RULE-MAKING ORDER

CR-103P (May 2009)
(Implements RCW 34.05.360)

Agency: Health Care Authority, Washington Apple Health

Permanent Rule Only

Effective date of rule:

Permanent Rules

☒ 31 days after filing.

☐ Other (specify) _____ **(If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)**

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?

☐ Yes ☒ No If Yes, explain:

Purpose:

The agency is amending WAC 182-544-0325, Vision care – Covered eyeglass frames – Clients age twenty and younger, to remove the limitation for durable or flexible frames and add limitations for incidental repairs to eyeglass frames and replacement of lost or broken eyeglass frames. The agency is amending WAC 182-544-0350, Vision care – Covered eyeglass lenses – Clients age twenty and younger, to add limitations for lost or broken eyeglass lenses; add diagnosed medical conditions for coverage of polycarbonate lenses; and move subsections (3)(b) through (d) to subsection (1). The other sections of Chapter 182-544 WAC contain housekeeping changes and some clarifying language. WAC 182-531-1000, Ophthalmic services, contains housekeeping changes and adds clarifying language in regards to eye examinations.

Citation of existing rules affected by this order:

Repealed:

Amended: 182-531-1000; 182-544-0010, -0050, -0150, -0250, -0300, -0325, -0350, -0400, -0500, -0550, -0560, -0575, -0600

Suspended:

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 17-09-067 on April 18, 2017.

Describe any changes other than editing from proposed to adopted version: See attached.

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

Name: phone ( ) _____

Address: fax ( ) _____

e-mail _____

Date adopted: June 29, 2017

NAME (TYPE OR PRINT)
Wendy Barcus

SIGNATURE

TITLE
HCA Rules Coordinator

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: June 29, 2017
TIME: 1:50 PM

WSR 17-14-067

(COMPLETE REVERSE SIDE)

Note: If any category is left blank, it will be calculated as zero. No descriptive text.

Count by whole WAC sections only, from the WAC number through the history note. A section may be counted in more than one category.

The number of sections adopted in order to comply with:

Federal statute:	New	_____	Amended	_____	Repealed	_____
Federal rules or standards:	New	_____	Amended	_____	Repealed	_____
Recently enacted state statutes:	New	_____	Amended	_____	Repealed	_____

The number of sections adopted at the request of a nongovernmental entity:

New _____ Amended _____ Repealed _____

The number of sections adopted in the agency's own initiative:

New _____ Amended _____ Repealed _____

The number of sections adopted in order to clarify, streamline, or reform agency procedures:

New _____ Amended 14 Repealed _____

The number of sections adopted using:

Negotiated rule making:	New	_____	Amended	_____	Repealed	_____
Pilot rule making:	New	_____	Amended	_____	Repealed	_____
Other alternative rule making:	New	_____	Amended	14	Repealed	_____

WAC 182-531-1000(2)
Removed reference to limitation extension:

(2) The agency ~~considers requests for a limitation extension for~~ covers additional eye examinations and refraction services ~~outside the limitations described in subsection (1) of this section~~ when:

WAC 182-544-0010(4)
Added reference to WAC 182-500-0070:

(4) The agency evaluates requests for covered services that do not meet clinical criteria based on the definition of medical necessity in WAC 182-500-0070 and the process ~~found~~ in WAC 182-501-0165.

WAC 182-544-0325(1)
Removed limitation:

(1) The medicaid agency covers durable or flexible frames when the client has a diagnosed medical condition that ~~has contributed to two or more~~ contributes to broken eyeglass frames ~~in a twelve-month period~~.

WAC 182-544-0575
Added subsection (3) regarding the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program:

(3) When a noncovered service is recommended based on the early and periodic screening, diagnosis, and treatment (EPSDT) program, the agency evaluates the request for medical necessity based on the definition in WAC 182-500-0070 and the process in WAC 182-501-0165.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-531-1000 Ophthalmic services. Refer to chapter ((~~388-544~~)) 182-544 WAC for vision-related hardware coverage ((~~for clients twenty years of age and younger~~)).

