Washington Apple Health (Medicaid)

Vision Hardware Program
Billing Guide
(For clients age 20 and younger)

July 1, 2019

Every effort has been made to ensure this guide’s accuracy. If an actual or apparent conflict between this document and an agency rule arises, the agency rules apply.
About this guide*

This publication takes effect July 1, 2019, and supersedes earlier billing guides to this program.

HCA is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

What has changed?

<table>
<thead>
<tr>
<th>Subject</th>
<th>Change</th>
<th>Reason for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated managed care regions</td>
<td>Effective July 1, 2019, a new integrated managed care region, called North Sound, will be implemented. North Sound region includes Island, San Juan, Skagit, Snohomish and Whatcom counties.</td>
<td>New integrated managed care region</td>
</tr>
<tr>
<td>Behavioral Health Organization (BHO)</td>
<td>Updated the information for Behavioral Health Organization</td>
<td>The agency manages the remaining contracts for behavioral health services.</td>
</tr>
</tbody>
</table>

How can I get agency provider documents?

To access provider alerts, go to the agency’s provider alerts webpage.

To access provider documents, go to the agency’s provider billing guides and fee schedules webpage.

*This publication is a billing instruction.*
Where can I download agency forms?

To download an agency provider form, go to HCA’s Billers and providers webpage, select Forms & publications. Type the HCA form number into the Search box as shown below (Example: 13-835).

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</tr>
</thead>
<tbody>
<tr>
<td>Becoming a provider or submitting a change of address or ownership</td>
<td>See the agency’s ProviderOne Resources webpage</td>
</tr>
<tr>
<td>Finding out about payments, denials, claims processing, or agency managed care organizations</td>
<td></td>
</tr>
<tr>
<td>Electronic billing</td>
<td></td>
</tr>
<tr>
<td>Finding agency documents (e.g., billing guides and fee schedules)</td>
<td></td>
</tr>
<tr>
<td>Private insurance or third-party liability, other than agency managed care</td>
<td></td>
</tr>
<tr>
<td>Where do I order hardware?</td>
<td>Order hardware from the agency’s contractor: CI Optical</td>
</tr>
<tr>
<td></td>
<td>11919 West Sprague Avenue</td>
</tr>
<tr>
<td></td>
<td>PO Box 1959</td>
</tr>
<tr>
<td></td>
<td>Airway Heights, WA 99001-1959</td>
</tr>
<tr>
<td></td>
<td>Customer Service Telephone 888-606-7788 (toll free)</td>
</tr>
<tr>
<td></td>
<td>Fax: 888-606-7789 (toll free)</td>
</tr>
<tr>
<td>Who do I contact if I have a client who needs low vision aids?</td>
<td>Community Services for the Blind and Partially Sighted (Seattle)</td>
</tr>
<tr>
<td></td>
<td>Telephone: 800-458-4888 (toll free)</td>
</tr>
<tr>
<td></td>
<td>Lilac Blind Foundation (Spokane)</td>
</tr>
<tr>
<td></td>
<td>Telephone: 800-422-7893 (toll free)</td>
</tr>
<tr>
<td>How do I obtain prior authorization (PA) or a limitation extension (LE)?</td>
<td>Providers may submit their requests online (See the agency’s Prior Authorization web page) or by submitting the request in writing. Written or faxed requests for prior authorization or limited extensions must include:</td>
</tr>
<tr>
<td></td>
<td>• A completed, TYPED General Information for Authorization form, HCA 13-835. This request form MUST be the initial page when you submit your request.</td>
</tr>
<tr>
<td></td>
<td>• A completed Vision Care Limitation Extension form, HCA 13-739, and all the documentation listed on this form and any other medical justification.</td>
</tr>
<tr>
<td></td>
<td>Fax your request to: 866-668-1214.</td>
</tr>
<tr>
<td></td>
<td>See the agency’s Prior Authorization webpage. For information about downloading agency forms, see Where can I download agency forms?</td>
</tr>
</tbody>
</table>
Definitions

Vision Hardware for Clients Age 20 and Younger

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to Chapter 182-500 WAC for a complete list of definitions for Washington Apple Health.

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 182-544-0050)

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 agency generally approves only those lenses that are designed to be worn as daily wear (remove at night). (WAC 182-544-0050)

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 agency generally approves only those lenses that are designed to be worn as daily wear (remove at night). (WAC 182-544-0050)

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 182-544-0050)

ICD 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.

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, 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 182-544-0050)

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 182-544-0050)
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 182-544-0050)
About the Program

What is the scope of vision hardware program?
(Chapter 182-544 WAC)

The vision hardware program is available to eligible clients who are age 20 and younger.

What is the purpose of the program?

The purpose of the program is to provide the following hardware to eligible clients age 20 and younger:

- Ocular prosthetics (see the Ocular Prosthetics section in the Coverage Table for coverage for clients age 21 and older)
- Prescription eyeglasses (frames and lenses)
- Contact lenses

What are the general guidelines?
(WAC 182-544-0010 (1))

The agency covers the vision hardware listed in this billing guide, according to agency rules and subject to the limitations and requirements found in the coverage section of this guide. The agency pays for vision hardware when it is:

- Covered
- Within the scope of the eligible client's medical care program
- Medically necessary (see Chapter 182-500 WAC)
- Authorized, as required within this billing guide, any applicable provider alerts, and Chapters 182-501 and 182-502 WAC
- Billed according to this billing guide and Chapters 182-501 and 182-502 WAC
What provider requirements must be met?  
(WAC 182-544-0150 (1))

Eye care providers who are enrolled or contracted with the agency must:

- Meet the requirements in Chapter 182-502 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 agency clients from the agency’s designated supplier. See Ordering Vision Hardware
- Return all unclaimed hardware and contact lenses to the agency’s designated supplier using a postage-paid envelope furnished by the supplier

**Note:** Check the accuracy of all prescriptions and order forms submitted to the agency’s contracted provider.

Who may provide vision hardware to agency clients?  
(WAC 182-544-0150 (2))

The following providers are eligible to enroll or contract with the agency to provide and bill for vision hardware furnished to eligible clients:

- Ophthalmologists
- Optometrists
- Opticians
- Ocularists
Client Eligibility

Who is eligible?
(WAC 182-544-0100 (1))

Eligible clients who are age 20 and younger may receive the vision hardware described in this billing guide depending on their benefit package.

