has a diagnosed medical condition that has contributed to two or more broken eyeglass frames in a 12-month period. To receive payment, the provider must:

- Follow the Department's expedited prior authorization (EPA) process. See **EPA # 619 and EPA #620** in Section D – *Authorization*; and
- Order the "durable" or "flexible" frames through the Department's designated supplier.

The Department will cover Miraflex frames for clients when all of the following clinical criteria are met:

- The client is younger than 5 years of age; and
- The provider has documented the reason(s) that the standard Airway Optical frame is not suitable for the client.

In order to receive payment, providers must follow the Department's expedited prior authorization (EPA) process. See EPA #611 in Section D.

Coating of Frames and Incidental Repairs
[Refer to WAC 388-544-0325 (2)]

The Department covers all of the following, without PA:

- Coating contract eyeglass frames to make the frames nonallergenic. Clients must have a medically diagnosed and documented allergy to the materials in the available eyeglass frames.
- Incidental repairs to a client's eyeglass frames. To receive payment, all of the following must be met:

- ✓ The provider typically charges the general public for the repair or adjustment;
- ✓ The contractor's one-year warranty period has expired;
- ✓ The cost of the repair does not exceed the Department's cost for replacement frames and a fitting fee; and
- ✓ The frequency of the repair does not exceed two per client in a six-month period. This limit does not apply to clients 20 years of age or younger or to clients of the Division of Developmental Disabilities, regardless of age.

Replacement Frames **[Refer to WAC 388-544-0325 (3)]**

The Department covers replacement eyeglass frames that have been lost or broken as follows:

- Authorization is not required for clients 20 years of age or younger or for clients of the Division of Developmental Disabilities.

- To receive payment for clients 21 years of age or older, excluding clients of the Division of Developmental Disabilities, providers must follow the Department's EPA process. See **EPA # 618** in Section D – *Authorization.*

Coverage

Eyeglass Lenses and Services

Eyeglass Lenses and Services [Refer to WAC 388-544-0350 (1)(2)]

The Department covers the following plastic scratch-resistant eyeglass lenses without prior authorization (PA):

- Single vision lenses;
- Round or flat top D-style bifocals;
- Flat top trifocals; and
- Slab-off and prism lenses (including Fresnel lenses).

Note: The Department's contractor supplies **all** plastic eyeglass lenses with a scratch-resistant coating.

Eyeglass lenses must be placed into a frame that is, or was, purchased by the Department.

High Index Eyeglass Lenses [Refer to WAC 388-544-0350 (3)(a)]

The Department covers, without PA, high index lenses when the client's medical need in at least one eye is diagnosed and documented as:

- A spherical refractive correction of plus or minus 6.0 diopters or greater; or
- A cylinder correction of plus or minus 3.0 diopters or greater.

To receive payment, providers must follow the Expedited Prior Authorization (EPA) process. See **EPA # 625** in Section D- *Authorization*.

Plastic Photochromatic Lenses [Refer to WAC 388-544-0350 (3)(b)]

The Department covers, without PA, plastic photochromatic lenses when the client's medical need is diagnosed and documented as either of the following:

Medical Problems	ICD-9-CM Diagnosis Codes
Ocular Albinism	270.2
Retinitis pigmentosa	362.74

Polycarbonate Lenses [Refer to WAC 388-544-0350 (3)(c)]

The Department covers, without PA, polycarbonate lenses for:

- Clients of the Division of Developmental Disabilities.
- Clients not of the Division of Developmental Disabilities as follows:

Medical Problems	ICD-9-CM Diagnosis Codes
For clients who are blind in one eye and need protection for the other eye, regardless of whether a vision correction is required	369.60 - 369.69 369.70 - 369.76
For infants and toddlers with motor ataxia	331.89, 781.2 334.0-334.3, 334.8-334.9, 781.3
For clients 20 years of age or younger who are diagnosed with strabismus	378.00 - 378.9
For clients 20 years of age or younger who are diagnosed with amblyopia	368.01 - 368.03

Replacing Bifocal or Trifocal Lenses

[Refer to WAC 388-544-0350 (3)(d)]

The Department covers, without prior authorization, bifocal lenses to be replaced with single vision or trifocal lenses, or trifocal lenses to be replaced with bifocal or single vision lenses when:

- The client has attempted to adjust to the bifocals or trifocals for at least 60 days;
- The client is unable to make the adjustment; and
- The bifocal or trifocal lenses being replaced are returned to the provider.

