

Washington Apple Health (Medicaid)

Vision Hardware Program Billing Guide

(For clients age 20 and younger)

January 1, 2020

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 January 1, 2020, and supersedes earlier billing guides to this program.

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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?

Subject	Change	Reason for Change
Behavioral Health Organization (BHO)	Removed this section	Effective January 1, 2020, behavioral health services in all regions will be provided under integrated managed care.
<u>Integrated Managed Care Regions</u>	Effective January 1, 2020, integrated managed care is being implemented in the last three regions of the state: <ul style="list-style-type: none"> • Great Rivers (Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum counties) • Salish (Clallam, Jefferson, and Kitsap counties) • Thurston-Mason (Mason and Thurston counties) 	Effective January 1, 2020, HCA completed the move to whole person care to allow better coordination of care for both body (physical health) and mind (mental health and substance use disorder treatment, together known as “behavioral health”). This delivery model is called Integrated Managed Care (IMC).

*This publication is a billing instruction.

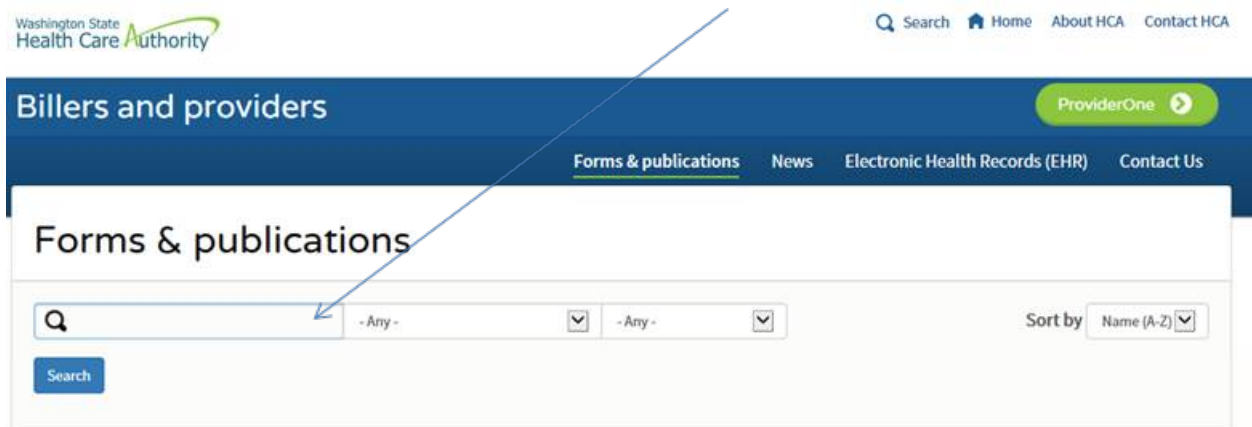
How can I get agency provider documents?

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.

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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Resources Available

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See the agency's ProviderOne Resources webpage
Finding out about payments, denials, claims processing, or agency managed care organizations	
Electronic billing	
Finding agency documents (e.g., billing guides and fee schedules)	
Private insurance or third-party liability, other than agency managed care	
Where do I order hardware?	<p>Order hardware from the agency's contractor: CI Optical 11919 West Sprague Avenue PO Box 1959 Airway Heights, WA 99001-1959 Customer Service Telephone 888-606-7788 (toll free) Fax: 888-606-7789 (toll free)</p>
Who do I contact if I have a client who needs low vision aids?	<p>Community Services for the Blind and Partially Sighted (Seattle) Telephone: 800-458-4888 (toll free)</p> <p>Lilac Blind Foundation (Spokane) Telephone: 800-422-7893 (toll free)</p>
How do I obtain prior authorization (PA) or a limitation extension (LE)?	<p>Providers may submit their requests online (See the agency's Prior Authorization webpage) or by submitting the request in writing. Written or faxed requests for prior authorization or limited extensions must include:</p> <ul style="list-style-type: none"> • A completed, TYPED <i>General Information for Authorization</i> form, HCA 13-835. This request form MUST be the initial page when you submit your request. • A completed <i>Vision Care Limitation Extension</i> form, HCA 13-739, and all the documentation listed on this form and any other medical justification. <p>Fax your request to: 866-668-1214.</p> <p>See the agency's Prior Authorization webpage. For information about downloading agency forms, see Where can I download agency forms?</p>

Definitions

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](#) webpage 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.

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](#) webpage.

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?

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.

All medical services covered under an agency-contracted MCO must be obtained by the client through designated facilities or providers. The MCO is responsible for:

- Payment of covered services
- Payment of services referred by a provider participating with the plan to an outside provider

Note: A client's enrollment can change monthly. Providers who are not contracted with the MCO must receive approval from **both** the MCO and the client's primary care provider (PCP) prior to serving a managed care client.

Send claims to the client's MCO for payment. Call the client's MCO to discuss payment prior to providing the service. Providers may bill clients only in very limited situations as described in [WAC 182-502-0160](#).

