Washington State Health Care Authority

Washington Apple Health (Medicaid)

Vision Hardware Program Billing Guide

(For clients age 20 and younger)

January 1, 2017

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, 2017, 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?

Subject	Change	Reason for Change
All	Fixed broken links, clarified language, etc.	Housekeeping
Where can I download agency forms?	Added a new section to help providers more easily find the agency's forms on the new web page.	Clarification
Fee-for-service clients with other primary health insurance to be enrolled into managed care	Added a new section regarding additional changes for some fee-for-service clients.	Policy Change

*This publication is a billing instruction.

How can I get agency provider documents?

To access provider alerts, go to the agency's provider alerts web page.

To access provider documents, go to the agency's provider billing guides and fee schedules web page.

Where can I download agency forms?

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

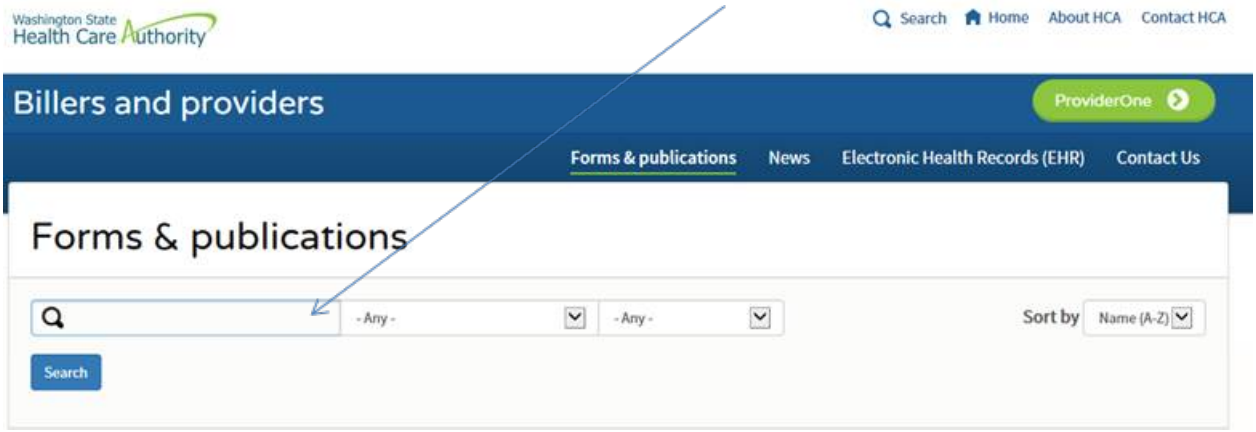

Table of Contents

Alert! This Table of Contents is automated. Click on a page number to go directly to the page.

Alert! This Table of Contents is automated. Click on a page number to go directly to the page.

Resources Available

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See the agency's ProviderOne Resources web page
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?	Order hardware from the agency's contractor: **CI Optical** 11919 West Sprague Avenue PO Box 1959 Airway Heights, WA 99001-1959 Customer Service Phone 888-606-7788 (toll free) Fax: 888-606-7789 (toll free)
Who do I contact if I have a client who needs low vision aids?	**Community Services for the Blind and Partially Sighted (Seattle)** Phone: 800-458-4888 (toll free) **Lilac Blind Foundation (Spokane)** Phone: 800-422-7893 (toll free)
How do I obtain prior authorization (PA) or a limitation extension (LE)?	For all PA or LE requests, the following documentation is **Required**: • A completed, TYPED *General Information for Authorization* form, HCA 13-835. This request form MUST be the initial page when you submit your request. • A completed *Vision Care Limitation Extension* form, HCA 13-739, and all the documentation listed on this form and any other medical justification. Fax your request to: 866-668-1214. See the agency's ProviderOne Resources web page. For information about downloading agency forms, see Where can I download agency forms?

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)

This billing guide applies 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 Coverage. 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 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 Coverage.

- The agency requires PA for covered vision hardware when the clinical criteria found in Coverage 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 written 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 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 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.

How can I verify a patient's eligibility?

Providers must verify that a patient has Washington 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 Washington Apple Health.** For detailed instructions on verifying a patient's eligibility for Washington Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's current ProviderOne Billing and Resource Guide.

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

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

Note: Patients who wish to apply for Washington Apple Health can do so 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.

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.

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, 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.

Effective January 1, 2017, some fee-for-service clients who have other primary health insurance will be enrolled into managed care

On January 1, 2017, the agency enrolled some fee-for-service Apple Health clients who have other primary health insurance into an agency-contracted managed care organization (MCO).

This change did not affect all fee-for-service Apple Health clients who have other primary health insurance. The agency continues to cover some clients under the fee-for-service Apple Health program, such as dual-eligible clients whose primary insurance is Medicare.

For additional information, see the agency's Managed Care web site, under Providers and Billers.

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 agency's 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) and repairs

(WAC 182-544-0300 (1))

The agency covers eyeglasses without prior authorization (PA) once every 12 months 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

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, without PA. In this case, the limitations listed in Eyeglasses (Frames and Lenses) and repairs 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.