Tinting **[Refer to WAC 388-544-0350 (4)]**

The Department covers, without PA, the tinting of plastic lenses as follows:

- The client's medical need must be diagnosed and documented as one or more of the following chronic (expected to last longer than 3 months) eye conditions causing photophobia:

Medical Problems	ICD-9-CM Diagnosis Codes
Blindness	369.00 - 369.9
Chronic corneal keratitis	370.00 - 370.07
Chronic iritis, iridocyclitis (uveitis)	364.10 - 364.11 364.51 - 364.59
Diabetic retinopathy	362.01 - 362.06
Fixed pupil	379.42 -379.43, 379.45-379.46, 379.49
Glare from cataracts	366.00 - 366.9
Macular degeneration	362.50 - 362.66
Migraine disorder	346.00 - 346.91
Ocular albinism	270.2
Optic atrophy and/or optic neuritis	377.10 - 377.63
Rare photo-induced epilepsy conditions	345.00 - 345.91
Retinitis pigmentosa	362.74

- The tinting must be performed by the Department's designated lens supplier.

Replacements Due to Lost or Broken Lenses

[Refer to WAC 388-544-0350 (5)]

The Department covers replacement lenses when the lenses are lost or broken as follows:

Clients. . .	Prior Authorization?
20 years of age or younger	No.
of the Division of Developmental Disabilities, regardless of age	No.
21 years of age or older	No. Providers must follow the expedited prior authorization process. See **EPA# 623** in Section D.

Replacements Due to Refractive Changes [WAC 388-544-0350 (6)]

The Department covers replacements lenses, without PA, when the client meets one of the following clinical criteria:

- **Eye surgery**, the **effect(s) of prescribed medication**, or **one or more diseases affecting vision**:

  ✓ The client has a stable visual condition. See Definitions section for a definition of *stable visual condition*;

  ✓ The client's treatment is stabilized;

  ✓ The lens correction must have a 1.0 or greater diopter change between the sphere or cylinder correction in at least one eye; **and**

  ✓ The previous and new refractions are documented in the client's record.

  To receive payment, providers must follow the EPA process (see Section D – *Authorization* **EPA# 622**).

- **Headaches**, **blurred vision**, or **visual difficulty in school or at work**. In this case, all of the following must be documented in the client's file:

  ✓ Copy of the current prescription (less than 18 months old);

  ✓ Date of last dispensing, if known;

  ✓ Absence of a medical condition that is known to cause temporary visual acuity changes (e.g., diabetes, pregnancy, etc.); **and**

  ✓ A refractive change of at least .75 diopter or greater between the sphere or cylinder correction in at least one eye.

  To receive payment, providers must follow the EPA process. See **EPA# 624** in Section D- *Authorization*.

Coverage

Contact Lenses and Services

Contact Lenses and Services [Refer to WAC 388-544-0400 (1) (2)]

The Department covers contact lenses, without prior authorization (PA), as the client's primary refractive correction method when the client has a spherical correction of plus or minus 6.0 diopters or greater in at least one eye. **See next page for exceptions to the plus or minus 6.0 diopters criteria.** The spherical correction may be from the prescription for the glasses or the contact lenses and may be written in either "minus cyl" or "plus cyl" form.

The Department covers the following contact lenses with limitations:

- **Conventional soft** or **rigid gas permeable** contact lenses that are prescribed for daily wear; or

- **Disposable** contact lenses that are prescribed for daily wear and have a monthly or quarterly planned replacement schedule, as follows:

  ✓ 12 pairs of monthly replacement contact lenses; or
  ✓ 4 pairs of 3-month replacement contact lenses.

Medical Problems	ICD-9-CM Diagnosis Code
Hypermetropia	367.0
Myopia	367.1

Note: The Department's opinion is that the prolonged use of overnight wear may increase the risk of corneal swelling and ulceration. Therefore, the Department approves their use in limited situations where they are used as a therapeutic contact bandage lens or for aphakic clients. [Refer to WAC 388-544-0050]

Soft Toric Contact Lenses [Refer to WAC 388-544-0400 (3)]

The Department covers soft toric contact lenses, without PA, for clients with astigmatism when the following clinical criteria are met:

- The client's cylinder correction is plus or minus 1.0 diopter in at least one eye; and
- The client has a spherical correction of plus or minus 6.0 diopters or greater in at least one eye.

Medical Problems	ICD-9-CM Diagnosis Code
Astigmatism	367.20 - 367.22

Exceptions

The Department covers contact lenses, without PA, when the following clinical criteria are met. In these cases, the limitations (spherical correction of +/- 6.0 diopters or greater in at least one eye) do not apply:

- For clients diagnosed with high anisometropia.
  - ✓ The client's refractive error difference between the two eyes is at least plus or minus 3.0 diopters; and
  - ✓ Eyeglasses cannot reasonably correct the refractive errors.