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. However, some clients may still start their first month of eligibility in the FFS program because their qualification for MC enrollment is not established until the month following their Medicaid eligibility determination.

Vision Hardware for Clients Age 20 and Younger

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.

Apple Health – Changes for January 1, 2020

Effective January 1, 2020, the Health Care Authority (HCA) completed the move to whole-person care to allow better coordination of care for both body (physical health) and mind (mental health and substance use disorder 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).

IMC is implemented in the last three regions of the state:

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

These last three regions have plan changes, with only Amerigroup, Molina, and United Healthcare remaining. There are changes to the plans available in these last three regions. The only plans that will be in these regions are Amerigroup, Molina and United Healthcare. If a client is currently enrolled in one of these three health plans, their health plan will not change.

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account:**
Go to [Washington HealthPlanFinder website](#).
- **Available to all Apple Health clients:**
 - ✓ Visit the [ProviderOne Client Portal website](#):
 - ✓ Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.
 - ✓ Request a change online at [ProviderOne Contact Us](#) (this will generate an email to Apple Health Customer Service). Select the topic “Enroll/Change Health Plans.”

For online information, direct clients to HCA’s [Apple Health Managed Care](#) webpage.

Clients who are not enrolled in an agency-contracted managed care plan for physical health services

Some Medicaid clients do not meet the qualifications for managed care enrollment. These clients are eligible for services under the FFS Medicaid program. In this situation, each Integrated Managed Care (IMC) plan will have Behavioral Health Services Only (BHSO) plans available for Apple Health clients who are not in managed care. The BHSO covers only behavioral health treatment for those clients. Clients who are not enrolled in an agency-contracted managed care plan are automatically enrolled in a BHSO with the exception of American Indian/Alaska Native clients. Some examples of populations that may be exempt from enrolling into a managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption support and Foster Care alumni.

Integrated managed care

Clients qualified for managed care enrollment and living in integrated managed care (IMC) regions will receive all physical health services, mental health services, and substance use disorder treatment through their agency-contracted managed care organization (MCO).

American Indian/Alaska Native (AI/AN) clients have two options for Apple Health coverage:

- Apple Health Managed Care; or
- Apple Health coverage without a managed care plan (also referred to as fee-for-service [FSS]).

If a client does 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 [Apple Health managed care webpage](#) and scroll down to “Changes to Apple Health managed care.”

Integrated managed care regions

Clients residing in 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](#).

Region	Counties	Effective Date
Great Rivers	Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum	January 1, 2020
Salish	Clallam, Jefferson, Kitsap	January 1, 2020
Thurston-Mason	Thurston, Mason	January 1, 2020
North Sound	Island, San Juan, Skagit, Snohomish, and Whatcom	July 1, 2019
Greater Columbia	Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Yakima, and Whitman	January 1, 2019
King	King	January 1, 2019
Pierce	Pierce	January 1, 2019
Spokane	Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens counties	January 1, 2019
North Central	Grant, Chelan, Douglas, and Okanogan	January 1, 2018 January 1, 2019 (Okanogan)
Southwest	Clark, Skamania, and Klickitat	April 2016 January 1, 2019 (Klickitat)

Integrated Apple Health Foster Care (AHFC)

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 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.”

The Apple Health Customer Services staff can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact the agency's Foster Care Medical Team at 1-800-562-3022, Ext. 15480.

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 Services Organization (BHSO). 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 contact 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:

Medical Problems	ICD Diagnosis Codes
Ocular Albinism	Use the appropriate ICD-10 code for the medical condition that allows the client to receive plastic photochromatic lenses
Retinitis pigmentosa	

Polycarbonate lenses

(WAC 182-544-0350 (3)(c))

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

Medical Problems	ICD Diagnosis Codes
Amblyopia	Use the appropriate ICD-10 code for the medical condition that allows the client to receive polycarbonate lenses
Attention deficit hyperactivity disorder (ADHD)	
Autism	
Bipolar	
Blind in one eye and needs protections for the other eye, regardless of whether a vision correction is required	
Cerebral palsy	
Developmental delay	
Down Syndrome	
Infants and toddlers with motor ataxia	
Multiple sclerosis	
Schizophrenia	
Seizure disorder	
Strabismus	

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:

Medical Problems	ICD Diagnosis Codes
Blindness	Use the appropriate ICD-10 code for the medical condition that allows the client to receive tinted plastic lenses
Chronic corneal keratitis	
Chronic iritis, iridocyclitis (uveitis)	
Diabetic retinopathy	
Fixed pupil	
Glare from cataracts	
Macular degeneration	
Migraine disorder	
Ocular albinism	
Optic atrophy and/or optic neuritis	
Rare photo-induced epilepsy conditions	
Retinitis pigmentosa	

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.

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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

Medical Problems	ICD Diagnosis Code
Hypermetropia	Use the appropriate ICD-10 code for the medical condition that allows the client to receive contact lenses
Myopia	

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.