Note: Refer to the Program Benefit Packages and Scope of Services web page for an up-to-date listing of benefit packages.

Most Apple Health clients are enrolled in an agency-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO’s provider network, unless prior authorized or to treat urgent or emergent care. See the agency’s Apple Health managed care page for further details.

It is important to always check a client’s eligibility prior to providing any services because it affects who will pay for the services.

Limited coverage

- The agency covers vision hardware under the Alien Emergency Medical (AEM) program as described in WAC 182-501-0160, when the hardware is necessary to treat a qualifying emergency medical condition only.

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

How do I verify a client’s eligibility?

Check the client’s Services Card or follow the two-step process below to verify that a client has Apple Health coverage for the date of service and that the client’s benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

Is the client enrolled in an agency-contracted managed care organization (MCO), in a behavioral health organization (BHO), or is the client receiving services through fee-for-service (FFS) Apple Health?
Verifying eligibility is a two-step process:

**Step 1. Verify the patient’s eligibility for Apple Health.** For detailed instructions on verifying a patient’s eligibility for Apple Health, see the Client Eligibility, Benefit Packages, and Coverage Limits section in the agency’s ProviderOne Billing and Resource Guide.

If the patient is eligible for Apple Health, proceed to **Step 2.** If the patient is **not** eligible, see the note box below.

**Step 2. Verify service coverage under the Apple Health client’s benefit package.** To determine if the requested service is a covered benefit under the Apple Health client’s benefit package, see the agency’s Program Benefit Packages and Scope of Services web page.

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**Note:** Patients who are not Apple Health clients may submit an application for health care coverage in one of the following ways:

1. By visiting the Washington Healthplanfinder’s website at: www.wahealthplanfinder.org
2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)
3. By mailing the application to: Washington Healthplanfinder PO Box 946 Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit www.wahealthplanfinder.org or call the Customer Support Center.
Are clients enrolled in an agency-contracted managed care organization (MCO) eligible?
(WAC 182-544-0100 (2))

Yes. Most Medicaid-eligible clients are enrolled in one of the agency’s contracted managed care organizations (MCOs). For these clients, managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne. Eligible clients enrolled in an MCO are covered for vision hardware as follows:

- **Eye exams, fitting fees, refractions, and visual fields** must be requested and provided directly through the client’s MCO.

- **Eyeglass frames, lenses, and contact lenses** must be ordered from the agency’s contractor. These items are paid through fee-for-service (FFS). See Ordering Vision Hardware. Use the guidelines found in this billing guide for clients enrolled in an agency-contracted MCO.

**Note:** To prevent billing denials, 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 agency-contracted MCO, if appropriate. See the agency’s ProviderOne Billing and Resource Guide for instructions on how to verify a client’s eligibility.

**Managed care enrollment**

Apple Health (Medicaid) places clients into an agency-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. This eliminates a person being placed temporarily in FFS while they are waiting to be enrolled in an MCO or reconnected with a prior MCO. This enrollment policy also applies to clients in FFS who have a change in the program they are eligible for.

New clients are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health managed care. Renewing clients are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

**Checking eligibility**

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder’s Get Help Enrolling page.

- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO’s requirements and be compliant with the MCO’s policies.
Behavioral Health Organization (BHO)

The Health Care Authority manages the contracts for behavioral health services (mental health and substance use disorder) for the following three Regional Service Areas (RSAs):

- **Great Rivers**: Includes Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum counties
- **Salish**: Includes Clallam, Jefferson, and Kitsap counties
- **Thurston-Mason**: Includes Thurston and Mason counties

To view a map and table of the integrated managed care plans available within each region, see [Changes coming to Washington Apple Health](Changes coming to Washington Apple Health). You may also refer to the agency’s [Apple Health managed care webpage](Apple Health managed care webpage).

See the agency’s [Mental Health Services Billing Guide](Mental Health Services Billing Guide) for details.

Apple Health – Changes for July 1, 2019

**Effective July 1, 2019,** HCA is continuing to shift to whole-person care to allow better coordination of care for both body (physical health) and mind (mental health and drug or alcohol treatment, together known as “behavioral health”). This delivery model is called Integrated Managed Care (formerly Fully Integrated Managed Care, or FIMC, which still displays in ProviderOne and Siebel).

Agency-contracted managed care organizations (MCOs) in certain Regional Service Areas (RSAs) will expand their coverage of behavioral health services (mental health and substance use disorder treatment), along with continuing to cover physical health services. The RSAs are outlined in the [Integrated Managed Care Regions](Integrated Managed Care Regions) section.

Apple Health clients who are not enrolled in an agency-contracted MCO for their physical health services (e.g., dual-eligible Medicare-Medicaid clients) will still receive their behavioral health services through one of the agency-contracted MCOs. The MCO will provide only behavioral health services for the client.

Most clients will remain with the same health plan, except in regions where client’s plan will no longer be available. HCA will auto-enroll these clients to one of the offered plans.

Clients can change their plan at any time by:

- Visiting the [ProviderOne Client Portal](ProviderOne Client Portal).
- Calling Apple Health Customer Service toll-free at 1-800-562-3022. This automated system is available 24 hours a day, 7 days a week.
- Requesting a change through our secure [Contact us – Apple Health (Medicaid) client web form](Contact us – Apple Health (Medicaid) client web form). Select the topic “Enroll/Change Health Plans.”
Vision Hardware for Clients Age 20 and Younger

- Visiting the Washington Healthplanfinder (only for clients with a Washington Healthplanfinder account).

**Integrated managed care**

For clients who live in an integrated managed care region, all physical health services, mental health services, and drug and alcohol treatment are covered and coordinated by the client’s agency-contracted MCO. The BHO will not provide behavioral health services in these regions. Clients living in an integrated managed care region will enroll with an MCO of their choice that is available in that region. If the client does not choose an MCO, the client will be automatically enrolled into one of the available MCOs, unless the client is American Indian/Alaska Native (AI/AN). Clients currently enrolled in one of the available MCOs in their region may keep their enrollment when the behavioral health services are added.