Medical Problems	ICD-9-CM Diagnosis Code
High anisometropia	367.31

- Specialty contact lens designs for clients who are diagnosed with one or more of the following:

Medical Problems	ICD-9-CM Diagnosis Code
Aphakia	379.31 743.35
Keratoconus	371.60-371.62 743.41
Corneal softening	371.23

- Therapeutic contact bandage lenses only when needed immediately after eye injury or eye surgery.

Replacement Contact Lenses – Lost or Damaged

[Refer to WAC 388-544-0400 (5)]

The Department covers replacement contact lenses, limited to once every 12 months, when lost or damaged as follows:

Clients	Prior Authorization?
20 years of age or younger	No.
of the Division of Developmental Disabilities, regardless of age	No.
21 years of age or older	No. Providers must follow the expedited prior authorization process. See **EPA# 627** in Section D.

Replacement Contact Lenses – Surgery/Medication/Disease

[Refer to WAC 388-544-0400 (6)]

The Department covers replacement contact lenses when all of the clinical criteria are met. The Department requires authorization as follows:

Clients	Prior Authorization?
20 years of age or younger	No.
of the Division of Developmental Disabilities, regardless of age	No.
21 years of age or older	No. Providers must follow the expedited prior authorization process. See **EPA# 621** in Section D.

The clinical criteria are:

- One of the following caused the vision change:

  ✓ Eye surgery;
  ✓ The effect(s) of prescribed medication; or
  ✓ One or more diseases affecting vision**.**

(continued on next page.)

- The client has a stable visual condition (see Definitions section – *stable visual condition*);
- The client's treatment is stabilized; **and**
- The lens correction has a 1.0 or greater diopter change in at least one eye between the sphere or cylinder correction. The previous and new refraction must be documented in the client's record.

Coverage

Ocular Prosthetics and Surgeries

Ocular Prosthetics [Refer to WAC 388-544-0500]

The Department covers ocular prosthetics when provided by any of the following:

- An ophthalmologist;
- An ocularist; or
- An optometrist who specializes in prosthetics.

Cataract Surgery [Refer to WAC 388-544-0550 (1)]

The Department covers cataract surgery, without PA, when the following clinical criteria are met:

- Correctable visual acuity in the affected eye at 20/50 or worse, as measured on the Snellen test chart; or

- One or more of the following conditions:

  - ✓ Dislocated or subluxated lens;
  - ✓ Intraocular foreign body;
  - ✓ Ocular trauma;
  - ✓ Phacogenic glaucoma;
  - ✓ Phacogenic uveitis;
  - ✓ Phacoanaphylactic endopthalmitis; or
  - ✓ Increased ocular pressure in a person who is blind and is experiencing ocular pain.

Surgery for Strabismus [WAC 388-544-0550 (2)]

The Department covers strabismus surgery as follows:

Clients	Policy
17 years of age or younger	The provider must clearly document the need in the client's record. The Department does not require authorization.
18 years of age or older	Covered when the clinical criteria are met. To receive payment, providers must follow the expedited prior authorization (EPA) process. The clinical criteria are: • The client has double vision; and • The surgery is not being performed for cosmetic reasons. To receive payment for clients 18 years of age or older, providers must use the Department's EPA process (see the current Department/MPA *Physician-Related Services Billing Instructions*, Section I).

Surgery for Blepharoplasty or Blepharoptosis
[WAC 388-544-0550 (3)]

The Department covers blepharoplasty or blepharoptosis surgery when all of the clinical criteria are met. To receive payment, providers must follow the Department's EPA process. The clinical criteria are:

- The client's excess upper eyelid skin is blocking the superior visual field; and
- The blocked vision is within 10 degrees of central fixation using a central visual field test.

Noncovered Services

What Is Not Covered? [WAC 388-544-0575]

The Department does not cover the following:

- Executive style eyeglass lenses;
- Bifocal contact lenses;
- Daily and two week disposable contact lenses;
- Extended wear soft contact lenses, except when used as therapeutic contact bandage lenses or for aphakic clients;
- Custom colored contact lenses;
- Services for cosmetic purposes only;
- Glass lenses;
- Group vision screening for eyeglasses;
- Nonglare or anti-reflective lenses;
- Progressive lenses;
- Refractive surgery of any type that changes the eye's refractive error. The intent of the refractive surgery procedure is to reduce or eliminate the need for eyeglass or contact lens corrections; **Exception:** Intraocular lens implantation following cataract surgery.
- Sunglasses and accessories that function as sunglasses (e.g., "clip-ons"); and
- Upgrades at private expense to avoid the Department's contract limitations. For example:

  ✓ Frames that are not available through the Department's contract; or
  ✓ Noncontract frames or lenses for which the client or other person pays the difference between the Department's payment and the total cost.