(1) The ((~~department covers, without prior authorization,~~)) medicaid agency covers eye examinations, refraction and fitting services ((~~with the following limitations~~)). The agency pays for these services without prior authorization as follows:

(a) Once every twenty-four months for asymptomatic clients age twenty-one ((~~years of age~~)) and older;

(b) Once every twelve months for asymptomatic clients age twenty ((~~years of age~~)) and younger; or

(c) Once every twelve months, regardless of age, for asymptomatic clients of the division of developmental disabilities.

(2) The ((~~department~~)) agency covers additional eye examinations and refraction services ((~~outside the limitations described in subsection (1) of this section~~)) when:

(a) The provider is diagnosing or treating the client for a medical condition that has symptoms of vision problems or disease;

(b) The client is on medication that affects vision; or

(c) ((~~The service~~)) An eye examination or refraction is necessary due to lost or broken ((~~eyeglasses/contacts~~)) eyeglasses or contacts. In this case:

(i) No type of authorization is required for clients age twenty ((~~years of age~~)) or younger or for clients of the division of developmental disabilities, regardless of age.

(ii) Providers must follow the ((~~department's~~)) agency's expedited prior authorization process to receive payment for clients age twenty-one ((~~years of age~~)) or older. Providers must also document the following in the client's file:

(A) The eyeglasses or contacts are lost or broken; and

(B) The last examination was at least eighteen months ago.

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

(a) The extent of the testing;

(b) Why the testing was reasonable and necessary for the client; and

(c) The medical basis for the frequency of testing.

(4) The ((~~department~~)) agency covers orthoptics and vision training therapy. Providers must obtain prior authorization from the ((~~department~~)) agency.

(5) The ((~~department~~)) agency covers ocular prosthetics for clients when provided by any of the following:

(a) An ophthalmologist;

(b) An ocularist; or

(c) An optometrist who specializes in prosthetics.

(6) The ((~~department~~)) agency covers cataract surgery, without prior authorization when the following clinical criteria are met:

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

(b) One or more of the following conditions:

(i) Dislocated or subluxated lens;

(ii) Intraocular foreign body;

(iii) Ocular trauma;
(iv) Phacogenic glaucoma;
(v) Phacogenic uveitis;
(vi) Phacoanaphylactic endopthalmitis; or
(vii) Increased ocular pressure in a person who is blind and is experiencing ocular pain.

(7) The ((~~department~~)) agency covers strabismus surgery as follows:

(a) For clients age seventeen ((~~years of age~~)) and younger. The provider must clearly document the need in the client's record. The ((~~department~~)) agency does not require authorization for clients age seventeen ((~~years of age~~)) and younger; and

(b) For clients age eighteen ((~~years of age~~)) and older, when the clinical criteria are met. To receive payment, providers must follow the expedited prior authorization process. The clinical criteria are:

(i) The client has double vision; and
(ii) The surgery is not being performed for cosmetic reasons.

(8) The ((~~department~~)) agency covers blepharoplasty or blepharoptosis surgery for clients when all of the clinical criteria are met. To receive payment, providers must follow the ((~~department's~~)) agency's expedited prior authorization process. The clinical criteria are:

(a) The client's excess upper eyelid skin is blocking the superior visual field; and

(b) The blocked vision is within ten degrees of central fixation using a central visual field test.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-544-0010 Vision care—General. (1) The ((~~department~~)) medicaid agency covers the vision care services listed in this chapter for clients age twenty and younger, according to ((~~department~~)) agency rules and subject to the limitations and requirements in this chapter. The ((~~department~~)) agency pays for vision care when it is:

(a) Covered;

(b) Within the scope of the ((~~eligible~~)) client's ((~~medical care program~~)) benefit package;

(c) Medically necessary as defined in WAC ((~~388-500-0005~~)) 182-500-0070;

(d) Authorized, as required within this chapter, chapter((~~s 388-501 and 388-502~~)) 182-501 WAC, and the ((~~department's~~)) agency's published billing instructions ((~~and numbered memoranda~~)); and

(e) Billed according to this chapter, chapters ((~~388-501 and 388-502~~)) 182-501 and 182-502 WAC, and the ((~~department's~~)) agency's published billing instructions ((~~and numbered memoranda~~)).