Medical Problems	ICD Diagnosis Code
Astigmatism	Use the appropriate ICD-10 code for the medical condition that allows the client to receive soft toric contact lenses

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.

Medical Problems	ICD Diagnosis Code
High anisometropia	Use the appropriate ICD-10 code for the medical condition that allows the client to receive contact lenses

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

Medical Problems	ICD Diagnosis Code
Aphakia	Use the appropriate ICD-10 code for the medical condition that allows the client to receive specialty contact lenses
Keratoconus	
Corneal softening	

- 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)

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- 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.

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

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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CPT Code	Modifier	Short Description	PA?	Policy/ Comments	Maximum Allowable Fee
General Ophthalmological Services					
92002		Eye exam, new patient	No		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		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	Requires PA/EPA	
92065	TC	Orthoptic/pleoptic training	Yes	Requires PA/EPA	
92065	26	Orthoptic/pleoptic training	Yes	Requires PA/EPA	
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		

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

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CPT Code	Modifier	Short Description	PA?	Policy/ Comments	Maximum Allowable Fee
92083		Visual field examination(s)	No		Fee Schedules*
92083	TC	Visual field examination(s)	No		
92083	26	Visual field examination(s)	No		
92100		Serial tonometry exam(s)	No		
92132		Cptr ophth dx img ant segment, uni or bilat			
92133		Cptr ophth dx img post segment, uni or bilat			
92134		Cptr ophth dx img post segment	Yes	PA or EPA required Limited to 12 per calendar year. EPA#870000051 See Physician-Related Health Care Services Billing Guide.	
92135		Ophthalmic dx imaging	No		
92136		Ophthalmic biometry	No		
92136	TC	Ophthalmic biometry	No		
92136	26	Ophthalmic biometry	No		

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

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CPT Code	Modifier	Short Description	PA?	Policy/ Comments	Maximum Allowable Fee
Ophthalmoscopy					
92225		Special eye exam, initial	No		<u>Fee Schedules*</u>
92226		Special eye exam, subsequent	No		
92230		Eye exam with photos	No	A report is required with image.	
92235		Eye exam with photos	No	A report is required with image.	
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	A report is required with image. Code not covered for routine eye exams.	
92250	TC	Eye exam with photos	No	A report is required with image. Code not covered for routine eye exams.	
92250	26	Eye exam with photos	No	A report is required with image. Code not covered for routine eye exams.	
92260		Ophthalmoscopy/ dynamometry	No		

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

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CPT Code	Modifier	Short Description	PA?	Policy/ Comments	Maximum Allowable Fee
Other Specialized Services					
92265		Eye muscle evaluation	No		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		

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

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CPT Code	Modifier	Short Description	PA?	Policy/ Comments	Maximum Allowable Fee
Contact Lens Services					
92310		Contact lens fitting	No		Fee Schedules*
92311		Contact lens fitting	No		
92312		Contact lens fitting	No		
92313		Contact lens fitting	No		
CPT Code	Modifier	Short Description	PA?	Policy/ Comments	Maximum Allowable Fee
Contact Lens Services					
92314		Prescription of contact lens	No		Fee Schedules
92315		Prescription of contact lens	No		
92316		Prescription of contact lens	No		
92317		Prescription of contact lens	No		
HCPCS Code	Modifier	Short Description	PA?	Policy/ Comments	Maximum Allowable Fee
Ocular Prosthesis					
L8610		Ocular implant	No	Available for clients age 21 and older	See the Outpatient Hospital Fee Schedules

*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 [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 webpage](#)) or by submitting the request in writing on:

- A completed *General Information for Authorization* form, HCA [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, HCA [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, HCA [13-739](#), **AND** *General Information for Authorization* form, HCA [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

Frame type	EPA Code	Criteria
Durable Frames	870000619	<ul style="list-style-type: none"> • 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	<p>When the provider documents one of the following in the client’s record:</p> <ul style="list-style-type: none"> • 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

Reason for replacement / lense type	EPA Code	Criteria
Replacement due to eye surgery/effects of prescribed medication/diseases affecting vision	870000622	<p>Within one year of last dispensing when:</p> <ul style="list-style-type: none"> • 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. • Lost or broken lenses

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Reason for replacement / lense type	EPA Code	Criteria
Replacement due to headaches/blurred vision/difficulty with school or work	870000624	<p>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:</p> <ul style="list-style-type: none"> • The client has symptoms e.g., headaches, blurred vision, difficulty with school or work. • Copy of current prescription • 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
High index eyeglass lenses	870000625	<p>When the provider documents one of the following in the client's record:</p> <ul style="list-style-type: none"> • A spherical refractive correction of +/- 6.0 diopters or greater • A cylinder correction of +/- 3.0 diopters or greater

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](https://www.wa.gov/govdocs/default.aspx?nid=13&tid=13&id=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.

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- 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.