Note: A provider may request an exception to rule (ETR) for a noncovered service as described in WAC 388-501-0160. Refer to WAC 388-502-0160 for rules on billing a client.

Coverage Table

Due to its licensing agreement with the American Medical Association, the Department publishes only the official, brief CPT® procedure code descriptions. To view the entire description, please refer to your current CPT book.

Procedure Code	Modifier	Brief Description	PA?	Policy/ Comments	Maximum Allowable Fee
Contact Lens Services					
92070		Fitting of contact lens	No	(Does not include any follow-up days)	On-line Fee Schedules*
Spectacle Fitting fees, monofocal					
92340		Fitting of spectacles	No		On-line Fee Schedules
92352		Special spectacles fitting	No		
Spectacle Fitting fees, bifocal					
92341		Fitting of spectacles	No		On-line Fee Schedules
Spectacle Fitting fees, multifocal					
92342		Fitting of spectacles	No		On-line Fee Schedules
92353		Special spectacles fitting	No		
Other					
92354		Special spectacles fitting	Yes		On-line Fee Schedules
92355		Special spectacles fitting	Yes		
92370		Repair & adjust spectacles	No		
92371		Repair & adjust spectacles	No		
92499		Eye service or procedure	No		

Note: Fitting fees are *not* currently covered by Medicare and may be billed directly to the Department without attaching a Medicare denial.

***Note:** To view the Department's maximum allowable fees for any of these codes, download the Department/MPA Vision Care Fee Schedule at: http://hrsa.dshs.wa.gov/rbrvs/index.html.

Procedure Code	Modifier	Brief Description	PA?	Policy/ Comments	Maximum Allowable Fee
General Ophthalmological Services					
92002		Eye exam, new patient	No		On-line Fee Schedules*
92004		Eye exam, new patient	No		
92012		Eye exam established pat	No		
92014		Eye exam & treatment	No		
Special Ophthalmological Services					
92015		Refraction	No		On-line Fee Schedules
92018		New eye exam & treatment	No		
92019		Eye exam & treatment	No		
92020		Special eye evaluation	No		
92025		Corneal topography	Yes		
92025	TC	Corneal topography	Yes		
92025	26	Corneal topography	Yes		
92060		Special eye evaluation	No		
92060	TC	Special eye evaluation	No		
92060	26	Special eye evaluation	No		
92065		Orthoptic/pleoptic training	Yes		
92065	TC	Orthoptic/pleoptic training	Yes		
92065	26	Orthoptic/pleoptic training	Yes		
92081		Visual field examination(s)	No		
92081	TC	Visual field examination(s)	No		
92081	26	Visual field examination(s)	No		
92082		Visual field examination(s)	No		
92082	TC	Visual field examination(s)	No		
92082	26	Visual field examination(s)	No		

***Note:** To view the Department's maximum allowable fees for any of these codes, download the Department Vision Care Fee Schedule at: http://maa.dshs.wa.gov/rbrvs/index.html

Procedure Code	Modifier	Brief Description	PA?	Policy/ Comments	Maximum Allowable Fee
92083		Visual field examination(s)	No		On-line Fee Schedules*
92083	TC	Visual field examination(s)	No		
92083	26	Visual field examination(s)	No		
92100		Serial tonometry exam(s)	No		
92120		Tonography & eye evaluation	No		
92130		Water provocation tonography	No		
92135		Opthalmic dx imaging	No		
92135	TC	Opthalmic dx imaging	No		
92135	26	Opthalmic dx imaging	No		
92136		Ophthalmic biometry	No		
92136	TC	Ophthalmic biometry	No		
92136	26	Ophthalmic biometry	No		
92140		Glaucoma provocative tests	No		

***Note:** To view the Department's maximum allowable fees for any of these codes, download the Department Vision Care Fee Schedule at: http://maa.dshs.wa.gov/rbrvs/index.html

Procedure Code	Modifier	Brief Description	PA?	Policy/ Comments	Maximum Allowable Fee
Ophthalmoscopy					
92225		Special eye exam, initial	No		On-line Fee Schedules*
92226		Special eye exam, subsequent	No		
92230		Eye exam with photos	No		
92235		Eye exam with photos	No		
92235	TC	Eye exam with photos	No		
92235	26	Eye exam with photos	No		
92240		Icg angiography	No		
92240	TC	Icg angiography	No		
92240	26	Icg angiography	No		
92250		Eye exam with photos	No		
92250	TC	Eye exam with photos	No		
92250	26	Eye exam with photos	No		
92260		Ophthalmoscopy/ dynamometry	No		