**American Indian/Alaska Native (AI/AN)** clients living in an integrated managed care region of Washington may choose to enroll in one of the agency-contracted MCOs available in that region or they may choose to receive all these services through Apple Health FFS. If they do not choose an MCO, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the agency’s [American Indian/Alaska Native webpage](#).

For more information about the services available under the FFS program, see the agency’s [Mental Health Services Billing Guide](#) and the [Substance Use Disorder Billing Guide](#).

For full details on integrated managed care, see the agency’s [Changes to Apple Health managed care webpage](#).
Integrated managed care regions

Clients who reside in the following integrated managed care regions and who are eligible for managed care enrollment must choose an available MCO in their region. Details, including information about mental health crisis services, are located on the agency’s Apple Health managed care webpage.

<table>
<thead>
<tr>
<th>Region</th>
<th>Counties</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Sound (new)</td>
<td>Island, San Juan, Skagit, Snohomish, and Whatcom</td>
<td>July 1, 2019</td>
</tr>
<tr>
<td>Greater Columbia</td>
<td>Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Yakima, and Whitman</td>
<td>January 1, 2019</td>
</tr>
<tr>
<td>King</td>
<td>King</td>
<td>January 1, 2019</td>
</tr>
<tr>
<td>Pierce</td>
<td>Pierce</td>
<td>January 1, 2019</td>
</tr>
<tr>
<td>Spokane</td>
<td>Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens</td>
<td>January 1, 2019</td>
</tr>
<tr>
<td>North Central</td>
<td>Grant, Chelan, Douglas, and Okanogan</td>
<td>January 1, 2018</td>
</tr>
<tr>
<td></td>
<td></td>
<td>January 1, 2019 (Okanogan)</td>
</tr>
<tr>
<td>Southwest</td>
<td>Clark, Skamania, and Klickitat</td>
<td>April 2016</td>
</tr>
<tr>
<td></td>
<td></td>
<td>January 1, 2019 (Klickitat)</td>
</tr>
</tbody>
</table>
Integrated Apple Health Foster Care (AHFC)

Effective January 1, 2019, children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care of Washington’s (CCW) Apple Health Foster Care program will receive both medical and behavioral health services from CCW.

Clients under this program are:

- Under the age of 21 who are in foster care (out of home placement)
- Under the age of 21 who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni)

These clients are identified in ProviderOne as “Coordinated Care Healthy Options Foster Care.”

Fee-for-service Apple Health Foster Care

Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Administrative Services Organization (BH-ASO). For details, see the agency’s Mental Health Services Billing Guide, under How do providers identify the correct payer?
Coverage

What services are covered?

Ocular Prosthetics
(WAC 182-531-1000)

The agency covers ocular prosthetics for eligible clients when provided by any of the following:

- An ophthalmologist
- An ocularist
- An optometrist who specializes in prosthetics

See the Coverage Table for more information on coverage for ocular prosthetics and the Outpatient Prospective Payment System (OPPS) and Outpatient Hospitals fee schedule.

Vision therapy

The agency covers orthoptics and vision therapy. See the Physician-Related Services/Healthcare Professional Services Medicaid Billing Guide for coverage criteria.

The agency requires prior authorization (PA) or expedited prior authorization (EPA) for orthoptic and pleoptic training.

Note: EPA covers the first 48 units (15 minutes per unit). CPT codes 97110, 97112, and 97530 may be billed in combination with no more than 48 units total. An additional 48 units may be requested by submitting a prior authorization request for a limitation extension.
Eyeglasses (frames and lenses)
(WAC 182-544-0300 (1))

The agency covers eyeglasses once in a calendar year for eligible clients when the following clinical criteria are met:

- The eligible client has a stable visual condition.
- The eligible client's treatment is stabilized.
- The prescription is less than 18 months old.
- 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
  - Add power equal to, or greater than, 1.0 diopter for bifocals and trifocals

If the above criteria are not met, prior authorization (PA) is required.

Eyeglasses for clients with accommodative esotropia or strabismus
(WAC 182-544-0300 (2))

The agency covers eyeglasses (frame and lenses), for eligible clients with a diagnosis of accommodative esotropia or any strabismus correction. In this case, the limitations listed in Eyeglasses (Frames and Lenses) do not apply.

Back-up eyeglasses
(WAC 182-544-0300 (3))

The agency covers one pair of back-up eyeglasses for eligible clients who wear contact lenses as their primary visual correction aid (see Contact lenses) limited to once every two years for eligible clients.

Lost or broken frames or lenses
(WAC 182-544-0325(2), 182-544-0350 (5))

The agency covers up to:

- Two replacement frames in a calendar year, due to lost or broken (WAC 182-544-0325(2)(c)).
- Four replacement lenses in a calendar year, due to lost or broken (WAC 182-544-0350(5)).
Prior authorization is required. If additional frames or lenses are needed beyond the allowed amount, a provider must request a limitation extension. See Washington State EPA criteria coding list for EPA codes.

**Note:** If a client loses their eyeglasses, one replacement frame and two lenses for the frame count towards the per calendar year replacement total. Therefore, the client would have one replacement frame and two lenses remaining in their yearly allowed amount. Providers must document the reason for replacement in the client file.

**Note:** Frames are covered by a one-year warranty against manufacturer defects.

### Durable or flexible frames
(WAC 182-544-0325 (1))

The agency covers durable or flexible frames when the eligible client has a diagnosed medical condition that contributes to broken eyeglass frames. To receive payment, the provider must:

- Follow the agency’s expedited prior authorization (EPA) process. See EPA# 870000619 and EPA# 870000620 in the authorization section of this guide.
- Document reasons that the standard CI Optical frame is not suitable for the client. For example, a reason may be that the client is age five or younger.
- Order the durable or flexible frames through the agency’s designated supplier

See Lost or broken frames or lenses for replacement frames for clients who do not have a diagnosed medical condition that contributes to broken eyeglass frames.