(2) The ((~~department~~)) agency does not require prior authorization for covered vision care services that meet the clinical criteria set forth in this chapter.

(3) The ((~~department~~)) agency requires prior authorization for covered vision care services when the clinical criteria set forth in this chapter are not met, including the criteria associated with the expedited prior authorization process.

(4) The ((~~department~~)) agency evaluates ((~~these~~)) requests ((~~on a case-by-case basis to determine whether they are medically necessary, according to~~)) for covered services that do not meet clinical criteria based on the definition of medical necessity in WAC 182-500-0070 and the process ((~~found~~)) in WAC ((~~388-501-0165~~)) 182-501-0165.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-544-0050 Vision care—Definitions. The following definitions and those found in chapter 182-500 WAC ((~~388-500-0005~~)) apply to this chapter. Unless otherwise defined in this chapter, medical terms are used as commonly defined within the scope of professional medical practice in the state of Washington.

"Blindness" - A diagnosis of visual acuity for distance vision of twenty/two hundred 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 twenty degrees from central.

"Conventional soft contact lenses" or **"rigid gas permeable contact lenses"** - FDA-approved contact lenses that do not have a scheduled replacement (discard and replace with new contacts) plan. The soft lenses usually last one year, and the rigid gas permeable lenses usually last two years. Although some of these lenses are designed for extended wear, the ((~~department~~)) medicaid agency generally approves only those lenses that are designed to be worn as daily wear (remove at night).

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

"Expedited prior authorization" - A form of authorization used by the provider to certify that the ((~~department-published~~)) agency-published clinical criteria for a specific vision care service(s) have been met.

"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 contact lenses or disposable contact lenses designed to be worn for several days and nights before removal.

"Hardware" - Eyeglass frames and lenses and contact lenses.

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

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

"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.

"Visual field exams 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.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-544-0150 Vision care—Provider requirements. (1) Enrolled/contracted eye care providers must:

(a) Meet the requirements in chapter ((~~388-502~~)) 182-502 WAC;

(b) Provide only those services that are within the scope of the provider's license;

(c) Obtain all hardware (including the tinting of eyeglass lenses) and contact lenses for clients from the ((~~department's~~)) medicaid agency's designated supplier as published in the ((~~department's~~)) agency's current vision care billing instructions; and

(d) Return all unclaimed hardware and contact lenses to the ((~~department's~~)) agency's designated supplier using a postage-paid envelope furnished by the supplier.

(2) The following providers are ((~~eligible~~)) to enroll/contract with the ((~~department~~)) agency to provide and bill for vision care services furnished to ((~~eligible~~)) clients:

(a) Ophthalmologists;

(b) Optometrists;

(c) Opticians; and

(d) Ocularists.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-544-0250 Vision care—Covered eye services (examinations, refractions, visual field testing, and vision therapy). See WAC ((~~388-531-1000~~)) 182-531-1000 Ophthalmic services.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-544-0300 Vision care—Covered eyeglasses (frames ((~~and/or~~)) and lenses) ((~~and repair~~))—Clients age twenty ((~~years of age~~)) and younger. ((~~This section applies to eligible clients who are twenty years of age and younger.~~))

(1) The ((~~department~~)) medicaid agency covers eyeglasses((~~, without prior authorization,~~)) once every twelve months for ((~~eligible~~)) clients when the following clinical criteria are met:

(a) The ((~~eligible~~)) client has a stable visual condition;

(b) The ((~~eligible~~)) client's treatment is stabilized;

(c) The prescription is less than eighteen months old; and

(d) One of the following minimum correction needs in at least one eye is documented in the client's file:

(i) Sphere power equal to, or greater than, plus or minus 0.50 diopter;

(ii) Astigmatism power equal to, or greater than, plus or minus 0.50 diopter; or

(iii) Add power equal to, or greater than, 1.0 diopter for bifocals and trifocals.

(2) ((~~The department covers eyeglasses (frames/lenses), for eligible clients with~~)) If the client has a diagnosis of accommodative esotropia or any strabismus correction((~~, without prior authorization. In this case~~)), the limitations of subsection (1) of this section do not apply.