***Note:** To view the Department's maximum allowable fees for any of these codes, download the Department Vision Care Fee Schedule at: http://maa.dshs.wa.gov/rbrvs/index.html

Procedure Code	Modifier	Brief Description	PA?	Policy/ Comments	Maximum Allowable Fee
Other Specialized Services					
92265		Eye muscle evaluation	No		On-line Fee Schedules
92265	TC	Eye muscle evaluation	No		
92265	26	Eye muscle evaluation	No		
92270		Electro-oculography	No		
92270	TC	Electro-oculography	No		
92270	26	Electro-oculography	No		
92275		Electroretinography	No		
92275	TC	Electroretinography	No		
92275	26	Electroretinography	No		
92283		Color vision examination	No		
92283	TC	Color vision examination	No		
92283	26	Color vision examination	No		
92284		Dark adaptation eye exam	No		
92284	TC	Dark adaptation eye exam	No		
92284	26	Dark adaptation eye exam	No		
92285		Eye photography	No		
92285	TC	Eye photography	No		
92285	26	Eye photography	No		
92286		Internal eye photography	No		
92286	TC	Internal eye photography	No		
92286	26	Internal eye photography	No		
92287		Internal eye photography	No		

***Note:** To view the Department's maximum allowable fees for any of these codes, download the Department Vision Care Fee Schedule at: http://maa.dshs.wa.gov/rbrvs/index.html

Procedure Code	Modifier	Brief Description	PA?	Policy/ Comments	Maximum Allowable Fee
Contact Lens Services					
92310		Contact lens fitting	No		On-line Fee Schedules*
92311		Contact lens fitting	No		
92312		Contact lens fitting	No		
92313		Contact lens fitting	No		
Ocular Prosthesis					
V2623		Plastic eye prosth custom	No		On-line Fee Schedules*
V2624		Polishing artificial eye	No		
V2625		Enlargemnt of eye prosthesis	No		
V2626		Reduction of eye prosthesis	No		
V2627		Scleral cover shell	No		
V2628		Fabrication & fitting	No		
V2630		Anter chamber intraocul lens	No		
V2631		Iris support intraoclr lens	No		
V2632		Post chmbr intraocular lens	No		
Contact Lens Services					
92314		Prescription of contact lens	No		On-line Fee Schedules
92315		Prescription of contact lens	No		
92316		Prescription of contact lens	No		
92317		Prescription of contact lens	No		
Miscellaneous Vision Services					
V2799		Miscellaneous vision service	No	*Use for operating costs in nursing homes. (Allowed once per visit, per facility, regardless of how many clients are seen, when eyeglass fitting or eligible repair services are performed.)*	On-line Fee Schedules

***Note:** To view the Department's maximum allowable fees for any of these codes, download the Department Vision Care Fee Schedule at: http://maa.dshs.wa.gov/rbrvs/index.html

Authorization

Note: Please see the Department/MPA *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for more information on requesting authorization.

General Guidelines **[Refer to WAC 388-544-0560]**

- The Department requires providers to obtain authorization for covered vision care services as required in Chapters 388-501 and 388-502 WAC, these billing instructions and numbered memos, or when the required clinical criteria are not met. [**WAC 388-544-0560 (1)]**
- Please note that authorization requirements are not a denial of service.
- When a service requires authorization, the provider **must properly request** written authorization in accordance with the Department's rules, these billing instructions, and applicable numbered memos.
- When the provider does not properly request authorization, the Department returns the request to the provider for proper completion and resubmission. The Department does not consider the returned request to be a denial of service.
- Upon request, a provider must provide documentation to the Department showing how the client's condition met the criteria for PA and EPA.
- The Department's authorization of service(s) does not necessarily guarantee payment.

Prior Authorization

Prior authorization (PA) is a form of authorization used by the provider to obtain the Department's written approval for a specific vision care service(s). The Department's approval is based on medical necessity and must be received before the service(s) are provided to clients as a precondition for payment.

Limitation Extensions [Refer to WAC 388-544-0560 (6)]

The Department evaluates requests for authorization of covered vision care services that exceed limitations in these billing instructions on a case-by-case basis in accordance with WAC 388-501-0169.

The provider must justify that the request is medically necessary for that client.

> **Note:** Requests for limitation extensions must be appropriate to the client's eligibility and/or program limitations. Not all eligibility programs cover all services.
>
> **For example**: Eyeglasses are not covered under the Family Planning Only Program.