### Coating of frames and incidental repairs
(WAC 182-544-0325 (2))

The agency covers:

- Coating contract eyeglass frames to make the frames nonallergenic. Eligible clients must have a medically diagnosed and documented allergy to the materials in the available eyeglass frames.
- Four incidental repairs to a client's eyeglass frames in a calendar year. To receive payment, all 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 agency’s cost for replacement frames and a fitting fee.

**Eyeglass lenses**  
(WAC 182-544-0350 (1)(2))

The agency covers the following plastic scratch-resistant eyeglass lenses.

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

**Note:** The agency’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 agency.

**High index eyeglass lenses**  
(WAC 182-544-0350 (3)(a))

The agency covers high index lenses with PA/EPA when the eligible 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# 870000625 in the authorization section of this guide.

**Plastic photochromatic lenses**  
(WAC 182-544-0350 (3)(b))

The agency covers plastic photochromatic lenses. The eligible client’s medical need must be diagnosed and documented as one of the following:

<table>
<thead>
<tr>
<th>Medical Problems</th>
<th>ICD Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ocular Albinism</td>
<td>Use the appropriate ICD-10 code for the medical condition that allows the client to receive plastic photochromatic lenses</td>
</tr>
<tr>
<td>Retinitis pigmentosa</td>
<td></td>
</tr>
</tbody>
</table>
The agency covers polycarbonate lenses. The eligible client’s medical need must be diagnosed and documented as one of the following:

<table>
<thead>
<tr>
<th>Medical Problems</th>
<th>ICD Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amblyopia</td>
<td></td>
</tr>
<tr>
<td>Attention deficit hyperactivity disorder (ADHD)</td>
<td></td>
</tr>
<tr>
<td>Autism</td>
<td></td>
</tr>
<tr>
<td>Bipolar</td>
<td></td>
</tr>
<tr>
<td>Blind in one eye and needs protections for the other eye, regardless of whether a vision correction is required</td>
<td>Use the appropriate ICD-10 code for the medical condition that allows the client to receive polycarbonate lenses</td>
</tr>
<tr>
<td>Cerebral palsy</td>
<td></td>
</tr>
<tr>
<td>Developmental delay</td>
<td></td>
</tr>
<tr>
<td>Down Syndrome</td>
<td></td>
</tr>
<tr>
<td>Infants and toddlers with motor ataxia</td>
<td></td>
</tr>
<tr>
<td>Multiple sclerosis</td>
<td></td>
</tr>
<tr>
<td>Schizophrenia</td>
<td></td>
</tr>
<tr>
<td>Seizure disorder</td>
<td></td>
</tr>
<tr>
<td>Strabismus</td>
<td></td>
</tr>
</tbody>
</table>
Replacement of bifocal or trifocal lenses
(WAC 182-544-0350 (3)(d))

The agency covers bifocal lenses to be replaced with single vision or trifocal lenses, or trifocal lenses to be replaced with bifocal or single vision lenses when all the following are true:

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

Tinting
(WAC 182-544-0350 (4))

The agency covers the tinting of plastic lenses as follows:

- The tinting must be performed by the agency’s designated lens supplier
- The eligible client’s medical need must be diagnosed and documented as one or more of the following chronic (expected to last longer than three months) eye conditions causing photophobia:

<table>
<thead>
<tr>
<th>Medical Problems</th>
<th>ICD Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blindness</td>
<td></td>
</tr>
<tr>
<td>Chronic corneal keratitis</td>
<td></td>
</tr>
<tr>
<td>Chronic iritis, iridocyclitis (uveitis)</td>
<td></td>
</tr>
<tr>
<td>Diabetic retinopathy</td>
<td></td>
</tr>
<tr>
<td>Fixed pupil</td>
<td>Use the appropriate ICD-10 code for the medical condition that allows the client to receive tinted plastic lenses</td>
</tr>
<tr>
<td>Glare from cataracts</td>
<td></td>
</tr>
<tr>
<td>Macular degeneration</td>
<td></td>
</tr>
<tr>
<td>Migraine disorder</td>
<td></td>
</tr>
<tr>
<td>Ocular albinism</td>
<td></td>
</tr>
<tr>
<td>Optic atrophy and/or optic neuritis</td>
<td></td>
</tr>
<tr>
<td>Rare photo-induced epilepsy conditions</td>
<td></td>
</tr>
<tr>
<td>Retinitis pigmentosa</td>
<td></td>
</tr>
</tbody>
</table>
Replacement lenses due to refractive change
(WAC 182-544-0350 (6))

The agency covers replacements lenses with PA/EPA when the eligible client meets one of the following clinical criteria:

- **The client had eye surgery, the effect(s) of prescribed medication, or one or more diseases affecting vision:**
  - The client must have a stable visual condition. See the definition of stable visual condition.
  - The client’s treatment must be stabilized.
  - The lens correction must have a 1.0 or greater diopter change between the sphere or cylinder correction in at least one eye.
  - The previous and new refractions are documented in the client’s record.

To receive payment, providers must follow the agency’s expedited prior authorization (EPA) process (see EPA# 870000622 in the authorization section of this guide).

- **The client experiences headaches, blurred vision, or visual difficulty in school or at work.** In this case, all 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)
  - 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 agency’s EPA process. See EPA# 870000624 in the authorization section of this guide.

Contact lenses
(WAC 182-544-0400 (1) (2))

The agency covers contact lenses as the eligible 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 exceptions to the plus or minus 6.0 diopters criteria for contact lenses. 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 agency covers the following contact lenses with limitations:

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

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

<table>
<thead>
<tr>
<th>Medical Problems</th>
<th>ICD Diagnosis Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypermetropia</td>
<td>Use the appropriate ICD-10 code for the medical condition that allows the client to receive contact lenses</td>
</tr>
<tr>
<td>Myopia</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** The agency’s opinion is that the prolonged use of overnight wear may increase the risk of corneal swelling and ulceration. Therefore, the agency approves their use in limited situations where they are used as a therapeutic contact bandage lens or for aphakic clients (see WAC 182-544-0050).