Durable or flexible frames

(WAC 182-544-0325 (1))

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

- Follow the agency's expedited prior authorization (EPA) process. See **EPA# 870000619 and EPA# 870000620** in Authorization
- Order the **durable** or **flexible** frames through the agency's designated supplier

The agency covers flexible frames for eligible clients when the provider documents one of the following in the client's record:

- The client has a diagnosed medical condition that has contributed to two or more broken eyeglass frames in a 12-month period.
- Reasons that the standard CI Optical frame is not suitable for the client.

To receive payment, providers must follow the agency's EPA process. See **EPA# 870000620** in Authorization.

Coating of frames, incidental repairs, and replacement frames

(WAC 182-544-0325 (2))

The agency covers, without PA:

- 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.
- Incidental repairs to a client's eyeglass frames. 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.
- Replacement eyeglass frames that have been lost or broken. Provider must document the reason for replacement in the client file.

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

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

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

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

Note: 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 without PA 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
- 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 Authorization.

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

The agency covers plastic photochromatic lenses without PA. The eligible client's medical need must be diagnosed and documented as one of the following:

Medical Problems	ICD Diagnosis Codes
Ocular Albinism	See the agency's Approved Diagnosis Codes by Program web page for Physician-Related/Professional Services
Retinitis pigmentosa	

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

The agency covers polycarbonate lenses without prior authorization (PA). The eligible client's medical need must be diagnosed and documented as one of the following:

Medical Problems	ICD Diagnosis Codes
Amblyopia	See the agency's Approved Diagnosis Codes by Program web page for Physician-Related/Professional Services
Blind in one eye and needs protections for the other eye, regardless of whether a vision correction is required	
Infants and toddlers with motor ataxia	
Strabismus	

Replacement of bifocal or trifocal lenses
(WAC 182-544-0350 (3)(d))

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

- 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	See the agency's Approved Diagnosis Codes by Program web page for Physician-Related/Professional Services
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	

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

Lost or broken lenses

(WAC 182-544-0350 (5))

The agency covers replacement lenses without PA for eligible clients when the lenses are lost or broken.

Replacement lenses due to refractive change

(WAC 182-544-0350 (6))

The agency covers replacements lenses without prior authorization (PA) 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).

- **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 Authorization.

Contact lenses

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

The agency covers contact lenses, without prior authorization (PA), 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

Medical Problems	ICD Diagnosis Code
Hypermetropia	See the agency's Approved Diagnosis Codes by Program web page for Physician-Related/Professional Services
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, without prior authorization (PA), 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	See the agency's Approved Diagnosis Codes by Program web page for Physician-Related/Professional Services

Exceptions to the plus or minus 6.0 diopters criteria for contact lenses

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

- For 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	See the agency's Approved Diagnosis Codes by Program web page for Physician-Related/Professional Services

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

Medical Problems	ICD Diagnosis Code
Aphakia	See the agency's Approved Diagnosis Codes by Program web page for Physician-Related/Professional Services
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, without prior authorization (PA), 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.

CPT Code	Modifier	Short Description	PA?	Policy/ Comments	Maximum Allowable Fee
Contact Lens Services					
92071		Contact lens fitting for tx		1 fitting every 12 months –	Fee Schedules*
92072		Fit contac lens for managmnt		2 fittings every 12 months. Limited to diagnosis range 371.60 to 371.62	
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.

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.

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		
92120		Tonography & eye evaluation	No		
92130		Water provocation tonography	No		
92135		Opthalmic dx imaging	No		
92135	TC	Opthalmic dx imaging	No		
92135	26	Opthalmic dx imaging	No		
92136		Ophthalmic biometry	No		
92136	TC	Ophthalmic biometry	No		
92136	26	Ophthalmic biometry	No		
92140		Glaucoma provocative tests	No		

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

CPT Code	Modifier	Short Description	PA?	Policy/ Comments	Maximum Allowable Fee
Ophthalmoscopy					
92225		Special eye exam, initial	No		Fee Schedules*
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.

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.

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	Avaliable 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?

(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** written 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) and expedited prior authorization (EPA).
- The agency's authorization of a service does not necessarily guarantee payment.

What is prior authoriation?

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

What if my request exceeds the limitations in this billing guide?

(WAC 182-544-0560 (6))

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?

There are two ways to request a limitation extension (LE):

- Complete the *Vision Care Authorization Request* form**, 13-739.** This form is required for any vision hardware authorization request.

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

The written request must state the following:

✓ 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

Send your written request to the agency (see Resources Available).

D**ownload** 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 create an EPA number using those authorization codes.

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	When the provider documents in the client's record that the client has a diagnosed medical condition that has contributed to two or more broken eyeglass frames in a 12-month period.
Flexible Frames	870000620	When the provider documents one of the following in the client's record: • The client has a diagnosed medical condition that has contributed to two or more broken eyeglass frames in a 12-month period. • Reasons that the standard CI Optical frame is not suitable for the client.

Replacement Eyeglass Lenses

Reason for replacement / lense type	EPA Code	Criteria
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.

Reason for replacement / lense type	**EPA Code**	**Criteria**
Replacement due to headaches/blurred vision/difficulty with school or work	870000624	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: • 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	When the provider documents **one** of the following in the client's record: • 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 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

Effective for claims billed on and after October 1, 2016
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 web page, 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) web page.

Payment

(WAC 182-544-0600)

How much does the agency pay for vision care?

- 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.

- 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.