Requesting a Limitation Extension

There are two ways to request a limitation extension:

1) ***Complete*** the **Vision Care Authorization Request form, DSHS 13-739.** This form is required for any Vision Care authorization request; or

2) Follow the EPA process for certain limitation extensions by using an EPA number. These EPA numbers will be subject to post payment review as in any other authorization process.

   The written request must state the following:

   1. The client's name and ProviderOne Client ID;
   2. The provider's full name, NPI and fax number;
   3. Additional service(s) requested;
   4. Date of last dispensing and copy of last two prescriptions;
   5. The primary diagnosis code and applicable procedure code; and
   6. Client-specific clinical justification for additional services.

   Send your written request to the Department (see *Important Contacts* section).

> **Note**: To **view and download** a Vision Care Authorization Request form, DSHS 13-739, or ProviderOne Request form, DSHS 13-835, visit the Department Forms and Records Management Service web site: http://www.dshs.wa.gov/msa/forms/eforms.html.

Expedited Prior Authorization (EPA)

[Refer to WAC 388-544-0560]

The Expedited Prior Authorization (EPA) process allows providers to apply the Department's clinical criteria and certify medical necessity. The Department establishes clinical criteria and identifies the criteria with specific codes. Providers then create an EPA number using those authorization codes.

To bill the Department for diagnoses, procedures and services that meet the EPA criteria on the following pages, the provider must **create a 9-digit EPA number.** The first six digits of the EPA number must be **870000**. The last 3 digits must be the code assigned to the diagnostic condition, procedure, or service that meets the EPA criteria in this section. Enter the EPA number in field **23** on the hard copy billing form, or in the *Authorization* or *Comments* field when billing electronically.

Example: The 9-digit authorization number for an exam for an adult client, who has had an exam 20 months ago but now has lost his or her glasses, would be **870000610.**

870000 = first six digits of all expedited prior authorization numbers
610 = last three digits of an EPA number indicating the service and which criteria the case meets

- The Department denies payment for vision care claims submitted without the required EPA number, or the appropriate diagnosis, procedure code, or service as indicated by the last three digits of the EPA number.
- The Department may recoup any payment made to a provider if the Department later determines that the service was not properly authorized or did not meet the EPA criteria. Refer to WAC 388-502-0100(1)(c) and WAC 388-544-0560(7).
- When a client's situation does not meet the EPA criteria for vision care a provider must request prior authorization.

See Expedited Prior Authorization Criteria Coding List on next page…

Washington State
Expedited Prior Authorization Criteria Coding List
Use these codes on claims forwarded to the Department and the Department's contractor

Code	Criteria	Code	Criteria

Exams

Visual Exam/Refraction
(Optometrists/Ophthalmologists only)
CPT: 92014-92015

610 **Eye Exam/Refraction - Due to loss or breakage:** For adults within 2 years of last exam when no medical indication exists and the provider documents **both** of the following in the client's record:

1) Glasses that are broken or lost or contacts that are lost or damaged; **and**
2) Last exam was at least 18 months ago.

Note: You do not need an EPA # when billing for children or any client of the Division of Developmental Disabilities.

Replacement Glasses

Dispensing/Fitting Fees
CPT: 92340-92342

615 **Glasses (both frames and lenses) – Due to loss or breakage** for adults - glasses may be replaced only once in a 24 month period (without PA.) The provider must document **all** of the following in the client's record:

1) Copy of current prescription (less than 18 months old); **and**
2) Date of last dispensing; **and**
3) Both frames and lenses are broken or lost.

Note: You do not need an EPA # when billing for children or any client of the Division of Developmental Disabilities.

Replacement Frames

Dispensing/Fitting Fees
CPT: 92340-92342

618 **Replacement Frames –Due to loss or breakage:** For adults - lost or broken frames may be replaced when the provider documents **all** of the following in the client's record:

1) No longer covered under the manufacturer's 1-year warranty; **and**
2) Copy of current prescription demonstrating the medical necessity for prescription eye wear; (see pg. C.3) **and**
3) Documentation of broken or lost frames.

Note: You do not need an EPA # when billing for children or any client of the Division of Developmental Disabilities.

Specialty Frames

611 **Miraflex Frames** for children when all of the following clinical criteria are met:

- The client is less than 5 years of age; and
- The provider has documented the reason(s) that the standard Airway Optical frame is not suitable for the client.

Washington State
Expedited Prior Authorization Criteria Coding List
Use these codes on claims forwarded to the Department and the Department's contractor

Code	Criteria
619	**Durable Frames** for adults and children - when the provider documents in the client's record that the client has a diagnosed medical condition that has contributed to two or more broken eyeglass frames in a 12-month period.
620	**Flexible Frames** for adults and children - when the provider documents in the client's record that the client has a diagnosed medical condition that has contributed to two or more broken eyeglass frames in a 12-month period.