### Soft toric contact lenses

(WAC 182-544-0400 (3))

The agency covers soft toric contact lenses for clients with astigmatism when all of the following clinical criteria are met:

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

<table>
<thead>
<tr>
<th>Medical Problems</th>
<th>ICD Diagnosis Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Astigmatism</td>
<td>Use the appropriate ICD-10 code for the medical condition that allows the client to receive soft toric contact lenses</td>
</tr>
</tbody>
</table>
Exceptions to the plus or minus 6.0 diopters criteria for contact lenses

The agency covers contact lenses 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 eligible clients diagnosed with high anisometropia:
  - The refractive error difference between the two eyes is at least plus or minus 3.0 diopters between the sphere or cylinder correction.
  - Eyeglasses cannot reasonably correct the refractive errors.

<table>
<thead>
<tr>
<th>Medical Problems</th>
<th>ICD Diagnosis Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>High anisometropia</td>
<td>Use the appropriate ICD-10 code for the medical condition that allows the client to receive contact lenses</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Medical Problems</th>
<th>ICD Diagnosis Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aphakia</td>
<td>Use the appropriate ICD-10 code for the medical condition that allows the client to receive specialty contact lenses</td>
</tr>
<tr>
<td>Keratoconus</td>
<td></td>
</tr>
<tr>
<td>Corneal softening</td>
<td></td>
</tr>
</tbody>
</table>

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

Lost or damaged contact lenses
(WAC 182-544-0400 (5))

The agency covers eligible clients’ replacement contact lenses when they are lost or damaged.
Replacement contact lenses for clients whose vision has changed due to surgery, medication, or disease (WAC 182-544-0400 (6))

The agency covers replacement contact lenses for eligible clients when all the following clinical criteria are met:

- The client’s vision has changed because of:
  - Eye surgery
  - The effect(s) of prescribed medication
  - One or more diseases affecting vision

- The client has a stable visual condition (see the definition of stable visual condition).

- The client’s treatment is stabilized.

- 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.

What is not covered?

The agency does not cover:

- Bifocal contact lenses
- Custom colored contact lenses
- Daily and two week disposable contact lenses
- Executive style eyeglass lenses
- Extended wear soft contact lenses, except when used as therapeutic contact bandage lenses or for aphakic clients
- Glass lenses
- Nonglare or anti-reflective lenses
- Progressive lenses
- Sunglasses and accessories that function as sunglasses (e.g., clip-ons)
Upgrades at private expense to avoid the agency’s contract limitations. For example:

☑ Frames that are not available through the agency’s contract
☑ Noncontract frames or lenses for which the client or other person pays the difference between the agency’s payment and the total cost

**Note:** A provider may request an exception to rule (ETR) for noncovered hardware as described in WAC 182-501-0160. For rules on billing a client, see WAC 182-502-0160.
Coverage Table

Due to its licensing agreement with the American Medical Association, the agency publishes only the official, brief Current Procedural Terminology (CPT) procedure code descriptions. To view the entire description, see the current CPT book.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Modifier</th>
<th>Short Description</th>
<th>PA?</th>
<th>Policy/Comments</th>
<th>Maximum Allowable Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contact Lens Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>92071</td>
<td></td>
<td>Contact lens fitting for tx</td>
<td>1 fitting in a calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92072</td>
<td></td>
<td>Fit contact lens for management</td>
<td>2 fittings in a calendar year. Refer to Contact lenses for diagnosis range limitations</td>
<td>Fee Schedules*</td>
<td></td>
</tr>
<tr>
<td><strong>Spectacle Fitting fees, monofocal</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>92340</td>
<td></td>
<td>Fitting of spectacles</td>
<td>No</td>
<td></td>
<td>Fee Schedules</td>
</tr>
<tr>
<td>92352</td>
<td></td>
<td>Special spectacles fitting</td>
<td>No</td>
<td></td>
<td>Fee Schedules</td>
</tr>
<tr>
<td><strong>Spectacle Fitting fees, bifocal</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>92341</td>
<td></td>
<td>Fitting of spectacles</td>
<td>No</td>
<td></td>
<td>Fee Schedules</td>
</tr>
<tr>
<td><strong>Spectacle Fitting fees, multifocal</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>92342</td>
<td></td>
<td>Fitting of spectacles</td>
<td>No</td>
<td></td>
<td>Fee Schedules</td>
</tr>
<tr>
<td>92353</td>
<td></td>
<td>Special spectacles fitting</td>
<td>No</td>
<td></td>
<td>Fee Schedules</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>92354</td>
<td></td>
<td>Special spectacles fitting</td>
<td>Yes</td>
<td></td>
<td>Fee Schedules</td>
</tr>
<tr>
<td>92355</td>
<td></td>
<td>Special spectacles fitting</td>
<td>Yes</td>
<td></td>
<td>Fee Schedules</td>
</tr>
<tr>
<td>92370</td>
<td></td>
<td>Repair &amp; refitting spectacles</td>
<td>Yes</td>
<td></td>
<td>Fee Schedules</td>
</tr>
<tr>
<td>92371</td>
<td></td>
<td>Repair &amp; refitting spectacles</td>
<td>No</td>
<td></td>
<td>Fee Schedules</td>
</tr>
<tr>
<td>92499</td>
<td></td>
<td>Eye service or procedure</td>
<td>No</td>
<td></td>
<td>Fee Schedules</td>
</tr>
</tbody>
</table>

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

*See the agency’s Physician-Related Services/Health Care Professional Services Fee Schedule for information about maximum allowable fees.*

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# Vision Hardware for Clients Age 20 and Younger

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Modifier</th>
<th>Short Description</th>
<th>PA?</th>
<th>Policy/Comments</th>
<th>Maximum Allowable Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>92002</td>
<td></td>
<td>Eye exam, new patient</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92004</td>
<td></td>
<td>Eye exam, new patient</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92012</td>
<td></td>
<td>Eye exam established patient</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92014</td>
<td></td>
<td>Eye exam &amp; treatment</td>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## General Ophthalmological Services