(3) The ((~~department~~)) agency covers one pair of back-up eyeglasses for ((~~eligible~~)) clients who wear contact lenses as their primary visual correction aid (see WAC ((~~388-544-0400~~)) 182-544-0400(1)) limited to once every two years ((~~for eligible clients twenty years of age or younger~~)).

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-544-0325 Vision care—Covered eyeglass frames and repairs—Clients age twenty ((years of age)) and younger. ((This section applies to eligible clients who are twenty years of age and younger.))

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

(a) Follow the department's expedited prior authorization process; and

(b))) order the "durable" or "flexible" frames through the ((department's)) agency's designated supplier.

(2) The ((department)) agency covers all of the following for ((eligible)) clients ((without prior authorization)):

(a) 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.

(b) Four incidental repairs to a client's eyeglass frames in a calendar year. To receive payment, all of the following must be met:

(i) The provider typically charges the general public for the repair or adjustment;

(ii) The contractor's one year warranty period has expired; and

(iii) The cost of the repair does not exceed the ((department's)) agency's cost for replacement frames and a fitting fee.

(c) Up to two replacement eyeglass frames ((that)) in a calendar year when the eyeglass frames have been lost or broken. Lost or broken eyeglass frames must be documented in the client's medical record.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-544-0350 Vision care—Covered eyeglass lenses—Clients age twenty ((years of age)) and younger. ((This section applies to eligible clients who are twenty years of age and younger.))

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

(a) Single vision lenses;

(b) Round or flat top D-style bifocals;

(c) Flat top trifocals; ((and))

(d) Slab-off and prism lenses (including Fresnel lenses);

(e) Plastic photochromatic lenses when the client's medical need is diagnosed and documented as ocular albinism or retinitis pigmentosa;

(f) Polycarbonate lenses when the client's medical need is diagnosed and documented as one of the following:

(i) Blind in one eye and needs protection for the other eye, regardless of whether a vision correction is required;

(ii) Infants and toddlers with motor ataxia;

(iii) Strabismus or amblyopia;

(iv) Seizure disorder, cerebral palsy, autism, attention deficit hyperactivity disorder (ADHD), developmental delay, Down syndrome, bipolar, schizophrenia, or multiple sclerosis.

(g) Bifocal lenses to be replaced with single vision or trifocal lenses, or trifocal lenses to be replaced with bifocal or single vision lenses when:

(i) The client has attempted to adjust to the bifocals or trifocals for at least sixty days;

(ii) The client is unable to make the adjustment; and

(iii) The trifocal lenses being replaced are returned to the provider.

(2) Eyeglass lenses((~~, as described in~~)) covered under subsection (1) of this section must be placed into a frame that is, or was, purchased by the ((~~department~~)) agency.

(3) The ((~~department covers, without prior authorization,~~)) agency covers the following high index lenses for ((~~eligible~~)) clients when ((~~the~~)) clinical criteria are met((~~:~~

~~(a) High index lenses. Providers must follow the department's expedited prior authorization process~~)). The ((~~eligible~~)) client's medical need in at least one eye must be diagnosed and documented as:

((~~(i)~~)) (a) A spherical refractive correction of plus or minus six diopters or greater; or

((~~(ii)~~)) (b) A cylinder correction of plus or minus three diopters or greater.

((~~(b) Plastic photochromatic lenses. The eligible client's medical need must be diagnosed and documented as ocular albinism or retinitis pigmentosa.~~

~~(c) Polycarbonate lenses. The eligible client's medical need must be diagnosed and documented as one of the following:~~

~~(i) Blind in one eye and needs protection for the other eye, regardless of whether a vision correction is required;~~

~~(ii) Infants and toddlers with motor ataxia;~~

~~(iii) Strabismus or amblyopia.~~

~~(d) Bifocal lenses to be replaced with single vision or trifocal lenses, or trifocal lenses to be replaced with bifocal or single vision lenses when:~~

~~(i) The eligible client has attempted to adjust to the bifocals or trifocals for at least sixty days; and~~