Replacement Eyeglass Lenses

Dispensing/Fitting Fees
CPT: 92340-92342

Code	Criteria
623	**Replacement eyeglass lenses – Due to loss or breakage:** For adults, lost or broken lenses may be replaced when the provider documents **all** of the following in the client's record: 1) Copy of current prescription (prescription is less than 18 months old); **and** 2) Date of last dispensing (if known); **and** 3) Documentation of lens damage or loss.

Note: You do not need an EPA # when billing for children or any client of the Division of Developmental Disabilities.

Code	Criteria
622	**Replacement eyeglass lenses - Due to eye surgery/effects of prescribed medication/diseases affecting vision:** For adults and children - within 2 years of last dispensing when: 1) The client has a stable visual condition (see the *Definitions & Abbreviations* section); **and** 2) The client's treatment is stabilized; **and** 3) The lens correction must have a 1.0 or greater diopter change between the sphere or cylinder correction in at least one eye; **and** 4) The provider documents the previous and new refractions in the client record.

Washington State
Expedited Prior Authorization Criteria Coding List
Use these codes on claims forwarded to the Department and the Department's contractor

Code	Criteria

Eyeglass Lenses (cont.)

624 **Replacement eyeglass lenses – Due to headaches/blurred vision/difficulty with school or work:** For adults and children - within 2 years of last dispensing, for refractive changes (provider error is the responsibility of the provider to warranty their work and replace the lens at no charge) when the provider documents **all** of the following in the client's record:

1) The client has symptoms e.g., headaches, blurred vision, difficulty with school or work; **and**
2) Copy of current prescription (prescription is less than 18 months old for adults); **and**
3) Date of last dispensing, if known; **and**
4) Absence of a medical condition that is known to cause temporary visual acuity changes (e.g. diabetes, pregnancy); **and**
5) A refractive change of at least .75 diopter or greater between the sphere or cylinder correction in at least one eye.

625 **High index eyeglass lenses** for adults and children when the provider documents **one** of the following in the client's record:

1) A spherical refractive correction of +\- 6.0 diopters or greater; **or**
2) A cylinder correction of +\- 3.0 diopters or greater.

Contact Lenses

Dispensing/Fitting Fees
CPT: 92070, 92310-92317

627 **Replacement Contact Lenses – Due to loss or breakage**: For adults - once every 12 months when contact lenses are lost or damaged **and** the prescription is less than 18 months old.

Note: You do not need an EPA # when billing for children or any client of the Division of Developmental Disabilities.

621 **Replacement Contact Lenses – Due to eye surgery/effects of prescribed medication/one or more diseases affecting vision:** For adults - within 1 year of last dispensing when:

1) The client has a stable visual condition (see the *Definitions & Abbreviations* section); **and**
2) The client's treatment is stabilized; **and**
3) The lens correction has a 1.0 or greater diopter change in at least one eye between the sphere or cylinder correction; **and**
4) The provider documents the previous and new refraction in the client record.

Note: You do not need an EPA # when billing for children or any client of the Division of Developmental Disabilities.

Note: See the current Department/MPA *Physician-Related Services Billing Instructions*, Section I for EPA numbers for blepharoplasties and strabismus surgery.

Where and How Do I Order?

Who Is the Department's Eyeglass Contractor?

The Department's vision hardware contractor is Airway Optical, which is part of the Washington State Department of Correctional Industries.

Providers must obtain all hardware through Airway Optical. The Department does **not** pay any other optical manufacturer or provider for frames, lens, or contact lenses.
[Refer to WAC 388-544-0150]

Send or fax completed prescriptions and/or purchase orders for sample kits, eyeglass frames, eyeglass lenses, and contact lenses to:

Airway Optical
11919 West Sprague Avenue
PO Box 1959
Airway Heights, WA 99001-1959
Customer Service: 1-888-606-7788 (toll free)
Fax: 1-888-606-7789 (toll free)

General Ordering Information

- **Call Airway Optical for prescription order forms,** toll-free–
  Phone: 1-888-606-7788 or Fax: 1-888-606-7789.

- **For timely processing, all information on the prescription must be complete and legible**.

- Mail or fax eyeglass orders, along with a copy of the medical eligibility verification (MEV), to the contractor. Airway Optical requires that each fax page be legible. Keep a copy of the order on file, along with the fax transmittal.

- Include the appropriate ICD-9-CM diagnosis code (and EPA number, if applicable) on all order forms for eyeglasses and contact lenses. If this information is not included on the form, the contractor is required to reject and return the order.