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Modifier</th>
<th>Short Description</th>
<th>PA?</th>
<th>Policy/Comments</th>
<th>Maximum Allowable Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>92005</td>
<td></td>
<td>Refraction</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92018</td>
<td></td>
<td>New eye exam &amp; treatment</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92019</td>
<td></td>
<td>Eye exam &amp; treatment</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92020</td>
<td></td>
<td>Special eye evaluation</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92025</td>
<td></td>
<td>Corneal topography</td>
<td>Yes</td>
<td>Requires PA/EPA</td>
<td></td>
</tr>
<tr>
<td>92025</td>
<td>TC</td>
<td>Corneal topography</td>
<td>Yes</td>
<td>Requires PA/EPA</td>
<td></td>
</tr>
<tr>
<td>92025</td>
<td>26</td>
<td>Corneal topography</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92060</td>
<td>TC</td>
<td>Special eye evaluation</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92060</td>
<td>26</td>
<td>Special eye evaluation</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92065</td>
<td>TC</td>
<td>Orthoptic/pleoptic training</td>
<td>Yes</td>
<td>Requires PA/EPA</td>
<td></td>
</tr>
<tr>
<td>92065</td>
<td>26</td>
<td>Orthoptic/pleoptic training</td>
<td>Yes</td>
<td>Requires PA/EPA</td>
<td></td>
</tr>
<tr>
<td>92081</td>
<td>TC</td>
<td>Visual field examination(s)</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92081</td>
<td>26</td>
<td>Visual field examination(s)</td>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Special Ophthalmological Services

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Modifier</th>
<th>Short Description</th>
<th>PA?</th>
<th>Policy/Comments</th>
<th>Maximum Allowable Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>92082</td>
<td>TC</td>
<td>Visual field examination(s)</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92082</td>
<td>26</td>
<td>Visual field examination(s)</td>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*See the agency’s [Physician-Related Services/Health Care Professional Services Fee Schedule](#) for information about maximum allowable fees.

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<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Modifier</th>
<th>Short Description</th>
<th>PA?</th>
<th>Policy/Comments</th>
<th>Maximum Allowable Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>92083</td>
<td></td>
<td>Visual field examination(s)</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92083 T</td>
<td>C</td>
<td>Visual field examination(s)</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92083 26</td>
<td></td>
<td>Visual field examination(s)</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92100</td>
<td></td>
<td>Serial tonometry exam(s)</td>
<td>No</td>
<td></td>
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<tr>
<td>92132</td>
<td></td>
<td>Cptr ophth dx img ant segment, uni or bilat</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92133</td>
<td></td>
<td>Cptr ophth dx img post segment, uni or bilat</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92134</td>
<td></td>
<td>Cptr ophth dx img post segment</td>
<td>Yes</td>
<td>PA or EPA required Limited to 12 per calendar year. EPA#870000051 Fee Schedules*</td>
<td></td>
</tr>
<tr>
<td>92135</td>
<td></td>
<td>Ophthalmic dx imaging</td>
<td>No</td>
<td></td>
<td></td>
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<tr>
<td>92136</td>
<td></td>
<td>Ophthalmic biometry</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92136 T</td>
<td>C</td>
<td>Ophthalmic biometry</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92136 26</td>
<td></td>
<td>Ophthalmic biometry</td>
<td>No</td>
<td></td>
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</tbody>
</table>

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<table>
<thead>
<tr>
<th>CPT Code</th>
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<th>Short Description</th>
<th>PA?</th>
<th>Policy/Comments</th>
<th>Maximum Allowable Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>92225</td>
<td></td>
<td>Ophthalmoscopy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>92226</td>
<td></td>
<td>Ophthalmoscopy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>92230</td>
<td></td>
<td>Eye exam with photos</td>
<td>No</td>
<td>A report is required with image.</td>
<td></td>
</tr>
<tr>
<td>92235</td>
<td>TC</td>
<td>Eye exam with photos</td>
<td>No</td>
<td>A report is required with image.</td>
<td></td>
</tr>
<tr>
<td>92235</td>
<td>26</td>
<td>Eye exam with photos</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92240</td>
<td>TC</td>
<td>ICG angiography</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92240</td>
<td>26</td>
<td>ICG angiography</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92250</td>
<td>TC</td>
<td>Eye exam with photos</td>
<td>No</td>
<td>A report is required with image. Code not covered for routine eye exams.</td>
<td></td>
</tr>
<tr>
<td>92250</td>
<td>26</td>
<td>Eye exam with photos</td>
<td>No</td>
<td>A report is required with image. Code not covered for routine eye exams.</td>
<td></td>
</tr>
<tr>
<td>92260</td>
<td></td>
<td>Ophthalmoscopy/dynamometry</td>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*See the agency’s [Physician-Related Services/Health Care Professional Services Fee Schedule](#) for information about maximum allowable fees.

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**Vision Hardware for Clients Age 20 and Younger**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Modifier</th>
<th>Short Description</th>
<th>PA?</th>
<th>Policy/Comments</th>
<th>Maximum Allowable Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>92265</td>
<td></td>
<td>Eye muscle evaluation</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92265</td>
<td>TC</td>
<td>Eye muscle evaluation</td>
<td>No</td>
<td></td>
<td></td>
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<tr>
<td>92265</td>
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<td>Eye muscle evaluation</td>
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</tr>
<tr>
<td>92270</td>
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<td>Electro-oculography</td>
<td>No</td>
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<td></td>
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<tr>
<td>92270</td>
<td>TC</td>
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<tr>
<td>92270</td>
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<td>Electro-oculography</td>
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<tr>
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<td>Electoretinography</td>
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<td>92275</td>
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<td>Electoretinography</td>
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<tr>
<td>92283</td>
<td></td>
<td>Color vision examination</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92283</td>
<td>TC</td>
<td>Color vision examination</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92283</td>
<td>26</td>
<td>Color vision examination</td>
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<td></td>
</tr>
<tr>
<td>92284</td>
<td></td>
<td>Dark adaptation eye exam</td>
<td>No</td>
<td></td>
<td>Fee Schedules*</td>
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<td>92284</td>
<td>TC</td>
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<td>No</td>
<td></td>
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<tr>
<td>92284</td>
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<td>Dark adaptation eye exam</td>
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<td>92285</td>
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<td>Eye photography</td>
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<td>Internal eye photography</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

*See the agency’s [Physician-Related Services/Health Care Professional Services Fee Schedule](#) for information about maximum allowable fees.