~~(ii) The eligible client is unable to make the adjustment; and~~

~~(iii) The trifocal lenses being replaced are returned to the provider.~~))

(4) The ((~~department covers, without prior authorization,~~)) agency covers the tinting of plastic lenses when the ((~~eligible~~)) client's medical need is diagnosed and documented as one or more of the following chronic (expected to last longer than three months) eye conditions causing photophobia:

(a) Blindness;
(b) Chronic corneal keratitis;
(c) Chronic iritis, iridocyclitis;
(d) Diabetic retinopathy;
(e) Fixed pupil;
(f) Glare from cataracts;
(g) Macular degeneration;
(h) Migraine disorder;
(i) Ocular albinism;
(j) Optic atrophy ((~~and/or~~)) or optic neuritis;

(k) Rare photo-induced epilepsy conditions; or

(l) Retinitis pigmentosa.

(5) The ((~~department~~)) agency covers up to four replacement lenses ((~~for eligible clients without prior authorization~~)) in a calendar year when the lenses are lost or broken. Lost or broken lenses must be documented in the client's medical record.

(6) The ((~~department~~)) agency covers replacement lenses((~~, without prior authorization,~~)) when the ((~~eligible~~)) client meets one of the following clinical criteria((~~. To receive payment, providers must follow the expedited prior authorization process. The clinical criteria are~~)):

(a) Eye surgery or the effects of prescribed medication or one or more diseases affecting vision:

(i) The client has a stable visual condition;

(ii) The client's treatment is stabilized;

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

(iv) The previous and new refraction are documented in the client's medical record.

(b) Headaches, blurred vision, or visual difficulty in school or at work. In this case, all of the following must be documented in the client's ((~~file~~)) medical record:

(i) Copy of current prescription (less than eighteen months old);

(ii) Date of last dispensing, if known;

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

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

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-544-0400 Vision care—Covered contact lenses—Clients age twenty ((~~years of age~~)) and younger. ((~~This section applies to eligible clients who are twenty years of age and younger.~~))

(1) The ((~~department~~)) medicaid agency covers contact lenses((~~, without prior authorization,~~)) as the ((~~eligible~~)) client's primary refractive correction method when the ((~~eligible~~)) client has a spherical correction of plus or minus 6.0 diopters or greater in at least one eye. See subsection (4) of this section for exceptions to the plus or minus 6.0 diopter criteria. The spherical correction may be from the prescription for the glasses or the contact lenses and may be written in either "minus cyl" or "plus cyl" form.

(2) The ((~~department~~)) agency covers the following contact lenses ((~~with limitations~~)):

(a) Conventional soft contact lenses or rigid gas permeable contact lenses that are prescribed for daily wear; or

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

(i) Twelve pairs of monthly replacement contact lenses; or

(ii) Four pairs of three-month replacement contact lenses.

(3) The ((~~department~~)) agency covers soft toric contact lenses((~~, without prior authorization,~~)) for ((~~eligible~~)) clients with astigmatism when the following clinical criteria are met:

(a) The ((~~eligible~~)) client's cylinder correction is plus or minus 1.0 diopter in at least one eye; and

(b) The ((~~eligible~~)) client meets the spherical correction listed in subsection (1) of this section.

(4) The ((~~department~~)) agency covers contact lenses((~~, without prior authorization,~~)) when the following clinical criteria are met. In these cases, the limitations in subsection (1) of this section do not apply.

(a) For ((~~eligible~~)) clients diagnosed with high anisometropia.

(i) The ((~~eligible~~)) client's refractive error difference between the two eyes is at least plus or minus 3.0 diopters between the sphere or cylinder correction; and

(ii) Eyeglasses cannot reasonably correct the refractive errors.

(b) Specialty contact lens designs for ((~~eligible~~)) clients who are diagnosed with one or more of the following:

(i) Aphakia;

(ii) Keratoconus; or

(iii) Corneal softening.

(c) Therapeutic contact bandage lenses only when needed immediately after eye injury or eye surgery.