- Airway Optical rejects and returns orders for clients for whom the Department has already purchased a pair of lenses and/or complete frames or contact lenses within the applicable benefit period (12 or 24 months, as appropriate).

- The Department requires Airway Optical to process prescriptions within 15 working days, including shipping and handling time, after receipt of a **properly** completed order. The Department allows up to 20 working days for completing orders for specialty eyeglass lenses or contact lenses. Airway Optical must notify the provider when a prescription cannot be processed within either of these specified delivery timeframes.

- To obtain general information, or to inquire about overdue prescriptions, call Airway Optical at 1-888-606-7788 or fax the request to Airway optical at 1-888-606-7789. Please have the medical record number ready when you call. **The phone number for Airway Optical is for provider use only**. Airway Optical cannot check a client's eligibility. For questions regarding client eligibility, call the Department at 1-800-562-3022.

- Airway Optical ships the eyeglasses to the provider.

- Airway Optical bills the Department directly for all hardware for medical assistance clients.

Note: If a client does not return to the provider's office to pick up eyeglasses, then the provider should do the following:

- Keep the completed pair of eyeglasses for three months;
- Make a good faith effort (a minimum of three attempts) to contact the client; and
- After the above conditions are met, the provider may keep the glasses to use for repair parts.

An adult client is not eligible for glasses for 24 months from the date of last dispensing, unless prior authorization is obtained. This does not apply to clients of the Division of Developmental Disabilities, or to children.

Billing and Claim Forms

What Are the General Billing Requirements?

Providers must follow the Department/MPA *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html. These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments;
- What fee to bill the Department for eligible clients;
- When providers may bill a client;
- How to bill for services provided to primary care case management (PCCM) clients;
- Billing for clients eligible for both Medicare and Medicaid;
- Third-party liability; and
- Record keeping requirements.

Special Instructions for Vision Care Services

Special Ophthalmological Services - Bilateral Indicator: The Department considers special ophthalmological services to be bilateral if they are routinely provided on both eyes. This includes CPT code 92015, determination of refractive state**.** Do not use bilateral modifier 50 or modifiers LT and RT for these services since payment is based on a bilateral procedure.

Billing for Ocular Prosthetics: Refer to the Department's Physician-Related Services Fee Schedule for a complete list of CPT codes and maximum allowable fees. Refer to the Department/MPA Vision Care Fee Schedule for HCPCS procedure codes and maximum allowable fees.

Reporting Diagnoses: The Department requires a diagnosis for a medical condition. The diagnosis assigned to a procedure is the first-level justification for that procedure.

> **Note**: Use ICD-9-CM diagnosis code V72.0 (Examination of eyes and vision) only for eye exams in which no problems were found.

E & M Procedure Codes: Use evaluation and management (E&M) codes for eye examinations for a medical problem, **not** for the prescription of eyeglasses or contact lenses. ICD-9-CM diagnosis codes 367.0-367.9 and "V" codes are **not** appropriate when billing E&M services.

The Department does not pay for:

- E&M codes and an eye exam on the same day;
- Nursing home visits and an eye exam on the same day; or
- Any services with prescriptions over two years old.

Modifier 55 for Optometrists: When billing follow-up for surgery procedures, use the surgery code and modifier 55 to bill the Department.

- **Billing:** Since payment for the surgical procedure codes with modifier 55 is a one-time payment covering the postoperative period, the Department denies any claims submitted for related services provided during that period. You must bill any other specific problems treated during that period using modifier 25.

- **Payment:** The amount allowed for postoperative management is based on the Physician-Related Services Fee Schedule.

Billing for Vision Care Services Provided to Clients Eligible for Both Medicare Part B and Medicaid

- Bill the Department for refractions and fitting fees. Medicare does not currently cover these services.

- Refer to the Department/MPA ProviderOne Billing and Resource Guide at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for up-to-date information on billing for clients eligible for Medicare and Medicaid.

Completing the CMS-1500 Claim Form

Note: Refer to the Department/MPA *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on completing the CMS-1500 Claim Form.

Payment

[Refer to WAC 388-544-0600]

Payment Information

- To receive payment, vision care providers must bill the Department according to the conditions of payment found in these billing instructions. See *Billing and Claim Forms*, Section F, for more information.

- The Department pays 100% of the Department contract price for covered eyeglass frames, lenses, and contact lenses when these items are obtained through the Department's approved contractor. See *Where and How Do I Order?,* Section E, for more information.

Fee Schedule

You may access the Department/MPA Vision Care Fee Schedule at: http://hrsa.dshs.wa.gov/RBRVS/Index.html.