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### Vision Hardware for Clients Age 20 and Younger

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Modifier</th>
<th>Short Description</th>
<th>PA?</th>
<th>Policy/Comments</th>
<th>Maximum Allowable Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>92310</td>
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<td>Contact lens fitting</td>
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<td>Contact lens fitting</td>
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<td>92313</td>
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<td>Contact lens fitting</td>
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<td></td>
</tr>
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#### Contact Lens Services

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Modifier</th>
<th>Short Description</th>
<th>PA?</th>
<th>Policy/Comments</th>
<th>Maximum Allowable Fee</th>
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<tbody>
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<td>92315</td>
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<td>Prescription of contact lens</td>
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<td>92317</td>
<td></td>
<td>Prescription of contact lens</td>
<td>No</td>
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<td></td>
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</table>

---

**Fee Schedules**

### Ocular Prosthesis

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Modifier</th>
<th>Short Description</th>
<th>PA?</th>
<th>Policy/Comments</th>
<th>Maximum Allowable Fee</th>
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<tr>
<td>L8610</td>
<td></td>
<td>Ocular implant</td>
<td>No</td>
<td>Available for clients age 21 and older</td>
<td>See the Outpatient Hospital Fee Schedules</td>
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</table>

*See the agency’s [Physician-Related Services/Health Care Professional Services Fee Schedule](#) for information about maximum allowable fees.*
Authorization

See the agency’s current ProviderOne Billing and Resource Guide for more information on requesting authorization.

What are the general guidelines for authorization?
(WAC 182-544-0560)

- The agency requires providers to obtain authorization for covered vision hardware as required in Chapters 182-501 and 182-502 WAC, billing guides, or when the required clinical criteria are not met. (WAC 182-544-0560 (1))

- Note that authorization requirements are not a denial of service.

- When a service requires authorization, the provider must properly request authorization under the agency’s rules and billing guides.

- When the provider does not properly request authorization, the agency returns the request to the provider for proper completion and resubmission. The agency does not consider the returned request to be a denial of service.

- Upon request, a provider must provide documentation to the agency showing how the client’s condition met the criteria for prior authorization (PA) or expedited prior authorization (EPA).

- The agency’s authorization of a service does not necessarily guarantee payment.

What is prior authorization (PA)?
(WAC 182-544-0010 (2) and (3))

- PA is a form of authorization used by the provider to obtain the agency’s written approval for specific vision services, including hardware. The agency’s approval is based on medical necessity and must be received before the service is provided to clients as a precondition for payment.

- The agency does not require PA for covered vision hardware that meet the clinical criteria found in the coverage section of this guide.
• The agency requires PA for covered vision hardware when the clinical criteria found in the coverage section of this guide are not met, including the criteria associated with the expedited prior authorization (EPA) process. Note that authorization requirements are not a denial of service.

• For PA, a provider must submit a request to the agency (see Authorization). The agency evaluates these requests on a case-by-case basis to determine whether they are medically necessary, according to the process found in WAC 182-501-0165.

What if my request exceeds the limitations in this billing guide? (WAC 182-544-0560 (6))

If a request exceeds the limitations in this billing guide, providers must submit limitation extension (LE) must be submitted to the agency following the authorization process. The agency evaluates requests for authorization of covered vision hardware that exceed the limitations (a limitation extension (LE)) within this billing guide on a case-by-case basis under WAC 182-501-0169.

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

Note: A request for an LE must be appropriate to the client’s eligibility and program limitations. Not all eligibility programs cover all services.

For example: Eyeglasses are not covered under the Family Planning Only Program.

How do I request a limitation extension?

To request a limitation extension (LE), providers may submit a request through direct data entry into ProviderOne (See the agency’s Prior Authorization web page) or by submitting the request in writing on:

• A completed General Information for Authorization form, 13-835. See Where can I download agency forms? and the agency’s ProviderOne Billing and Resource Guide for more information.

• Complete the Vision Care Authorization Request form, 13-739. This form is required for any vision hardware authorization request.
The written request must state the following:

- The client’s name and ProviderOne Client ID
- The provider’s full name, NPI, and fax number
- Additional service(s) requested
- Date of last dispensing and copy of last two prescriptions
- The primary diagnosis code and applicable procedure code
- Client-specific clinical justification for additional services

Fax all forms and documentation to: 866-668-1214 (see Resources Available).

Download the Vision Care Authorization Request form, 13-739, AND General Information for Authorization form, 13-835. Fax both forms to the agency with the General Information for Authorization form as your cover letter.

What does the EPA process do?
(WAC 182-544-0560)

The EPA process allows providers to apply the agency’s clinical criteria and certify medical necessity. The agency establishes clinical criteria and identifies the criteria with specific codes. Providers then identify an the EPA number that meets the clinical criteria for the services requested and bills the agency with that EPA number.

To bill the agency 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 five or six digits of the EPA number must be 87000 or 870000. The last three or four digits must be the code assigned to the diagnostic condition, procedure, or service that meets EPA criteria. 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 nine-digit authorization number for an exam for a client who had an exam 20 months ago but just had eye surgery would be 870000622.

- 870000 = first six digits of all EPA numbers
- 622 = last three digits of an EPA number indicating the service and which criteria the case meets

- The agency denies payment for vision hardware 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 agency may recoup any payment made to a provider if the agency later determines that the service was not properly authorized or did not meet the EPA criteria. Refer to WAC 182-502-0100(1)(c) and WAC 182-544-0560 (7).
• When a client’s situation does not meet the EPA criteria for vision hardware a provider must request PA.

For EPA codes, see [EPA Criteria Coding List](#).