(5) The ((~~department~~)) agency covers replacement contact lenses for ((~~eligible~~)) clients when lost or damaged.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-544-0500 Vision care—Covered ocular prosthetics. See WAC ((~~388-531-1000~~)) 182-531-1000 Opthalmic services.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-544-0560 Vision care—Authorization. (1) The ((~~department~~)) medicaid agency requires providers to obtain authorization for covered vision care services as required in this chapter((~~, chapters 388-501 and 388-502 WAC, and in published department billing instructions and/or numbered memoranda or when the clinical criteria required in this chapter are not met~~)).

(a) For prior authorization (PA), a provider must submit a written request to the ((~~department~~)) agency as specified in the ((~~department's~~)) agency's published vision care billing instructions.

(b) For expedited prior authorization (EPA), a provider must meet the clinically appropriate EPA criteria outlined in the ((~~department's~~)) agency's published vision care billing instructions. The appropriate EPA number must be used when the provider bills the ((~~department~~)) agency.

(c) Upon request, a provider must provide documentation to the ((~~department~~)) agency showing how the client's condition met the criteria for PA or EPA.

(2) Authorization requirements in this chapter are not a denial of service.

(3) When a service requires authorization, the provider must properly request authorization in accordance with the ((~~department's~~)) agency's rules((~~,~~)) and billing instructions((~~, and numbered memoranda~~)).

(4) When authorization is not properly requested, the ((~~department~~)) agency rejects and returns the request to the provider for further action. The ((~~department~~)) agency does not consider the rejection of the request to be a denial of service.

(5) The ((~~department's~~)) agency's authorization of service(s) does not necessarily guarantee payment.

(6) The ((~~department~~)) agency evaluates requests for authorization of covered vision care services that exceed limitations in this chapter on a case-by-case basis in accordance with WAC ((~~388-501-0169~~)) 182-501-0169.

(7) The ((~~department~~)) agency may recoup any payment made to a provider if the ((~~department~~)) agency later determines that the service was not properly authorized or did not meet the EPA criteria. Refer to WAC ((~~388-502-0100 (1)(c)~~)) 182-502-0100.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-544-0575 Vision care—Noncovered eyeglasses and contact lenses. (1) The ((~~department~~)) agency does not cover the following:

(a) Executive style eyeglass lenses;

(b) Bifocal contact lenses;

(c) Daily and two week disposable contact lenses;

(d) Extended wear soft contact lenses, except when used as therapeutic contact bandage lenses or for aphakic clients;

(e) Custom colored contact lenses;

(f) Glass lenses;

(g) Nonglare or anti-reflective lenses;

(h) Progressive lenses;

(i) Sunglasses and accessories that function as sunglasses (e.g., "clip-ons");

(j) Upgrades at private expense to avoid the ((~~department's~~)) medicaid agency's contract limitations (e.g., frames that are not available through the ((~~department's~~)) agency's contract or noncontract frames or lenses for which the client or other person pays the difference between the ((~~department's~~)) agency's payment and the total cost).

(2) A noncovered service may be requested as an exception to rule (ETR)((~~,~~)) as described in WAC ((~~388-501-0160, may be requested for a noncovered service~~)) 182-501-0160.

(3) When a noncovered service is recommended based on the early and periodic screening, diagnosis, and treatment (EPSDT) program, the agency evaluates the request for medical necessity based on the definition in WAC 182-500-0070 and the process in WAC 182-501-0165.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-544-0600 Vision care—Payment methodology. (1) To receive payment, vision care providers must bill the ((~~department~~)) agency according to this chapter, chapters ((~~388-501 and 388-502~~)) 182-501 and 182-502 WAC, and the ((~~department's~~)) medicaid agency's published billing instructions and numbered memoranda.

(2) The ((~~department~~)) agency pays one hundred percent of the ((~~department~~)) agency contract price for covered eyeglass frames, lenses, and contact lenses when these items are obtained through the ((~~department's~~)) agency's approved contractor.

(3) See WAC ((~~388-531-1850~~)) 182-531-1850 for professional fee payment methodology.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-544-0550 Vision care—Covered eye surgery. See WAC ((~~388-531-1000 Opthalmic~~)) 182-531-1000 Ophthalmic services.