## Washington State EPA criteria coding list

Use these EPA codes on claims forwarded to the agency and the agency’s contractor

### Specialty Frames

<table>
<thead>
<tr>
<th>Frame type</th>
<th>EPA Code</th>
<th>Criteria</th>
</tr>
</thead>
</table>
| Durable Frames   | 870000619  | • When the provider documents in the client’s record that the client has a diagnosed medical condition that contributes to broken eyeglass frames.  
                 |            | • Lost or broken glasses                                                 |
| Flexible Frames  | 870000620  | When the provider documents one of the following in the client’s record:  
                 |            | • The client has a diagnosed medical condition that contributes to broken eyeglass frames.  
                 |            | • Reasons that the standard CI Optical frame is not suitable for the client. (e.g. client age five or younger)  
                 |            | • Lost or broken glasses                                                 |

### Replacement Eyeglass Lenses

<table>
<thead>
<tr>
<th>Reason for replacement / lense type</th>
<th>EPA Code</th>
<th>Criteria</th>
</tr>
</thead>
</table>
| Replacement due to eye surgery/effects of prescribed medication/diseases affecting vision | 870000622  | Within one year of last dispensing when:  
                 |            | • The client has a stable visual condition (see [Definitions](#)).  
                 |            | • The client’s treatment is stabilized.  
                 |            | • The lens correction has a 1.0 or greater diopter change between the sphere or cylinder correction in at least one eye.  
                 |            | • The provider documents the previous and new refractions in the client record.  
<pre><code>             |            | • Lost or broken lenses                                                 |
</code></pre>
<table>
<thead>
<tr>
<th>Reason for replacement / lense type</th>
<th>EPA Code</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Replacement due to headaches/blurred vision/difficulty with school or work</td>
<td>870000624</td>
<td>Within one year 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 the following in the client’s record:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The client has symptoms e.g., headaches, blurred vision, difficulty with school or work.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Copy of current prescription</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Date of last dispensing, if known</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Absence of a medical condition that is known to cause temporary visual acuity changes (e.g. diabetes, pregnancy)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A refractive change of at least .75 diopter or greater between the sphere or cylinder correction in at least one eye</td>
</tr>
<tr>
<td>High index eyeglass lenses</td>
<td>870000625</td>
<td>When the provider documents one of the following in the client’s record:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A spherical refractive correction of +(-6.0 diopters or greater</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A cylinder correction of +(-3.0 diopters or greater</td>
</tr>
</tbody>
</table>

**Note:** See the agency’s current [Physician-Related Services/Healthcare Professional Services Billing Guide](#), to locate EPA numbers for blepharoplasties and strabismus surgery.
Ordering Vision Hardware

Who is the agency’s vision hardware eyeglass contractor?

The agency’s vision hardware contractor is CI Optical, which is part of the Washington State Department of Correctional Industries.

Providers must obtain all hardware through CI Optical. The agency does **not** pay any other optical manufacturer or provider for frames, lenses, or contact lenses. *(WAC 182-544-0150)*

**Note:** CI Optical cannot provide client eligibility or benefit information.

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

**CI OPTICAL**

11919 West Sprague Avenue
PO Box 1959
Airway Heights, WA 99001-1959
Customer Service: 888-606-7788
Fax: 888-606-7789
Email: ciopticalcustomercare@doc1.wa.gov

Where is general ordering information?

- For timely processing, all information on the prescription must be complete and legible.
- For prescription order forms, call or fax CI Optical.
• Mail, email, or fax eyeglass orders, along with a copy of the medical eligibility verification (MEV), to the contractor. CI 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 diagnosis code (and expedited prior authorization (EPA) number, if applicable) on all order forms for eyeglasses and contact lenses. If this information is not included on the form, the contractor must reject and return the order.
• CI Optical rejects and returns orders for clients for whom the agency has already purchased a pair of lenses or complete frames or contact lenses within the applicable benefit period (12 or 24 months, as appropriate).
• The agency requires CI Optical to process prescriptions within 15 working days, including shipping and handling time, after receipt of a properly completed order. The agency allows up to 20 working days for completing orders for specialty eyeglass lenses or contact lenses. CI 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 or fax CI Optical. Have the medical record number ready when you call. The phone number for CI Optical is for provider use only. CI Optical cannot check a client’s eligibility. For questions regarding client eligibility, call the agency at 800-562-3022.
• CI Optical ships the eyeglasses to the provider.
• CI Optical bills the agency directly for all hardware for Washington Apple Health clients.

Note: If a client does not return to the provider’s office to pick up eyeglasses, then the provider must:

• Keep the completed pair of eyeglasses for three months.
• Make a good faith effort (a minimum of three attempts) to contact the client.
• After the above conditions are met, return the eyeglasses to the agency’s designated supplier.
Billing

All claims must be submitted electronically to the agency, except under limited circumstances. For more information about this policy change, see Paperless Billing at HCA. For providers approved to bill paper claims, see the agency’s Paper Claim Billing Resource.

What are the general billing requirements?

Providers must follow the agency’s ProviderOne Billing and Resource Guide. These billing requirements include:

• Time limits for submitting and resubmitting claims and adjustments
• What fee to bill the agency 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
• Record-keeping requirements

Billing instructions for special vision hardware and services

Special Ophthalmological Services - Bilateral Indicator
The agency 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
See the agency’s current Outpatient Prospective Payment System (OPPS) and Outpatient Hospitals fee schedule for a complete list of CPT codes and maximum allowable fees.

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

Note: Use ICD diagnosis code Z01.00 (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. V codes and diagnosis codes for disorders of refraction and accommodation are **not** appropriate when billing E&M services.

**The agency 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
- 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 agency.

- **Billing:** Since payment for the surgical procedure codes with modifier 55 is a one-time payment covering the postoperative period, the agency 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/Professional and Emergent Oral Healthcare Services Fee Schedule*.

**What if the client is eligible for both Medicare Part B and Medicaid?**

- Bill the agency for refractions and fitting fees. Medicare does not currently cover these services. The provider is not required to bill Medicare for a denial before billing the agency.

- Refer to the agency’s [ProviderOne Billing and Resource Guide](#) for current information on billing for clients eligible for Medicare and Medicaid.

**How do I bill claims electronically?**

Instructions on how to bill Direct Data Entry (DDE) claims can be found on the agency’s [Billers and Providers](#) webpage, under [Webinars](#).

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the [HIPAA Electronic Data Interchange (EDI)](#) webpage.
Payment

(WAC 182-544-0600)

How much does the agency pay for vision care?

- The agency pays 100% of the agency contract price for covered eyeglass frames, lenses, and contact lenses when these items are obtained through the agency’s approved contractor. For more information, see Ordering Vision Hardware.

- To receive payment, vision care providers must bill the agency according to the conditions of payment found in this billing guide. See Billing for more information.